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# 2022 Behavioral Health Workforce Assessment:

A report of the Behavioral Health  
Workforce Advisory Committee

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**WASHINGTON** Workforce  
Training & Education Coordinating  
**Board**

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## 2022 Behavioral Health Workforce Assessment: A report of the Behavioral Health Workforce Advisory Committee

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Behavioral/Mental Health, Substance Use Disorder Clinics and Residential Treatment Facilities. WA Health Workforce Sentinel Network. Fall, 2022. University of Washington Center for Health Workforce Studies and Washington Workforce Training and Education Coordinating Board.

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# Executive Summary

## Introduction

Although Washington's COVID-19 pandemic state of emergency has ended, the effects of the pandemic continue to reverberate through the behavioral health workforce. Prior to March 2020, the state was already experiencing the challenges of ensuring a workforce sufficient to serve the behavioral health needs of Washington's residents. Throughout the ongoing pandemic, the need for behavioral health services, defined in this report as mental health and substance use disorder (SUD) treatment, has continued to grow. The number of children and teens needing behavioral health services, particularly crisis services, has remained higher than was typical before the pandemic.<sup>1</sup> Deaths from drug overdoses have continued to increase for all ages of Washington residents, with a 66 percent increase in deaths in 2021 compared to 2019.<sup>2</sup>

The Workforce Training and Education Coordinating Board (Workforce Board) has led efforts to **address recruitment and retention of the behavioral health workforce since 2016**. The Behavioral Health Workforce Advisory Committee (BHWAC), a group of stakeholders convened by the Workforce Board since 2016 and formalized by the Legislature in 2021, includes health facility leaders, behavioral health providers, educators, organized labor, not-for-profit organizations, state, tribal, and local government agencies, and many more. The Workforce Board has produced this report, as charged in the 2021 state budget, to assess the progress of recommendations from the Workforce Board's previous assessments and update actionable policy recommendations. The Workforce Board contracted with Halcyon Northwest, LLC to assist with collecting feedback from stakeholders, analyzing data, and supporting the development of the final report.

In the course of completing this project, the BHWAC found the existing behavioral health workforce encompasses many highly competent, committed professionals working hard to deliver behavioral health services, but barriers to educational attainment needed to enter or advance in the field, along with recruitment and retention challenges, hamper the state's ability to meet the behavioral healthcare needs of its residents. While the majority of this project was retrospective with the goal of understanding the status of prior recommendations, there was much learned, and each section contains future considerations to advance the work. Looking forward, the state should focus on rebuilding lost capacity, supporting retention of the existing workforce, and making key improvements to better recruit and educate the future workforce.

## Executive Summary of Findings

To organize all the work contained in reports since 2016, the Workforce Board and Halcyon Northwest Team sorted the existing recommendations into six broad categories. Some items can be categorized into multiple areas, such as licensing requirements affecting supervision, reimbursement impacting employee retention, or educational training influencing care integration. Where possible the report contains references to related items elsewhere in the report. This summary contains key themes from the report sections, and more details are available in the full chapters.

<sup>1</sup> Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19, Department of Health, Fourth Quarter Update — 2022

<sup>2</sup> Overdose Deaths in Washington top 2,000 in 2021 and continue to rise, Department of Health, April 12, 2022

## Recruitment and Retention

Healthcare workforce planning requires policymakers to pay attention to the underlying systemic, structural, and perception challenges that affect the ability to recruit and retain a sufficiently large and diverse workforce to provide needed behavioral health services statewide.

Washington has made significant investments in both 2021 and 2022, totaling \$131 million, to help provide relief and stabilization funds to community behavioral health providers. Appropriations have also gone to support recruitment and retention of behavioral health providers by providing loan repayment in return for working at approved behavioral health sites. Career Connect Washington is creating a health sector strategy to help connect K-12 students and adults aged 30 and under with career training, including for behavioral health professions. The Legislature funded a Health Care Authority task force to examine the impacts of background check processes on the behavioral health workforce. The task force found that background checks continue to affect the behavioral health workforce, and more comprehensive solutions than the Certificate of Restoration of Opportunity program, covered later in this report, may be needed to drive change given the complexity of the issue.

While most of the work in this report consists of reviews of past recommendations and updates about their status, BHWAC added one new topic, educational debt, because it is intertwined in many of the other issues in the report. Previous recommendations focused on the Washington Health Corps' Behavioral Health Program, which provides loan repayment awards to behavioral health clinicians in order to incentivize retention in facilities that serve low-income Washingtonians. The BHWAC expanded the recommendations to propose broadening the policy solutions beyond loan repayment. This new series of recommendations seeks to address the effects of education debt across the behavioral health workforce through implementation of a range of strategies from short-, middle-, and long-term. Loan repayment programs remain an important short-term strategy to help retain the current workforce through service obligations.

### **Short-term strategies: Increase funds appropriated to support for Washington Health Corps' Behavioral Health Program, increase program flexibility, and evaluate program outcomes.**

**Recommendation 1:** As a short-term strategy, the Legislature should appropriate additional funds to support behavioral health loan repayment awards to address immediate retention challenges within a variety of behavioral health settings.

**Recommendation 2:** Washington Student Achievement Council (WSAC) should work with its planning committee, participating sites, potential applicants, and awarded providers to ensure clear understanding that behavioral health loan repayment participants' hours worked in community settings, such as crisis response services, homeless shelters, supportive housing, street outreach, and families' homes, may count towards the required service obligation hours.

**Recommendation 3:** As part of supporting the investments made in loan repayment programs in Washington, the Legislature should appropriate funds to support administration of the Washington Health Corps and require an evaluation of program outcomes.

Washington also needs to expand strategies to address the prevalence and high level of educational debt that cannot be dealt with via loan repayment programs alone. The U.S. Department of Education's Public Service Loan Repayment Program offers a categorical pathway to significant debt relief for employees of eligible behavioral health employers — both government agencies and 501(c)3 nonprofits. However, receiving loan forgiveness is a complicated process, and workers need assistance navigating the necessary steps.

It's also important to acknowledge that the cost of higher education, particularly at the graduate level, likely deters some potential students entirely. Conditional scholarships, also known as conditional grants, provide financial assistance to a student in return for an agreement to work in a certain sector or employer upon graduation. Ballmer Group, a private philanthropy, has made a significant investment in conditional grants via a donation to the University of Washington (UW) School of Social Work. This investment will provide grants to master's level behavioral health students and is being carried out by 13 universities across Washington. Successful conditional grants could help Washington make strides towards greater diversity in the clinical behavioral health workforce.

**Middle and long-term strategies: Expand awareness of, and assistance with, the federal Public Service Loan Forgiveness program to increase participation by behavioral health workers working at eligible employers. Monitor the outcomes of the philanthropically funded conditional grant program and consider public investment in conditional grants for behavioral health.**

**Recommendation 4:** As a middle- and long-term strategy, policymakers should require eligible behavioral health employers to provide Public Service Loan Forgiveness educational materials and information about the Office of the Student Loan Advocate at WSAC when hiring a new employee, annually, and at the time of separation. Within already appropriated resources, the Office of the Student Loan Advocate should conduct outreach to eligible behavioral health employers and assess if additional staff members are warranted to serve demand.

**Recommendation 5:** As a middle- and long-term strategy, if the philanthropically funded conditional grant program demonstrates successful outcomes in training and retaining a diverse master's-level workforce for community behavioral health settings, the Legislature should provide funding to continue the program beginning in the 2025-26 biennial budget.

## *Reimbursement*

Successfully recruiting and retaining a skilled behavioral health workforce relies on key reimbursement elements that help ensure competitive salaries and adequate support for workforce development functions, such as training new clinicians. The Legislature funded a two percent rate increase for the Medicaid behavioral health program in 2021 and a seven percent directed increase on top of that in 2022. Unfortunately, this combined increase is not enough to counteract the effects of inflation on top of multi-generational underinvestment in the community behavioral health system. Low wages for behavioral health providers continue to affect recruitment and retention. Additional rate increases are necessary but the state also must adopt a longer-term strategy, such as implementation of an alternative payment model, in order to make sustainable progress on wages. In 2022, the BHWAC supports a new recommendation to continue the expansion of Certified Community Behavioral Health Clinics (CCBHCs) in Washington.

**Recommendation 6:** Provide continuation funding for planning and development of CCBHCs. Build on foundational work from FY2022 to develop a sustainable, prospective payment system for comprehensive community behavioral health services by refining the CCBHC model, pursuing federal demonstration state status, conducting related actuarial analysis, obtaining continued technical assistance from the National Council for Mental Wellbeing, and proposing a pathway for statewide implementation of CCBHCs.



There is strong interest in providing financial support to community behavioral health agencies for their role in providing training to the behavioral health workforce. Since work began in 2016, BHWAC has consistently requested additional support via a Medicaid-reimbursement mechanism for community behavioral health agencies' important role in training the future behavioral health workforce. Health Care Authority (HCA) is completing a report concerning implementation of teaching clinic standards and teaching clinic enhancement rates for behavioral health agencies. Ballmer Group is funding a Council for Behavioral Health demonstration project that provides financial support to behavioral health agencies to help with their training role. Those participating in the program are both students and clinicians who have completed their formal education and are paid employees working towards their independent clinical license.

## *Education and Training*

Educational and training capacity are components that influence who and how many individuals enter the behavioral health workforce. The behavioral health educational output is greatly affected by shortages of clinical training sites across professions. Prior recommendations focused on creating behavioral health registered apprenticeships, enabling behavioral health agencies to accept more students, and promote increased collaboration between universities/colleges and behavioral health clinics. Several noteworthy projects are underway to help support behavioral health sites with the cost of training and supervision as well as expanded pathways, such as registered apprenticeships.

Beginning in 2021, Ballmer Group made several significant investments in behavioral health training in Washington, including conditional grant support for 415 students in Washington pursuing counseling, social work, and marriage and family therapy master's degrees. Three behavioral health registered apprenticeships, behavioral technician, peer counselor, and substance use disorder professional, are approved, and two have begun training apprentices. UW is developing a bachelor's level behavioral health support specialist role with the goal of increasing access to behavioral health interventions in primary care and other behavioral health populations. Peer counselors continue to grow as part of the behavioral health workforce with support from the Legislature and HCA.

Yet, even with new investments and innovations, traditional barriers remain and have been exacerbated by the COVID-19 pandemic. For example, stakeholders involved in advanced practice nursing education said that finding clinical sites for psychiatric mental health nurse practitioner students, while always challenging, has become dramatically more difficult since the beginning of the pandemic.

## *Licensing*

The Workforce Board's Behavioral Health Workforce Assessments from 2016-2021 found that delays in the application process and extensive paperwork requirements were major frustrations for stakeholders, particularly for clinicians seeking Washington licensure who trained and practiced in other states.

Progress has been made on this front. In 2019, Washington passed legislation intending to streamline Washington licensure processes for experienced behavioral health clinicians licensed in other states. If a licensed mental health counselor, marriage and family therapy, social worker, substance use disorder professional, or psychologist comes from a state that has a substantially equivalent scope of practice, but the individual does not meet Washington's licensing requirements, that person can receive a probationary license. The probationary license allows the holder to legally practice in some types of facilities for two years while obtaining the relevant Washington requirements. Washington also passed the psychology compact (PsyPact) in 2022, which facilitates telemedicine and allows for 30 days of in-person practice. Additional compacts are gaining momentum for the counseling and social work professions.

Previous Workforce Board reports also found that there were not enough providers with dual training and certification in mental health SUD treatment to meet the need for services by patients with both mental health and SUD needs. The Department of Health's alternative training pathway for the substance use disorder professional (SUDP) certification, which streamlines the training requirements for individuals seeking the SUDP credential who already hold one of several other behavioral health licenses, is in use. HCA is currently reviewing the possibility of expanding the allowable provider types for SUD services, to include social workers and therapists as part of a state Medicaid plan amendment. HCA plans to begin external stakeholder review in early Winter 2023, with potential implementation either January or July of 2024.

### *Supervision*

Obtaining the post-graduate supervised practice hours required for licensure in many behavioral health professions remains a barrier to the development of this workforce in Washington. There is stakeholder interest in understanding why different professions with similar scopes of work require different numbers of post-graduate supervision hours and standardizing the requirements.

Stakeholders support policymakers forming a workgroup or taskforce to work towards a legislative proposal to address disparate supervision requirements and create greater alignment between the master's level behavioral health supervision requirements. Additionally, there is strong interest from the behavioral health stakeholders in aligning Washington's licensed independent clinical social worker supervision hours with the standard of 3,000 hours that has been drafted in the social worker compact under development.

Several projects are underway with public and private funding to support community behavioral health agencies with their teaching functions. Many stakeholders emphasize that interns should be paid. Interns are pre-graduate students completing required clinical training experiences in community settings.

### *Care Integration*

Washington has made some progress in integrating behavioral and physical healthcare throughout the past five years. Unfortunately, even with improved access to behavioral healthcare services at primary care providers and via telehealth, the demand for behavioral healthcare treatment continues to significantly exceed the availability of services throughout the state. The Partnership Access Lines (PALs) have received stable funding and are an important resource for primary care providers treating behavioral health conditions. HCA received funding for a 10-clinic behavioral health pediatric clinic integration project that is currently in the starting process. While work is underway to integrate behavioral health into primary care settings, fully integrating primary care services into community behavioral health agencies remains challenging.



# Report Development

## *Methods and Process*

Stakeholder engagement for the 2022 Behavioral Health Workforce Policy Review and BHWAC Recommendations began in early 2022, building on the work done for the preliminary report in 2021. The Halcyon Northwest team reviewed progress of recommendations and policy impact from 2016-2021 reports. Then, in partnership with the Workforce Board, they conducted stakeholder engagement meetings and interviews to identify and report on recent progress toward meeting recommendations, any barriers or challenges, priority topic areas, and recommendations for topic areas to be improved or changed.

## *Key Informant Interviews*

Between July and August 2022, the Halcyon Northwest team completed key informant interviews with 24 individuals, virtually, by phone, or email. Candidates for interviews were selected to represent a broad cross-section of occupations, behavioral health settings, and geographic areas across the state. A semi-structured interview guide addressed themes to guide stakeholder conversations. In preparation for the key stakeholder meetings, Halcyon Northwest asked interviewees about recent progress made in their respective areas of expertise. The list below includes a list of key informant organizations.

### **2022 Key Informant Interviews — Participant Organizations**

|  |  |
|--|--|
| Greater Health Now (formerly Greater Columbia Accountable Community of Health) | Washington State Allied Health Center of Excellence, Yakima Valley College |
| Kitsap Mental Health Services  | Washington State Board for Community and Technical Colleges                |
| Partners for Our Children (P4C)  | Washington State Department of Health                                      |
| SEIU Healthcare 1199NW Multi-Employer Training Fund                            | Washington State Health Care Authority                                     |
| UW Center for Health Workforce Studies   | Washington State House of Representatives                                  |
| UW School of Social Work   | Washington State Senate  |
| UW School of Medicine, Department of Psychiatry and Behavioral Sciences        | Washington State University  |
| Washington Council for Behavioral Health                                       | Washington Student Achievement Council                                     |

## *Listening Sessions — Stakeholder Feedback Meetings*

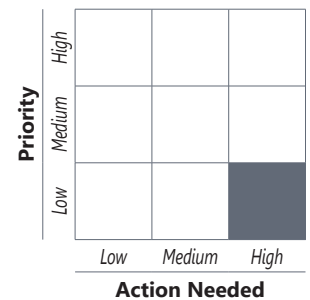
More than 300 stakeholders were invited to participate in seven feedback meetings between August and September 2022. These sessions, which built upon the key informant interviews and added to the knowledge already collected by the Project Team, were focused on identifying progress regarding recommendations from 2016-2021, based on the experience of those working in the behavioral healthcare environment.

The seven virtual feedback sessions hosted 105 stakeholders from a broad cross-section of healthcare stakeholders including providers, facilities, educational institutions, state and county agencies, tribes, labor organizations, and other settings with expertise in behavioral health. Each session focused on one topic area, such as licensure, supervision, etc. When the Workforce Board recognized educational debt as an area that needed additional recommendations, a focused feedback session was held with presenters from the Department of Health (DOH) and WSAC. Some stakeholders provided feedback over email. Participants provided updates regarding progress in the policy review, priorities, challenges, and improvements needed for each recommendation included in this report. The table on page 11 includes a list of participating stakeholders.

## Stakeholder Prioritization and Progress Assessment

Stakeholder feedback meetings included polls for each recommendation, in which stakeholders were asked to rank each recommendation on a scale of one to five to further identify information regarding priority, progress, or actions related to the recommendation. The polls included an “I don’t know” option so that the data would reflect the feedback of informed stakeholders.

Halcyon staff subsequently reviewed the stakeholder responses to these polling questions. The data from their responses were used to develop the priority and action grids seen in the chapters. Priority is on the y-axis, and “progress” was translated into “action needed” and mapped onto the x-axis. “Action Needed” reflects that the stakeholders said that there had not been sufficient progress on the original recommendation; therefore, it is identified for further action. Stakeholders found some older recommendations no longer relevant to their work with corresponding “low action needed” scoring.



| How much of a <b>PRIORITY</b> is this recommendation to addressing BH workforce issues?  | How much <b>PROGRESS</b> has been made on this recommendation since it was first issued?                                     | How <b>UP TO DATE</b> is this recommendation?   |
|--|--|---|
| 1 — Lowest priority<br>2 — Low priority<br>3 — Mid-level priority<br>4 — High priority<br>5 — Highest priority<br>I don't know | 1 — No progress<br>2 — Little progress<br>3 — Some progress<br>4 — Good progress<br>5 — Significant progress<br>I don't know | 1 — Very outdated — needs changes<br>2 — Somewhat outdated<br>3 — Somewhat up to date<br>4 — Pretty well up to date<br>5 — Very well up to date<br>I don't know |

### Writing

Workforce Board staff and the Halcyon Northwest team wrote the BHWAC chapters based on input from the interviews and listening sessions. They provided historical context for the development of each recommendation, reviewed language, and solicited additional stakeholder feedback regarding legislative and other policy action taken in the years since those recommendations were issued. They also proposed items for future consideration based on stakeholder feedback.

### Review Process

Workforce Board staff sent report drafts, chapter by chapter, to stakeholders for review. Their input was reviewed and, wherever possible, incorporated into the final report sections.

## 2022 Listening Session — Participant Organizations

|  |  |
|--|--|
| Asian Counseling and Referral Service                          | Southwest Youth & Family Services  |
| Atlantic Street Center   | The Practice NW  |
| Ballmer Group  | U.S. Department of Defense   |
| Catholic Community Services                                    | United Healthcare  |
| Child and Adolescent Clinic                                    | UW Barnard Center for Infant and Early Childhood Mental Health                           |
| Children's Center, Vancouver                                   | UW Center for Health Workforce Studies   |
| Children's Village   | UW CoLab for Community and Behavioral Health Policy                                      |
| Community Health Plan of Washington                            | UW School of Medicine, Department of Psychiatry and Behavioral Sciences                  |
| Comprehensive Healthcare                                       | UW School of Social Work   |
| Coordinated Care   | Valley Cities Behavioral Health  |
| Cowlitz Indian Tribe   | Washington Allied Health Center of Excellence  |
| Crisis Connections   | Washington Association for Community Health  |
| Eastern Washington Area Health Education Center                | Washington Council for Behavioral Health   |
| Eastern Washington University, Occupational Therapy Department | Washington Mental Health Counselors Association  |
| Frontier Behavioral Health                                     | Washington Occupational Therapy Association  |
| Harborview Behavioral Health Institute                         | Washington State Board for Community & Technical Colleges                                |
| Healthcare Industry Leadership Table (HILT)                    | Washington State Council of Presidents   |
| HealthierHere  | Washington State Department of Health  |
| Lake Washington Institute of Technology                        | Washington State Department of Social and Health Services                                |
| Lifeline Connections   | Washington State Health Care Authority   |
| MultiCare Behavioral Health Network                            | Washington State House of Representatives  |
| National Association of Social Workers — Washington Chapter    | Washington State Senate  |
| Office of the Governor   | Washington State Psychological Association   |
| Partners for Our Children                                      | Washington State University, College of Pharmacy & Pharmaceutical Sciences, Rural Health |
| Peninsula Behavioral Health                                    | Washington Student Achievement Council   |
| Pioneer Human Services   | Workforce Development Council of Seattle-King County                                     |
| Rod's House  | Workforce Southwest Washington   |
| Saybrook University  | WorkSource Seattle-King County   |
| Seattle Children's Care Network                                | Yakama Nation Behavioral Health Services   |
| Seattle Children's, Workforce Development & Planning           | Yakima Neighborhood Health Services  |
| Seib Policy & Public Affairs, LLC                              | Yakima Valley Farm Workers Clinic  |
| SEIU Healthcare 1199NW   |  |
| SEIU Healthcare 1199NW Multi-Employer Training Fund            |  |

## Supplemental reports

This report also contains three additional studies to help inform policymakers' understanding of the behavioral health workforce landscape. The full versions can be found in the appendices. Summaries are provided here.

### **Washington State's Behavioral Health Workforce: Examination of Education and Training Needs and Priorities for Future Assessment, University of Washington Center for Health Workforce Studies (UW CHWS)**

This qualitative study sought to identify stakeholders' concerns and related recommendations regarding the education and training of Washington's behavioral health workforce. Conducted in Spring 2022, key findings include:

- New graduates in behavioral health occupations tend to be more prepared for private practice than for work in community settings.
- Case management is an important skill in community settings, but it is often not well developed in new graduates.
- Frequently, specific practical skills and knowledge are weak or lacking among new hires.
- Functioning effectively in integrated care settings remains a formidable challenge for both new and existing staff.
- While some employers are hiring more bachelor's-level workers, there is potential to expand this workforce.
- Supervision, mentorship, and general staff support are needed for both the new and incumbent behavioral health workforce.
- Increasing numbers of providers are obtaining their education through online learning.

Education and training priorities include:

- More qualified behavioral health job applicants, particularly with master's level credentials.
- Greater clarity on pathways into different behavioral health roles.
- New behavioral health education approaches and occupations, if financially viable.
- Increased behavioral health education program capacity and improved access.
- More applicants dually trained in counseling and substance use disorder treatment, with training in social determinants of health, to better serve those populations with higher incidence of co-occurring disorders and poverty.
- Early experiences to help behavioral health occupations students identify career goals and increase graduates' job match success.
- High quality supervision and mentorship support for both new and mid-career professionals.

Areas for further investigation suggested from this study include obtaining more input about behavioral health workforce demand from the Health Workforce Sentinel Network, surveying education programs to describe barriers to program expansion, analyzing data on education output over time, and surveying master's level professionals about factors affecting their professional paths and future plans.

## **Findings from Behavioral and Mental Healthcare Facilities — WA Sentinel Network 2022, UW CHWS and Washington Health Workforce Sentinel Network**

In Spring and Fall 2022, behavioral health organizations provided information about their top workforce needs through the Sentinel Network. Respondents indicated that the top occupations experiencing exceptionally long vacancies included mental health counselors, substance use disorder professionals, social workers, peer counselors, and marriage and family therapists. To cover absences and vacancies, many respondents asked current employees to expand their roles, but feared potential burnout among their workforce. Others had to implement patient waitlists or reduce the number of appointments for each patient to help manage workloads. Respondents indicated that childcare, enhanced medical coverage and family leave, behavioral health services, increased pay and wages, and flexible schedules would be among the most helpful benefits for improving retention. Some respondents indicated that the licensing process can be too long for out-of-state and new employees, making it difficult to recruit. Others highlighted the need for both public and private insurance reimbursement rate increases to allow for more competitive benefits and salaries.

In Fall 2022, 20 respondents representing 38 facilities employing behavioral health occupations were asked about the skills, knowledge, and educational preparation of applicants and newly hired behavioral health employees. Most (85%) respondents indicated these new entrants were somewhat or not well prepared for practice in their facility type, with half or more indicating this workforce was not well prepared in interdisciplinary team-based care as well as with working with high utilizers/high need populations. In response to themes identified from recent interviews with key informants across the state, nearly all (92%) of the Sentinel Network respondents agreed that behavioral health education programs should provide students with early exposure to, and experiences with, different client populations that they may serve in their careers, and most (84%) agreed new behavioral health education approaches and occupations are welcome, if financially viable. A majority (77%) agreed that distance education improves access to behavioral health education and increases workforce supply.

### **Behavioral Health Workforce — Building & Sustaining Career Pathways, Washington STEM**

Washington STEM identified behavioral health-specific occupations and credentials, detailed barriers to credentialing, and provided recommendations about increasing the supply of qualified and diverse individuals for behavioral health jobs. Washington STEM developed two dashboards, one on behavioral health-specific projected job openings and one on the quantitative capacity and related barriers for behavioral health-specific credentials and licensing programs.

Washington STEM identified significant barriers to accessing and completing the degrees, credentials, and licenses required to obtain many behavioral health occupations, including Licensed Mental Health Counselor, Behavioral Specialist, and Health Informatics Specialist. Despite earning credentials and/or licenses, professionals in behavioral health careers will find that only 31 percent of those jobs pay a family-sustaining wage (sufficient to support a single adult and infant). Similarly, 82 percent of behavioral health jobs require a postsecondary credential. This disparity may lead to lack of credential completion, burnout, and high debt-to-income ratios, among other supply and retention issues. For instance, the need for postsecondary credentials combined with low wages can make it difficult to pay off student loans, forcing behavioral health workers to leave the field in favor of higher wages.

Washington STEM provides several recommendations to address these findings, including increased funding for expanded capacity in particular credentialing programs, increased support for lowering tuition or forgiveness of loans (see also the new recommendations in the Recruitment and Retention chapter), and increased support of programming in K-12 to expose and prepare students for behavioral health pathways.

## Summary of Progress

This is a summary regarding legislative action and investments, and other high-level investments. Some recommendations had no significant action, and therefore are not noted here. For more detail, see each section in the *2022 Behavioral Health Workforce Assessment: A report of the Behavioral Health Workforce Advisory Committee*.

### Recruitment and Retention

|            |  |   |
|------------|--|---|
| <b>RR1</b> | Provide greater access to loan repayment resources   | <ul style="list-style-type: none"> <li>Budget (2021) — \$10.25M investment to WSAC for loan repayment.</li> <li>Budget (2021) — \$2M for WSAC for BH-specific loan repayment.</li> <li>HB 1504 (2021) — Required prioritization of state loan repayment applicants from underrepresented groups. <b>Chopp</b></li> </ul>  |
| <b>RR2</b> | Behavioral health career financial support: pandemic relief  | <ul style="list-style-type: none"> <li>Budget (2021) — \$31M for the Behavioral Health Provider Relief Fund.</li> <li>Budget (2022) — \$100M for the Workforce Stabilization Provider Relief Fund.</li> </ul>   |
| <b>RR3</b> | Identify skill mismatches  | <ul style="list-style-type: none"> <li>Budget (2021) — Funding to the Workforce Board to partner with UW on the CHWS report.</li> </ul>   |
| <b>RR5</b> | Paraprofessional care worker retention and career pathway creation   | <ul style="list-style-type: none"> <li>Behavioral health apprenticeship began operating in Fall 2022, with public and private funding.</li> </ul>   |
| <b>RR6</b> | Reduce barriers to behavioral health employment: Criminal background checks; Disqualifying List of Crimes and Negative Actions; and Certificate of Restoration of Opportunity (CROP) | <ul style="list-style-type: none"> <li>Budget (2021) — \$100K for the HCA Community Behavioral Health Program Task Force.</li> <li>Budget (2022) — \$250K to Office of Financial Management to explore creation of a centralized background check office.</li> <li>HB 1411 (2021) — Expanding healthcare workforce eligibility. <b>Simmons</b></li> <li>HB 1768 (2019) — Substance use disorder practice. <b>Davis</b></li> </ul> |

### Reimbursement

|           |   |  |
|-----------|---|--|
| <b>R1</b> | Increases to Medicaid reimbursement   | <ul style="list-style-type: none"> <li>Budget (2021) — 2% increase.</li> <li>Budget (2022) — 7% increase — passed directly to providers.</li> </ul>  |
| <b>R2</b> | Medicaid managed care behavioral health rate development                                    | <ul style="list-style-type: none"> <li>Budget (2021) — \$400K for a study to establish benchmark behavioral health payment rates and fee schedule.</li> <li>Budget (2022) — \$600K for development and implementation of a sustainable, alternative payment model for comprehensive community behavioral health services.</li> <li>The U.S. Substance Abuse and Mental Health Services Administration (SAMSHA) has awarded 17 CCBHC grants to Washington organizations to assist with the start-up costs of becoming CCBHCs and providing 24/7 comprehensive healthcare programs. (2020-present).</li> </ul> |
| <b>R3</b> | Reimbursement and incentives for student clinical training in community-based organizations | <ul style="list-style-type: none"> <li>Budget (2022) — \$150K for HCA to develop a teaching clinic enhancement rate.</li> <li>Ballmer Group provided \$1.1M in funding to the Council for Behavioral Health to conduct a demonstration project.</li> </ul>   |



## Education and Training

|    |  |   |
|----|--|---|
| E1 | Increase the ability of behavioral health agencies to accept students                      | <ul style="list-style-type: none"> <li>• HB 1311 (2021) — Substance use disorder professional certifications in apprenticeship programs. <b>Bronoske</b></li> <li>• The SEIU Healthcare 1199 NW Multi-Employer Training and Education Fund (the Training Fund) began a related apprenticeship program, with funding from Ballmer Group and King County.</li> <li>• SB 5600 (2022) — Concerning the sustainability and expansion of state registered apprenticeship programs. <b>Keiser</b></li> <li>• Washington State Behavioral Health Workforce Development Initiative is funding hundreds of conditional grants for master’s level behavioral health students at 13 Washington universities.</li> </ul> |
| E2 | Peer counselors  | <ul style="list-style-type: none"> <li>• SSB 5644 (2022) — Concerning providing quality behavioral health co-response services. <b>Wagoner</b></li> <li>• Budget (2021) — \$2M to HCA for work to integrate peers onto emergency response teams.</li> <li>• Budget (2021) — \$100K to HCA for a taskforce on criminal background checks in employment in the behavioral health setting.</li> <li>• Budget (2021-2022) — \$881K for Peer Support Program (PSP).</li> <li>• Budget (2022) — \$50K to increase services provided by Certified Peer Support Counselors in Clark County.</li> </ul>  |
| E4 | Expand access to the Integrated Basic Education and Skills Training Program (I-BEST) model | <ul style="list-style-type: none"> <li>• Budget (2020) — \$1.5M to Washington State Board of Community and Technical Colleges for the development and expansion of I-BEST.</li> </ul>   |

## Licensing

|    |  |   |
|----|--|---|
| L1 | Substance use disorder dual-credentialing  | <ul style="list-style-type: none"> <li>• HB 1768 (2019) — Substance use disorder professional practice (Created ability for agency affiliated counselors to work while their license is pending.) <b>Davis</b></li> </ul> |
| L2 | Simplify licensure requirements for established professionals moving to Washington | <ul style="list-style-type: none"> <li>• SB 5054 (2019) — Reciprocity program. <b>O’Ban</b></li> <li>• HB 1286 (2022) — Psychology Compact. <b>Chambers</b></li> </ul>  |

## Supervision

|    |  |  |
|----|--|--|
| S1 | Behavioral health supervision workgroup & required supervision hours | <ul style="list-style-type: none"> <li>• SHB 1907 (2019) — Substance use disorder treatment system. <b>Davis</b></li> </ul>  |
| S2 | Expand and incentivize supervision programs                          | <ul style="list-style-type: none"> <li>• HB 1504 (2021) — \$1M for the Workforce Education Investment Act (implemented a BH preceptorship program). <b>Chopp</b></li> </ul>  |
| S3 | Tele-precepting for supervision                                      | <ul style="list-style-type: none"> <li>• HB 1007 (2021) — Supervised experience through distance supervision. <b>Klippert</b></li> <li>• HB 1063 (2021) — Additional renewals for behavioral health professional trainee and associate credentials. <b>Harris</b></li> </ul> |

## Care Integration

|    |  |  |
|----|--|--|
| C1 | Single platform credentialing system                   | <ul style="list-style-type: none"> <li>• Budget (2018) — Directed HCA to implement a single platform provider credentialing system.</li> </ul>   |
| C3 | Primary care providers and prescriptions               | <ul style="list-style-type: none"> <li>• SB 5436 (2017) — Expanding patient access through telemedicine. <b>Becker</b></li> <li>• HB 1713 (2017) — Children’s mental health. <b>Senn</b></li> <li>• HB 2728 (2020) — Sustainable funding model for children’s mental health services consultation program center. <b>Slatter</b></li> <li>• Budget (2022) — \$505K to the University of Washington (UW) to create two positions for psychiatric pharmacist residents.</li> </ul> |
| C4 | Training for primary care behavioral health competency | <ul style="list-style-type: none"> <li>• Budget (2021) — \$2M to HCA for a 10-clinic behavioral health pediatric clinic integration project.</li> </ul>  |

# CATEGORY: Recruitment and Retention

## Background

Healthcare workforce planning requires policymakers to pay attention to the underlying systemic, structural, and perception challenges that affect the ability to recruit and retain a sufficiently large and diverse workforce to provide needed behavioral health services statewide.

As with most healthcare occupations, the behavioral health workforce — especially beyond entry-level roles — generally does not reflect the diversity of the population needing services by race, ethnicity, or gender.<sup>1</sup> As a result, it is difficult to provide culturally appropriate and responsive care in a proactive way that reduces the need for more acute behavioral health interventions.

Several ongoing, systemic issues continue to impact the behavioral health labor market, including barriers to employment and high turnover. While background checks are necessary for patient safety and are mandated by state laws, onerous and slow background check processes can delay hiring. Background checks and the Department of Social and Health Services (DSHS) disqualifying list of crimes also may present unnecessary barriers to employment for behavioral health professionals. These tools can slow or prevent employment of those individuals, such as peer counselors, able to provide a recognized therapeutic function *because of* their lived experiences. The social stigma associated with individuals with behavioral health diagnoses also reduces the number of individuals considering behavioral health careers. Finally, the high cost of graduate education can serve as a barrier to entry for those who cannot or don't want to take out large student loans.

In the five reports issued by the Workforce Board on the behavioral health workforce between 2016 and 2021, stakeholders identified a range of challenges to recruitment and retention for a diverse and sufficient behavioral health staff. Most of the work in this report consists of reviews of past recommendations and updates about their status. On the topic of educational debt, the Workforce Board saw a need for an update and brought forward new recommendations that recognized the degree of education debt experienced by some parts of the behavioral health workforce require a range of strategies from short-, mid-, and long-term. Once professionals are in the workforce, behavioral health worker retention can be affected by low wages, mismatches between employee skills and needs of employers, high worker turnover, large outstanding student loans, difficult working conditions, and lack of viable pathways to better-paying healthcare positions.

<sup>1</sup> Duffy FF, West JC, Wilk J, et al. Mental health practitioners and trainees. In RW Manderscheid & MJ Henderson (Eds.), *Mental health, United States, 2002* (pp. 327-368; DHHS Publication No. SMA 04- 3938). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2004

To address these ongoing challenges, the past reports made several recommendations to support and improve workforce supply, distribution, and diversity. This includes increasing knowledge of and engagement with several programs such as the National Health Service Corps and the Certificate of Restoration of Opportunity (CROP) Program due to their potential benefits to workforce supply.

## **Recommendations from the prior reports:**

- RR1:** Strengthen and fund loan repayment programs, including the established Washington Health Corps, that incentivize direct (clinical) behavioral health service provision.
- RR2:** Provide financial support and other incentives to those pursuing careers in behavioral health. Funding should be appropriated for grants providing COVID-19 pandemic-specific retention bonuses to be allocated to community behavioral health workers.
- RR3:** Convene education programs with behavioral healthcare providers to identify mismatches between the skills of graduates/completers and expectations of employers.
- RR4:** Improve behavioral health literacy as a foundation for healthcare careers.
- RR5:** Reduce paraprofessional care worker turnover and improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles.
- RR6:** Reduce barriers to behavioral health employment related to criminal background checks and disqualifying crimes.

# New Recommendations: Addressing the impacts of behavioral health professions' educational costs on the workforce

Many Washington residents are struggling under the burden of education costs and student loan debt. While the percentage of Washington's behavioral health workforce who financed their higher education by taking out public or private loans is not readily available, stakeholders report that high education costs as well as educational debt weigh heavily on behavioral health provider practice decisions. Behavioral Health Workforce Advisory Committee (BHWAC) stakeholders identify the low wages in the field, combined with the high student debt levels of some employees, as key drivers of staff recruitment challenges and turnover, particularly in community-based settings, where 85-95% of clients are Medicaid enrolled. It's also important to acknowledge that the cost of higher education, particularly at the graduate level, likely deters a proportion of potential students entirely.

Due to continuing impacts from the Great Recession, undergraduate tuition levels rose more than 40 percent from 2009 to 2019 at Washington's public four- and two-year institutions. Tuition at the state's four-year private nonprofit institutions rose 53 percent during the same 10-year period.<sup>2</sup>

Washington has recently increased financial assistance with postsecondary educational costs for low- and middle-income residents pursuing undergraduate programs or registered apprenticeships. The Washington College Grant provides need-based financial assistance to income-eligible resident students. Some level of financial support is available for students with incomes up to 100 percent of the state's median family income level. However, many of the highest-demand behavioral health professions require master's or even doctoral degrees, which are not covered by the Washington College Grant. Many behavioral health positions requiring master's degrees receive very low wages in comparison to the amount a student must borrow. This extreme debt-to-income ratio poses a retention barrier for employers serving low-income patients. Please see the graph on page 41, "Estimated Average Full Time Salaries of Selected Behavioral Health Occupations and Comparison Occupations in Washington State in 2016 and 2021."

The average debt reported by applicants to the Washington Health Corps, administered by Washington Student Achievement Council (WSAC), offers a window into the high levels of debt some Washington behavioral health providers carry. For example, while the average loan balance for all the licensed mental health counselors applying to the Health Corps was \$126,450.71, the loan balances ranged from \$12,000 to as much as \$500,000<sup>3</sup>. Given that the average 2022 salary for a licensed mental health counselor, which

| Washington Health Corps Loan Average Debt for Behavioral Health Profession Applicants |                      |               |
|---|----------------------|---------------|
| Profession  | Average Loan Balance | Debt Range    |
| Physicians (MD)   | \$423,311            | \$100K-\$600K |
| Clinical Psychologists  | \$322,171            | \$118K-\$691K |
| Independent Clinical Social Workers   | \$110,059            | \$21K-\$324K  |
| Marriage and Family Therapists  | \$145,153            | \$88K-\$201K  |
| Mental Health Counselors  | \$126,451            | \$12K-\$500K  |
| Licensed Practical Nurses   | \$32,984             | \$10K-\$84K   |
| Nurse Practitioners   | \$144,362            | \$30K-\$400K  |
| Registered Nurses   | \$49,310             | \$10K-\$115K  |
| Physician Assistants  | \$118,232            | \$37K-\$170K  |
| Substance Use Disorder Professionals  | \$49,755             | \$5K-\$164K   |

Washington Student Achievement Council, 2022

<sup>2</sup> Washington State Encyclopedia of Education Data, 2021, Washington Student Achievement Council

<sup>3</sup> [Washington Health Corps presentation](#) to the Behavioral Health Workforce Advisory Committee, September 9, 2022

requires a master's degree and 3,000 hours of post-graduate supervision, is \$56,500, some providers are burdened by student debt that can be two to ten times their annual salary. It's also important to note that stakeholders reported salaries in community behavioral health are often lower than the professional averages found in state level data.

In previous years the Workforce Board's Behavioral Health Workforce Assessments have focused on the role of the state loan repayment program supporting recruitment and retention of the behavioral health workforce. Loan repayment programs are typically used to influence the practice decisions of early- and mid-career licensed healthcare clinicians, including the behavioral health workforce. Evidence regarding the impact of loan repayment on long-term retention is mixed,<sup>4</sup> but loan repayment programs offer a highly desirable benefit that employers can use to help recruit a candidate or retain a qualified staff member.

Loan repayment programs can make a dramatic difference in the lives of the beneficiaries, but loan repayment should not be the sole policy focus to address education costs. Policymakers should consider a comprehensive framework to address the high cost of education and its effect on the behavioral health workforce. The ideal upstream solution to the challenge of student loan debt is for state and federal policymakers to collectively drive down the cost of higher education necessary for behavioral health careers.

A suite of tools is needed to accomplish a variety of behavioral health workforce goals. Conditional scholarships, loan repayment programs, and Federal Public Service Loan Forgiveness can work in tandem to provide targeted relief to a broader cross section of the behavioral health workforce than loan repayment alone. Additionally, while assisting with educational costs helps individuals greatly and can help retain a provider via a contractual service obligation, wages must also grow for retention to be achieved over longer periods. Some of the most in-demand behavioral health professions do not earn adequately high wages to offset the huge initial investment even with a loan repayment award. Those choosing to work in community behavioral health as a career likely experience a lifetime wage gap compared to their professional colleagues working in other settings.

## Washington Health Corps Loan Repayment Programs

Loan repayment programs are the most common tools used to help steer clinicians towards some practice situations over others, particularly incentivizing clinicians to both stay in or consider lower-paying, more challenging, or geographically remote employment opportunities. The WSAC's Washington Health Corps has been a topic of several BHWAC recommendations in previous reports. Stakeholders and the report authors identified several challenges with the current program addressed by recommendations here.

**Recommendation 1:** As a short-term strategy, the Legislature should appropriate additional funds to support behavioral health loan repayment awards to address immediate retention challenges within a variety of behavioral health settings.

The Washington Health Corps continues to receive many more applications from behavioral health clinicians than it can award with allocated funds. This gap is occurring without significant advertising of the program and with constraints on what types of settings and service types qualify. Behavioral health stakeholders are highly invested in the Washington Health Corps programs and expressed a desire for the program to continue to receive significant appropriations to increase its scope.

<sup>4</sup> National Health Service Corps – An Extended Analysis, Lewin Group, 2016



**Recommendation 2:** WSAC should work with its planning committee, participating sites, potential applicants, and awarded providers to ensure clear understanding that behavioral health loan repayment participants' hours worked in community settings, such as crisis response services, homeless shelters, supportive housing, street outreach, and families' homes, may count towards the required service obligation hours.

Stakeholders would like the Washington Health Corps to offer greater flexibility in where awarded clinicians can work. Currently behavioral health stakeholders have a perception that participating clinicians can only count hours worked at specifically approved site locations towards their service obligation time. The effect of this perceived restriction is that hours worked in areas outside the clinic are not counted towards the required service obligation hours. WSAC should work with the planning committee and other stakeholders to ensure sites and applicants understand the flexibility of the program. Increasing awareness of the program's flexibility would help support Washington's focus on serving patients in non-traditional settings.

**Recommendation 3:** As part of supporting the investments made in loan repayment programs in Washington, the Legislature should appropriate funds to support administration of the Washington Health Corps and require an evaluation of program outcomes.

The Legislature has made significant investments in the Washington Health Corps programs. Communication and outreach about the program have been limited due to both staffing challenges and because there are already more applicants than can be funded. With the rapid increase in investments, additional resources are needed to support the administration of the greater number of awards, handle the increasing application volumes, and provide more outreach to priority facilities, students, and working professionals.

The outcomes of the Health Corps program have not been evaluated within the past 10 years. Such an evaluation is merited given the state's recent large investments in the program. Potential outcomes of interest to policymakers would include:

- Percentage of recipients completing their service obligations.
- Percentage of recipients competing service obligation at original site.
- Follow-up comparison of awarded participants vs. non-awarded participants to measure if receiving an award is associated with greater retention within a multi-year timeframe.
- Retention of recipients at original site one, three, and five years following the end of a service obligation.
- Recipients' and employers' experiences with the program.

Loan repayment programs are best deployed as a short-term strategy to address the acute retention challenge in concert with other changes to improve wages and working conditions. Loan repayment is only a benefit for some workers at the point in their career when they have eligible educational debt. However, it is important to note that while loan repayment programs assist in the retention of the existing workforce, they do not grow the overall

| Washington Health Corps Program Funding  |                |                |
|--|----------------|----------------|
| Program  | 19-21 Biennium | 21-23 Biennium |
| <b>State Health Program (includes Behavioral Health and other professions)</b> | \$7,650,000    | \$7,650,000    |
| <b>Behavioral Health Program</b>   | \$2,000,000    | \$10,250,000   |
| <b>Nurse Educator</b>  | -              | \$3,000,000    |
| <b>Federal Health Program Combined federal grant and state matching funds</b>  | \$3,050,000    | \$3,050,000    |

WSAC 2022

workforce. Loan repayment programs cannot help students from disadvantaged backgrounds overcome upfront cost barriers and they do not necessarily help retain staff past the completion of a service obligation period. They also are not an effective tool to retain the portion of the workforce that does not have student loans. This chapter will discuss other opportunities to address these issues.

## Public Service Loan Forgiveness

The conditional scholarships and loan repayment awards available through the Washington Health Corps are limited by statute to the licensed clinical workforce. Additionally, the Department of Health (DOH) must first determine that the profession is experiencing a shortage. Licensed clinicians can be the most challenging to hire, but behavioral health facilities employ many different types of workers who also have significant educational debt and are also key to serving clients.

The number of Washington master's level behavioral health licensees with student debt can be roughly extrapolated from the number of currently issued social work, counselor, and marriage and family therapists associate credentials and the nationally reported average student loan balances. That number is thousands of individuals higher than the 56 awards the Washington Health Corps made to social workers, counselors, and marriage/family therapists in 2022. In addition to associate level clinicians, many fully licensed behavioral health clinicians have educational debt. Loan repayment is highly valuable to those clinicians and sites able to access it and can be a helpful tool for recruitment and retention. But even at the current high funding levels, it cannot address what is a nationwide education debt crisis.

The Federal Public Service Loan Forgiveness (PSLF) program offers a categorical pathway to significant debt relief for employees of eligible behavioral health employers. Eligible employers include both government agencies and 501(c)3 non-profits providing health/behavioral health services. Clinicians working in private practice are not eligible, so PSLF offers a tool to help incentivize recipients to remain working at eligible employers for at least 10 years. While clinicians may work for several different organizations during the 10 years period and there is no obligation to work for a specific setting, there is a net benefit in providers being incentivized to remain with qualified employers in the public and non-profit sectors, which often serve the state's most diverse and low-income populations.

**Recommendation 4:** As a middle- and long-term strategy, policymakers should require eligible behavioral health employers to provide PSLF educational materials and information about the Office of the Student Loan Advocate at WSAC when hiring a new employee, annually, and at the time of separation. Within already appropriated resources, the Office of the Student Loan Advocate should conduct outreach to eligible behavioral health employers and assess if additional staff support is needed to serve demand.

The 2022 Legislature recognized the significance of the PSLF program by passing SB 5847, which required the state to notify state employees about the program, provide information created by WSAC, and simplify the process by which the employer attests to the Department of Education (DOE) that their staff person qualifies. Since the start of the program, the DOE has forgiven more than \$309 million in federal student loan debt for qualifying Washington residents.<sup>5</sup> PSLF has the potential to provide hundreds of millions of dollars in educational debt relief for the behavioral health workforce, extending benefits far beyond the licensed clinical workforce. While PSLF participants do not have a direct tie to a specific employer, as is the case with loan repayment programs, the program functions to help retain workers in the public and non-profit sector for a minimum of ten years. It can also provide relief to loan balances remaining after a clinician receives a loan repayment award.

<sup>5</sup> Washington State Student Loan Advocate/WSAC Presentation to the Health Workforce Council, October 13, 2022

In addition to state agencies, the Legislature should require eligible behavioral health employers to provide their staff with PSLF information (to be developed by WSAC) upon the commencement of employment, annually, and at the time of separation. In conversations with stakeholders on this topic, many behavioral providers were only aware of the program in very general terms and did not know state resources were available, making this information and outreach even more critical. When materials are available, the WSAC PSLF lead should conduct outreach to eligible behavioral health employers and monitor the volume of technical assistance requested. If the workload exceeds the staffing allotment, additional support should be provided by the Legislature.

## Conditional Scholarships

Conditional scholarships, also known as conditional grants, where a recipient receives financial assistance in return for an agreement to work in a certain sector or employer upon graduation, have a long history in Washington through the programs of WSAC, National Health Service Corps (NHSC), and the Child Welfare Training and Advancement Program. Conditional scholarships are useful to support the entry of individuals who may not have family resources or may not feel comfortable taking on large educational loan balances. These scholarships can be a key strategy to change the racial, ethnic, and gender composition of the workforce.

Ballmer Group, a philanthropic organization, has made a significant investment in conditional grants via a donation to the University of Washington (UW) School of Social Work. This investment will provide grants to 415 master's level behavioral health students over the five-year funding period and is being carried out by 13 universities across Washington. In return, clinical mental health counseling, marriage and family therapy, and social work students will have a three-year obligation to work at a community behavioral health agency following graduation. (For more information about the project, see recommendation E1.)

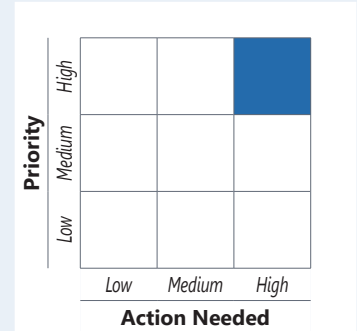
**Recommendation 5:** As a middle- and long-term strategy, if the philanthropically funded conditional grant program demonstrates successful outcomes in educating and retaining a diverse master's-level workforce for community behavioral health settings, the Legislature should provide funding to continue the program beginning in the 2025-26 biennial budget.

Ballmer Group's investment is for a five-year period. When the outcomes demonstrate success at meeting the project's goals, the state should make ongoing investments in conditional scholarships to continue the program starting during the 2025-26 biennium. This would create a pipeline of in-demand behavioral health clinicians graduating each year who would be obligated to work in high priority settings. WSAC's Washington Health Corps program's statute includes provisions for a conditional scholarship program, though legislation may prove necessary to change program operations to align with the Ballmer Group/UW awarding model more closely, if it proves to have desirable outcomes. Such statute change suggestions are beyond the scope of this report and the available data but could be considered in the future in conjunction with WSAC and the Washington Health Corps planning committee.

# RR1: Provide greater access to loan repayment resources

## 2022 Takeaways

In the most recent biennial budget, the Legislature provided \$10.25 million in funding for the Washington Health Corps Behavioral Health Program (BHP), administered by the WSAC. This has enabled a large expansion in the number of awards going to behavioral health providers.



Originally created in 2017, updated in 2020, and reissued with same language in 2021.

## Summary of Progress to Date

### *Increase funds for BHP*

In 2021-2022, the Legislature provided \$2 million to increase the number of loan repayment awards within BHP. The Legislature provided \$10.25 million in 2021-22 for WSAC for expenditure into the health professional loan repayment and scholarship program account. The amount was intended to increase loan repayment awards within the BHP. WSAC confirmed that 100 percent of this funding is going towards the BHP awards.

WSAC also confirmed that due to increased funding described above, they were able to increase the number of awardees from 14 in 2021 to 87 in 2022. The number of awards is expected to be even higher in 2023.

### *Increase access to the Washington Health Corps BHP*

In response to a previous report recommendation, WSAC discussed increasing the number of workers per profession site from two to three at their Fall 2022 meeting for the next cycle of awardees in January. Individuals at the associate licensure level are now eligible for the program.

WSAC evaluated increasing the number of service obligation hours allotted to administrative work from 20 percent to 30 percent. Instead, they changed the definition of direct patient care to include the administrative tasks needed for direct patient care. The definition now includes direct patient care hours, including job duties in the support of delivery of healthcare services to a particular patient. Examples include meeting with patients, charting, processing laboratory results, coordinating care, and travel during work hours to meet with patients and coordinate care.

In 2021, the Legislature passed **HB 1504 Modifying the workforce education investment act**. This legislation required a prioritization of non-federal funding in Washington Health Corps programs for applications that reflect demographically underrepresented populations.

## Prior Recommendations and Suggested Actions

Strengthen and fund loan repayment programs, including the established Washington Health Corps BHP, that incentivize direct (clinical) behavioral health service provision.

Strengthen and fund loan repayment programs, including the established Washington Health Corps, that incentivize direct (clinical) behavioral health service provision. Clinical direct service providers in community-based settings paid lower than administrative positions at state/managed care organizations, discouraging BH professionals from remaining in community-based organizations.

Provide support for concentrated loan repayment programs in direct service in community-based settings to help with long-term retention, with careful consideration to unique circumstances in rural settings.

Adjust the eligibility criteria and other administrative changes of established loan repayment programs to increase the number of eligible participants per profession per site from two to three.

**Suggested Action:** Increase funds allocated to the Washington Health Corps BHP to expand the number of behavioral health workers who receive loan payment support through BHP. Explore additional funding sources including private philanthropy/private sector. Establish a dedicated funding source.

**Suggested Action:** WSAC should make changes to the existing Washington Health Corps BHP model to increase access for eligibility/participation in the program.

1. Increase the number of workers per profession per site from two to three.
2. Permit the participation of individuals licensed at the associate level.
3. Increase the percentage of FTE allotted to administrative work to 30% to increase the ability of individuals providing clinical supervision to participate in programs

## Areas of Improvement Identified by Stakeholders

Community behavioral health stakeholders appreciate the Washington Health Corps BHP and how it has flexibility with the state-funded programs to respond to Washington's needs. Stakeholders representing federally qualified health centers also strongly support the Washington Health Corps program as a key recruitment and retention resource for providers. In addition to the state program, both community behavioral health agencies and FQHCs also use the federal National Health Service Corps loan repayment program and Public Service Loan Forgiveness.

Because not all agencies know about various the options, stakeholders recommended a centralized information location and education about all the various loan repayment and forgiveness programs. All stakeholders noted that the Washington Health Corps could use more funding. Community behavioral health agency stakeholders requested that WSAC and the planning committee extend program flexibility in the future, because it is a very narrow subset of people who can access loan repayment, and it is very challenging for some workers in community behavioral health to access. Participation is currently limited to individuals licensed by the DOH in a profession determined to be in shortage.

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*"We have staff almost each year that apply for and receive the NHSC loan repayment; it's such a vital program for our area!"*  
— Federally Qualified Health Center

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### Key Successes

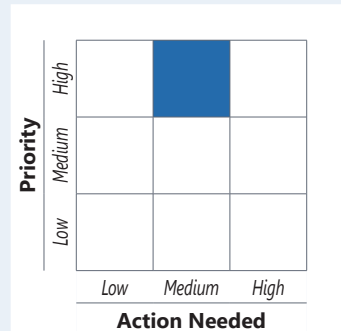
The Legislature provided \$10.25 million in funding for WSAC's Health Corps BHP loan repayment program.



# RR2: Behavioral health career financial support: COVID-19 pandemic relief

## 2022 Takeaways

The Legislature provided a total of \$131 million in 2021-2022 to support the behavioral health sector provider relief fund, which sought to support the behavioral health system during the COVID-19 pandemic. HCA will collect information about facilities retention outcomes in a report to the Legislature. These findings can be reviewed for best practices and possible continuation or expansion in the future.



Originally created in 2017, updated in 2020; considered relevant to needs created by the COVID-19 pandemic.

## Summary of Progress to Date

In 2021, the Legislature provided \$31 million for a behavioral health provider relief fund to the Health Care Authority (HCA), stating: “One-time funding will allow the Authority to aid payments to behavioral health providers who have experienced revenue loss or increased expenses because of the COVID-19 pandemic.”

In 2022, the Legislature appropriated \$100 million for a Workforce Stabilization Provider Relief Fund to be distributed via HCA. Eligible providers were non-hospital-based community behavioral health providers receiving payment for Medicaid services through Medicaid MCOs for immediate workforce retention and recruitment needs. The stipulations were:

- Funds must be used for immediate retention and recruitment needs and may include, but are not limited to, childcare stipends, student loan repayment, tuition assistance, relocation expenses, and other recruitment efforts to rebuild lost capacity.
- Funds must be distributed by October 1, 2022.
- HCA must conduct a qualitative analysis of how Workforce Stabilization Provider Relief Fund was used and report on findings by December 2023.

### Prior Recommendation and Suggested Action

Provide financial support and other incentives to those pursuing careers in behavioral health.

**Suggested Action:** Funding should be appropriated for grants providing COVID-19 pandemic-specific retention bonuses to be allocated to community behavioral health workers. Funding should be allocated to licensed and certified behavioral health agencies to distribute to their workers.

*“When the announcements for the Behavioral Health Provider Relief funds started going out, I did hear from organizations who were somewhat frustrated because of the potential administrative burden, and not knowing what reporting would be required with the funds.”*

— Government Agency



## Areas of Improvement Identified by Stakeholders

The \$31 million provider relief fund created in 2021 required providers to apply and demonstrate revenue losses. Depending on the circumstances of the agency, it was difficult for some to demonstrate a revenue loss despite real fiscal challenges.

The general sentiment is that stakeholders are pleased that the \$100 million in 2022 doesn't use this same approach. The 2022 funding package decoupled the \$100 million relief from the provider having to demonstrate need; it was not an application process like the \$31 million.

Stakeholders said they were also pleased with HCA directly issuing the funds to behavioral health agencies rather than routing the money through the MCOs. They are anticipating high transparency about where the funds go. HCA will report on the impact of funds in 2023. Stakeholders report that these funds will help fill the six-month gap before the seven percent Medicaid rate increase begins in 2023 (see Reimbursement, section R1).

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*"We're ecstatic that the Legislature said, 'yes, we're going to do something to support you,' but... a lot of agencies can't make any investment with that until the money's in their accounts."*

— Behavioral Health Agency

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### Key Successes

The Legislature provided \$131 million in 2021-2022 for pandemic relief for behavioral health.

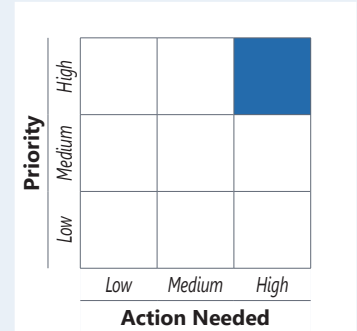
## Items for Future Consideration

HCA should make information regarding the uses and outcomes of the provider relief funds broadly available. This could allow for the identification of promising practices that helped behavioral health agencies improve retention and could be expanded.

# RR3: Identify skill mismatches

## 2022 Takeaways

Two studies are underway to evaluate the mismatches between college and university training programs and the needs of employers, one funded by Ballmer Group and the other by the Legislature. The report funded by the Legislature, conducted by the UW Center for Health Workforce Studies, can be found in the supplemental materials at the back of this report.



Originally created in 2017.

## Summary of Progress to Date

The Healthcare Industry Leadership Table's (HILT) King County Behavioral Health Committee has partnered with the UW School of Social Work's Workforce Development Initiative (WDI) to identify how well new employees' skills and knowledge meet employer needs. The WDI will use this information with the 13 graduate schools participating in the Ballmer-funded conditional grant program to help ensure the graduates are well prepared to work in community behavioral health agencies.

In a complementary effort, the Workforce Board has used Legislative funding to contract with the UW Center for Health Workforce Studies. This qualitative study sought to identify stakeholders' concerns and related recommendations regarding the education and training of Washington's behavioral health workforce. Conducted in Spring 2022, key findings include:

- New graduates in behavioral health occupations tend to be more prepared for private practice than for work in community settings.
- Case management is an important skill in community settings, but it is often not well developed in new graduates.

### Prior Recommendation and Suggested Action

Convene education programs with behavioral healthcare providers to identify mismatches between the skills of graduates/completers and expectations of employers.

**Suggested Action:** The Workforce Board, with support from DOH, WSAC, and the Allied Health Center of Excellence, should be resources to convene education programs, healthcare union representatives, and behavioral healthcare employers to identify mismatches between the skills of graduates/completers and expectations of employers.

*"This is really a barrier for growth and could actually increase efficiencies in the system if people could graduate with the skills needed rather than ... retraining [them]."*

— Behavioral Health Educator

- Specific practical skills and knowledge are frequently weak or lacking among new hires.
- Functioning effectively in integrated care settings remains a formidable challenge for both new and existing staff.
- While some employers are hiring more bachelor's-level workers, there is potential to expand this workforce.
- Supervision, mentorship, and general staff support are needed for both the new and incumbent behavioral health workforce.
- Increasing numbers of providers are obtaining their education through online learning.

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*"It seems like many clinicians coming out of graduate school are more trained for 'private practice,' not community mental health, plus the emphasis seems to be more on theory instead of practical application."*

— Practitioner

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Education and training priorities include:

- More qualified behavioral health job applicants are needed, particularly with master's-level credentials.
- Pathways into different behavioral health roles need greater clarity.
- New behavioral health education approaches and occupations are generally welcome, if financially viable.
- Increased behavioral health education program capacity and improved access are needed.
- More applicants dually trained in counseling and substance use disorder treatment, with training in social determinants of health, could better serve those populations with higher incidence of co-occurring disorders and poverty.
- Early experiences to help behavioral health occupations students identify career goals could increase graduates' job match success.
- High quality supervision and mentorship support is needed for both new and mid-career professionals.

Areas for further investigation suggested from this study include obtaining more input about behavioral health workforce demand from the Health Workforce Sentinel Network, surveying education programs to describe barriers to program expansion, analyzing data on education output over time, and surveying master's level professionals about factors affecting their professional paths and future plans. The full report is available in the supplemental materials at the back of this report.

## Key Successes

Behavioral health employers in King County are partnering with the UW School of Social Work to help improve understanding of what key skills are needed for master's level behavioral health students going to work in community behavioral health agencies.

## Areas of Improvement Identified by Stakeholders

Skill mismatches are still seen as a burden on the workforce, and a priority for resolution. Stakeholders suggest that this recommendation be updated and could benefit from becoming more specific.

Many agreed there is a particular lack in skills for those who work in community behavioral health. Most education is better suited for private practice, where functions differ greatly from community behavioral health agencies or integrated care settings such as Federally Qualified Health Centers (FQHCs). Stakeholders also suggested improved training in cultural differences to better serve diverse populations.

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*"It's high time for a coordinated dialogue back and forth [between universities and employers]."*

— Practitioner

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Stakeholders suggested that researchers look at other programs that have taken a “reverse-engineered” approach by starting with what the workforce needs and working backwards. For example, the new registered apprenticeship programs referenced in recommendation E1 were designed using this reverse-engineered approach. This can pose a challenge given the accreditation process for educational programs but could prove highly beneficial.

## Items for Future Consideration

Once the needs of behavioral health employers are identified, the education and training institutions and employers should collaborate to better align graduates with their future roles in community behavioral health.

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*"[Some FQHCs have to] retrain and update skills for the CHC (Community Health Center) landscape, which costs time and money. And this is very much an equity issue because FQHCs serve patients regardless of ability to pay."*

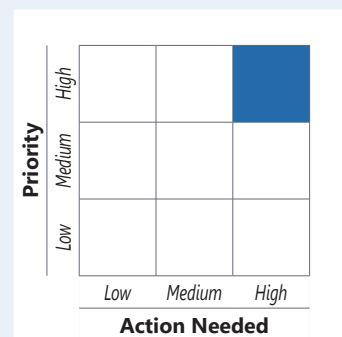
— Facility Association

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# RR4: Behavioral health literacy in healthcare careers and career pathways

## 2022 Takeaways

Career Connect Washington (CCW) is working to ensure 60 percent of young adults in the class of 2030 participate in career-connected learning Career Launch programs. Healthcare is one of the priority sectors. Several behavioral health professions, including SUD-Ps and peer counselors, have been identified as potentially good areas for Career Launch program expansion.



Originally created in 2017.

## Summary of Progress to Date

The BHWAC participants were not aware of progress being made to date on this recommendation. See following page for details. Due to the focus on youth behavioral health following the start of the COVID-19 pandemic, there may be efforts underway that were not captured in this report.

CCW is working to ensure 60 percent of young adults in the class of 2030 participate in career-connected learning Career Launch programs. Healthcare is one of the priority sectors and CCW selected SEIU Healthcare 1199NW Multi-Employer Training Fund (Training Fund) as the statewide Healthcare Sector Intermediary. The Training Fund is currently developing a Healthcare Sector Strategy and will release a report later this fall.

*"Graduate level clinicians don't see Community Behavioral Health as where they want to be. The work is harder, the pay is low, and the documentation is much more complex. ... People see us as a place to pass through as opposed to a rewarding place to spend your career. ... And I think that we're going to continue to see clinicians pass through the system on their way to private practice or primary care, as opposed to staying in the community system, until we develop an understanding that there is a career pathway that you can have a rewarding career here. That's never going to happen until we can pay people a reasonable and living wage for being expected to treat the hardest patients who often take longer to get better ... we have a lot of work to do in terms of creating career pathways in Community Behavioral Health just because it is not their trajectory. Very few people come out of college on that career pathway."*

— Behavioral Health Agency

## Prior Recommendations and Suggested Actions

Improve behavioral health literacy as a foundation for healthcare careers.

**Suggested Action:** Policymakers could enhance funding for behavioral health literacy education, using models such as the programs listed below, and emphasize support for programs which include training and resources for educators.

- Washington State University has a program in partnership with tribal groups focused on nursing, which could be adapted to include behavioral health as well.
- Office of Superintendent of Public Instruction (OSPI) is implementing Project AWARE (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues among school-aged youth, including training in mental health for school personnel, families, and community members, and collaboration to bring mental health literacy curriculum into high school health classes.
- UW Psychiatry and Psychology departments are collaborating to offer a new course and minor in behavioral medicine to UW undergraduate students in pre-health professional training programs (e.g., pre-medicine, pre-nursing, pre-physical therapy, pre-pharmacy).
- Lake Washington Institute of Technology will begin offering a Baccalaureate of Applied Science (BAS) degree in Behavioral Healthcare, beginning September 2018. The BAS in Behavioral Healthcare prepares students for work in the integrated treatment of mental illnesses, substance use disorders, physical illness, poverty, and homelessness.
- Eastern Washington University is poised to offer a new major in Health Sciences and has a relatively new course offered through their Psychology department, Introduction to the Helping Professions.
- Nebraska is offering a high school pre-vocational behavioral health course through an introduction to behavioral health careers curriculum.
- The Alaska Area Health Education Centers (AHECs) are offering behavioral health career camps.

**Suggested Action:** The Professional Educator Standards Board, OSPI, and selected teacher preparation programs could provide behavioral health literacy training for pre-service instructors, as well as in-service behavioral health literacy training for teachers and school staff.

**Suggested Action:** OSPI, Workforce Board, Educational Services Districts, and local districts, in collaboration with OSPI content specialists and program supervisors, could create and implement a Behavioral Health career pathway curriculum, based on promising practices in Washington, Nevada, Alaska, Nebraska and others, especially in areas that include rural, underserved, and diverse populations.

**Suggested Action:** Policymakers could increase emphasis in state funding for Washington AHECs to continue and expand their health career pathway programs, particularly those focused on behavioral health careers.

## Areas of Improvement Identified by Stakeholders

Many stakeholders agreed there is a lack of career pathways, especially for community behavioral health, which overlaps with both the skills mismatch (RR 4), and lack of funding for good quality pay. So many practitioners pass through community behavioral health employers only temporarily due to feeling unprepared by school, low pay, complex administrative work, significant caseload burdens, and lack of a career ladder.

## Items for Future Consideration

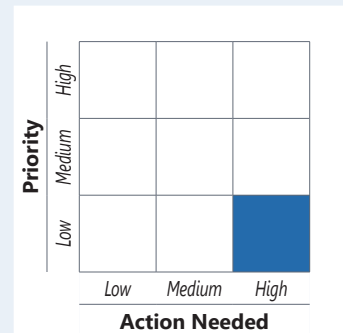
Inclusion of behavioral health professions in the CCW/Training Fund work offers a key strategy to make continued progress in connecting the K-12 educational system to the behavioral health workforce. The Training Fund's draft strategy document includes behavioral health professions, and they are in a strong position to continue to drive progress.



# RR5: Paraprofessional care worker retention and career pathway creation

## 2022 Takeaways

There has not been progress on creation of a Care Worker Task Force in Washington. Stakeholders expressed there are continuing challenges recruiting and retaining entry-level workers.



Originally created in 2017.

## Summary of Progress to Date

To date, neither the care worker task force nor the care worker career lattice have been created, due to lack of funding. Two pieces of legislation have been put forward in recent sessions, but neither passed:

- **HB 1851 Creating the care worker research and resource center** (2019). This center would have been tasked with collecting and analyzing data, developing career ladders for care workers, and translating workers' skills from one type of care work to another.
- **HB 1872 Establishing the care worker center to promote caregiving professions** (2022). This center would have elevated the care worker sector, increased retention and recruitment, and promoted the value and different employment options of care workers.

A related initiative is the registered apprenticeships developed by the Training Fund, which includes a one-year apprenticeship targeted towards behavioral health technicians. This is an entry-level role with a high turnover rate. The goal of the registered apprenticeship is to better support these workers via training and help create a career pathway via additional apprenticeships into licensed behavioral health professions. (See Recommendation E1, Increase the ability of behavioral health agencies to accept students, for more information.)

### Prior Recommendation and Suggested Action

Reduce paraprofessional care worker turnover and improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles.

**Suggested Action:** The Workforce Board, with funding from the state budget to support project staff, could work with the Health Workforce Council to establish a Care Worker Task Force and develop a care worker career lattice over an 18-24-month time period.

*"It may be easier for individual agencies to create their own pipeline/pathways and avoid any additional administrative burdens that may result from implementation requirements from outside entities."*

— Practitioner

## Areas of Improvement Identified by Stakeholders

Stakeholders cited continuing challenges in filling entry-level positions in behavioral health, especially in residential care and support positions. Stakeholders shared that this is likely because positions are under-defined and often not paid well enough to be considered a living wage.

Some reported that organizations made their own career pathways for paraprofessionals: they enter as paraprofessionals, then the organization provides an in-house career ladder; for example, peer 1, peer 2, peer supervisor.

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*"I think the career pathway is confounded by not paying a living wage."*

— Behavioral Health Educator

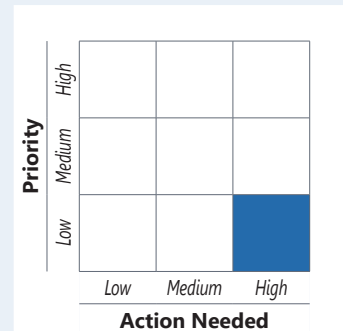
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# RR6: Reduce background check barriers to behavioral health employment

## 2022 Takeaways

HCA convened a task force to consider the role of criminal background checks in employment in behavioral health settings. That report found barriers to CROP participation and recommended the state explore a court-led pilot study to streamline the vacation of criminal convictions. Many stakeholders are still unaware of CROP.

Legislation in 2021 made changes to how the DSHS disqualifying list of crimes and negative actions applies to the long-term care workforce, and it charged DSHS with convening a task force to consider a process to allow clients to hire a home care aide with a disqualifying crime. The DSHS report is available December 2022. Office of Financial Management (OFM), as part of a budget proviso, is also exploring the creation of an office to handle applicant background checks.



Originally created in 2020.

## Summary of Progress to Date

### *Background checks and disqualifying crimes*

DSHS has adopted [a list of disqualifying crimes and negative actions](#), which they use to limit individuals who have unsupervised access to vulnerable individuals or access to federal tax information.

The DOH does not have a list of crimes that disqualify an applicant for professional credentials. Every applicant with a criminal background is reviewed by a panel, which decides to issue the license, issue with conditions, or deny the license. Only if an applicant has been found guilty of conduct deemed to be a patient safety concern will DOH deny to issue the license.

*"Recruitment and hiring of behavioral health volunteers, SUDP, Family/youth Peers, and Foster Parents [all] have a variety of background check processes required. ... So yes, it has been difficult to find some work staff. I've seen some [who] have incidents/crimes that are over 20 years old and did not get cleared to work."*

— Practitioner

Several budget items since 2017 have funded work into the adverse impacts of criminal background checks on the workforce, including behavioral health workers:

- The Legislature's 2021 budget provided \$100,000 for the HCA Community Behavioral Health Program to convene a task force to examine impacts and changes proposed to the use of criminal background checks in employment in behavioral health settings. The task force included representatives from: Office of the Attorney General, DOH, DSHS, Office of the Governor, the Division of Behavioral Health and Recovery within the HCA, behavioral health employers, and individuals with lived experience with the criminal justice system. Early data showed:

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*"We run into [background check issues] most when hiring peers."*

— Practitioner

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- Of the 2,724 background checks processed by DSHS, Background Check Central Unit (BCCU), 43 individuals were automatically disqualified because of a criminal record (about 1.5%).
- Of the thousands of applications for DOH licensure and certification every year, fewer than 100 are disqualified because of a criminal record.

### Prior Recommendations and Suggested Actions

Three recommendations fall under reduce barriers to behavioral health employment related to criminal background checks:

1. Convene leadership of state agencies with jurisdiction to reduce barriers to behavioral health employment related to criminal background checks. The concept of a specialized task force which includes legal/judicial, behavioral health professionals/employers, and those with lived experience navigating the criminal justice system surfaced as an effective step forward.
2. Conduct an evidence-based review of the DSHS Secretary's Disqualifying List of Crimes and Negative Actions as applied to behavioral health facilities/employers of behavioral health providers.
3. Expand community awareness and engagement with CROP and its potential benefits. CROP was implemented in 2017. Applications have been low compared to the number of eligible individuals. Stakeholders and experts on CROP speculated that this may be due to lack of knowledge and awareness among eligible participants. Direct engagement with soon-to-be-released incarcerated individuals could provide them awareness of the opportunities as potential behavioral health workers with lived experience in the criminal justice and substance use disorder

**Suggested Action:** Create a task force comprised of representatives from the Office of the Attorney General, DOH, DSHS, Office of the Governor, Division of Behavioral Health and Recovery within the HCA, behavioral health employers, and those with lived experience to examine the impacts and changes proposed to the use of criminal background checks in employment in behavioral health settings. The goal is to reduce barriers in developing and retaining a robust behavioral health workforce while maintaining patient safety measures.

**Suggested Action:** Specific to behavioral health occupations, use an evidence-based risk assessment framework to review and potentially amend the DSHS Secretary's Disqualifying List of Crimes and Negative Actions, focusing on: 1) optimizing reduction of risk to patients, 2) reducing opportunities for discrimination against legally protected groups, and 3) improving opportunities for lawful work and income among those with a criminal record.

**Suggested Action:** In partnership with relevant entities, develop an educational pilot program for incarcerated individuals approaching release that provides information and resources for participating in the CROP process, and potential career opportunities in behavioral health. The pilot could focus on participants with non-violent, substance use disorder related offenses.

Regarding the DSHS list of disqualifying crimes and negative actions, the [task force report](#) recommended:

- Conducting a review of the crimes on the Secretary’s list of disqualifying crimes to determine if additional crimes should be time-limited, if the time limits on crimes that currently have them could be reduced without increasing risk to vulnerable individuals, if the circumstances surrounding a crime should automatically be considered during the determination of suitability for employment, and whether there are certain crimes that are more impactful on individuals with lived experiences or disproportionately affect black, indigenous, people of color, or individuals who use a language other than English.
- Examining the use of a variance process for crimes on the DSHS list that are not prohibited by law.
- Supporting individualized decision-making when not prohibited by statute or regulation.
- Displaying information on how to apply for a variance or exception to automatic disqualification prominently on DSHS website with other information on criminal background checks.

In 2022, the Legislature provided \$250,000 to the Office of Financial Management (OFM) to explore the creation of a centralized office to review existing requirements and processes for conducting applicant background checks for impacted individuals, and to provide a feasibility study and implementation plan for establishing a state office to centrally manage criminal background check processes for impacted individuals.

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*“We’ve hired staff and then have had managed care organizations send us a letter that, although [that individual was] approved through the Department of Health for the licensure, [the organization] won’t allow that staff person because of their criminal background to treat any of their patients.”*

— Behavioral Health Agency

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Related legislation also passed, although one key law to create a pilot project to vacate criminal records automatically (HB 2793) was vetoed due to COVID-19-related costs:

- **HB 1411 Expanding healthcare workforce eligibility** (2021) modified some of the crimes from the list of disqualifying items that could be applied to long-term care workers. Employers may no longer automatically disqualify long-term care worker applicants for some crimes after a certain amount of time has passed. The bill amended the law to make six formerly permanently disqualifying convictions only be disqualifying for a period:
  - Selling marijuana.
  - Theft in the first degree.
  - Robbery in the second degree.
  - Extortion in the second degree.
  - Assault in the second degree.
  - Assault in the third degree.

Once the time has elapsed, the convictions are no longer disqualifying, and a long-term care employer (all settings) performs a Character, Competence, and Suitability review. For Individual Providers, the Consumer Directed Employer and the client perform this review.

HB 1411 was focused on allowing self-directed service recipients to have the choice to hire an Individual Provider with a disqualifying conviction history. The report from this work will be available in December 2022.

- **HB 1768 Concerning substance use disorder professional practice** (2019) prevents substance use disorder (SUD) professionals from being automatically denied employment at facilities that serve vulnerable adults based on certain crimes, if a certain time period has passed. It also changed the requirement for SUD professionals to participate in the voluntary substance abuse monitoring program from five years of recovery to one. Other professions, except for agency affiliated counselors working as peer counselors, must still participate until they have achieved five years of recovery.

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*"There's a lot of stereotyping out there and I think there's a lot of misunderstanding about what risks there are to employers for hiring [people with a criminal record]."*

— Government agency

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- **HB 2793 Vacating criminal records** (2020) passed the Legislature, but it was vetoed due to cost at a time when COVID-19 impacts were affecting the state budget. This legislation would have created a pilot project to allow individuals to apply to vacate some previous convictions after a period of time had elapsed.

## CROP

CROP is a vacation process in which an individual who achieves CROP is able to apply for employment and not disclose background history, with some exceptions.<sup>6</sup> CROP is not behavioral-health specific and may be used for any profession.

One additional task of SB 5092 Proviso 40 in the 2021 budget was to “Expand community awareness and engagement with Certificate of Restoration of Opportunity (CROP) and its potential benefits.” The report recommended:

- Conducting a study on streamlining the vacation of criminal convictions such as that proposed in HB 2793 (described above). This single policy action would increase access to employment and housing opportunities and close the gap between CROP eligibility and utilization.
- Making information about CROP available at the time individuals become eligible to vacate their record.
- Replicating Options Addiction Counselor Training Model in Washington State correctional facilities, which is also used in California. The primary goals of the program are to reduce the incidence of SUDs among incarcerated populations and improve employment opportunities post-release.

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*"This does disproportionately affect communities of color and [the] low-income population, so it's important for the people who get it. As for the overall impact to employment as a result of CROP — this is really hard to estimate. But if it affects YOU, then it matters."*

— Government agency

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## Areas of Improvement Identified by Stakeholders

### *Background checks and disqualifying crimes*

Background checks continue to be complex, and there are differing processes depending on profession, facility, and type of work.

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<sup>6</sup> Class A felonies, extortion, drive-by shootings, luring, and some sex-related crimes



Stereotyping and general misunderstanding of the risks of hiring people with a criminal record was seen as a barrier — and linked to the barrier of businesses using background checks even when not required by law. Businesses may also not know how to make employment determinations based on the information they find. Background check information can also be inaccurate.

Background checks impact substance use disorder professionals (SUDP), peer counselors, and those with lived experience more than other professions. Stakeholders report barriers to hiring some professionals who have a criminal background, and the steps to get it expunged are lengthy and difficult. This disproportionately impacts individuals with behavioral health conditions, people of color, and people with low incomes.

The behavioral health workforce most explicitly affected by the DSHS Secretary's List are DSHS employees and service providers. Workforce members can also fall under one of the [five disqualifying crimes lists](#) if they have access to personally identifiable information through state systems. However, stakeholders, particularly employers, reported that the DSHS Secretary's List is used as a general reference guide by facilities, government agencies, and others when interpreting background check results and in influencing hiring/admissions decisions. This indicates the DSHS Secretary's List has influence beyond its legal scope, and outside of DSHS's intended internal use.

## CROP

To be eligible for CROP, a person must have paid required fines, which can be substantial, and which have 12 percent interest. Populations who are experiencing higher barriers to employment because of their criminal history don't always have the money to hire someone who can represent them in these court processes. An equity issue arises in that this tends to impact people of color and people with low incomes the most.

Further limiting CROP's effectiveness, many stakeholders were unaware of CROP.

## Items for Future Consideration

Stakeholders believed background checks to be an intensely complicated topic given the multiple agencies involved. While previous recommendations brought forward useful ideas such as expanding awareness of CROP, multiple barriers continue to exist when agencies and employers must make high stakes decisions that could leave them liable for patient harm caused by a staff member. It could be that a more upstream approach to the issue, such as the pilot outlined in HB 2793 that would streamline the process for individuals seeking to vacate prior convictions, could be considered.

Of note, since 2018, seven states have passed [Clean Slate legislation](#), which creates automatic vacation processes. In the coming years, Washington will be able to assess the impacts of arrest and conviction record clearance on the workforce in other states.

### Key Successes

The Legislature passed HB 1411 in 2021, which placed limits on how the DSHS disqualifying crimes list is used for long-term care workers.

# CATEGORY: Reimbursement

In the reports issued by the Workforce Board on the behavioral health workforce between 2016 and 2021, stakeholders shared that several related reimbursement components are required to create the healthy workforce pipeline needed to fill the gaps from a continued shortage of essential behavioral health professionals. Successfully recruiting and retaining a skilled behavioral health workforce relies on several key reimbursement elements, including:

- Competitive compensation.
- Raising Medicaid rates to positively impact wages.
- Examining capitation rate setting and improving capitation rates.
- Making additional supportive services and professions reimbursable, such as outreach and patient navigation.
- Supporting and incentivizing agencies for their training and clinical supervision functions.
- Assessing salary improvements and incentives, including their impact on the workforce.

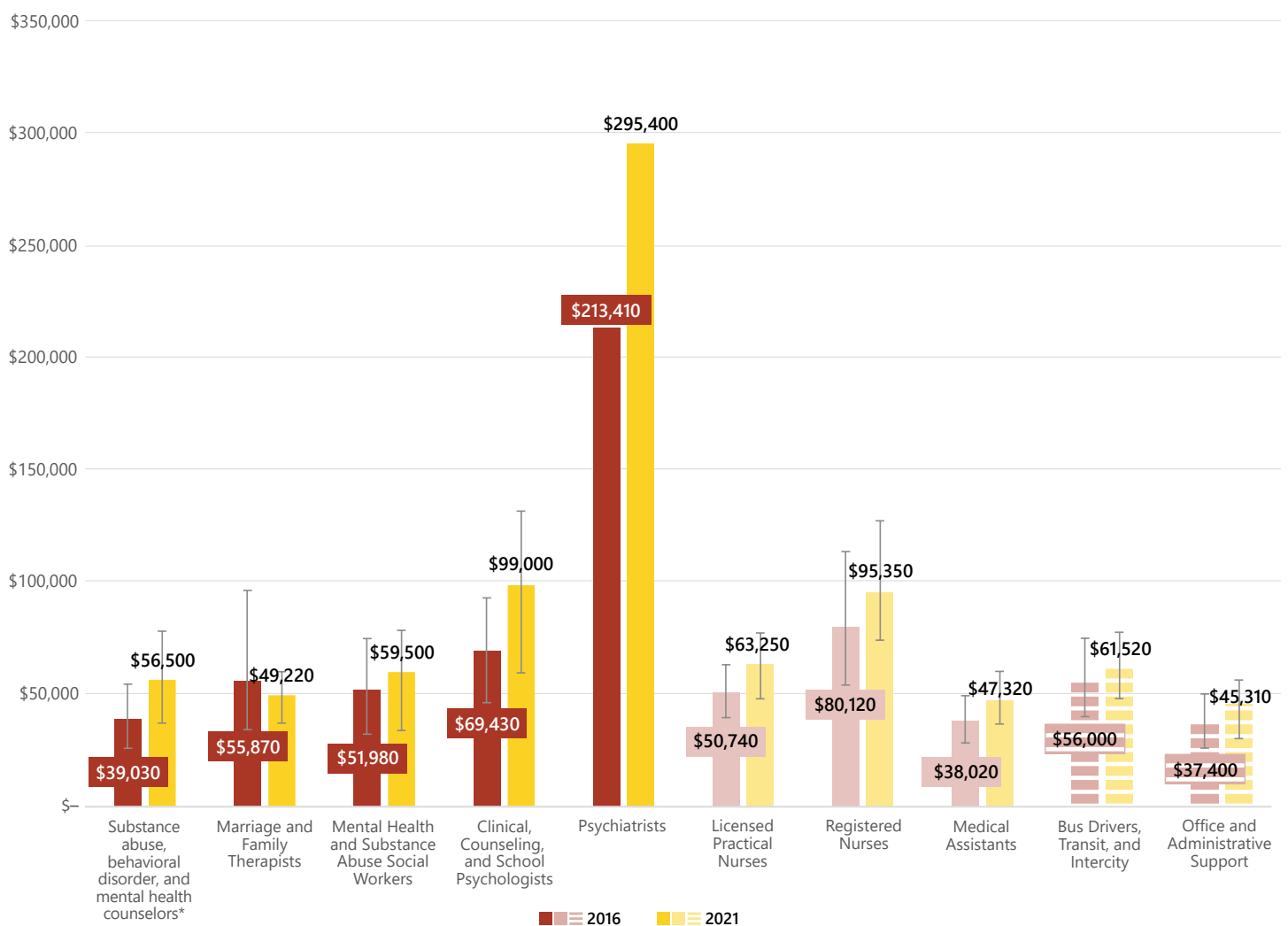
As early as 2016, the Department of Social and Health Services (DSHS) noted that the pay, for example, of a case manager who provides service coordination for clients was less than the U.S. Department of Housing and Urban Development's (HUD) "Very Low-Income Level" for the Seattle area for a family of three. In an updated assessment of salaries of behavioral health occupations in 2021 (see graph on next page), the data show that master's trained social worker and case manager salaries are now slightly above the "Very Low-Income Level," on average, but still are approximately \$20,000 less than the "Low-Income Level" as defined by HUD for the Seattle area for a family of three, and remain lower than other non-bachelor's or master's trained positions, such as bus/transit drivers. Any salary increases need to be consistent and high enough to achieve the desired effect of growing and retaining the behavioral health workforce. Systemwide, in addition to Medicaid rate increases, behavioral health wages could also be helped by rate increases by other payers, implementation of alternative payment models, such as prospective payment systems, and diversified revenue streams, such as the 0.1 percent sales and use tax authorized by **RCW 82.14.460**. Benton, Franklin, and Snohomish counties recently implemented the optional sales tax to provide additional funds for behavioral health services in those counties.

Lack of compensation for services as a training site negatively impacts community behavioral health agencies' (BHAs') ability to continue serving a critical workforce development role for students and new graduates. The COVID-19 pandemic severely compounded these challenges. Support for these agencies to continue as necessary training grounds for the state's behavioral health workforce is important. The Workforce Board's multiple reports over the years have consistently called attention to the fact that our state's community facilities are acting as de-facto

training grounds for much of the behavioral health workforce by offering clinical training and supervision for incoming and new providers. Developing and sustaining funding mechanisms for the vital training and supervision functions of community BHAs remains a priority.

In addition to master’s level behavioral health professions, other behavioral health-focused professions, such as psychiatric mental health nurse practitioners (PMHNP), are experiencing clinical training bottlenecks. These bottlenecks are limiting universities’ ability to train PMHNP students. While private philanthropy is currently providing stipend support for sites training PMHNPs, it is necessary for policymakers to consider how to create sustainable solutions for clinical training of all behavioral health professions.

### Estimated Average Full Time Salaries of Selected Behavioral Health Occupations and Comparison Occupations in Washington State in 2016 and 2021.



\*The BLS combined the individual salary estimates for these occupations after 2017, so separate estimates for each occupation are no longer available. Ranges on bars indicate 10th and 90th percentiles of salaries for each occupation. 2022 Graphic updated from 2017 Washington State Behavioral Health Workforce Assessment. Olympia, WA: Washington Workforce Training and Education Coordinating Board; using Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics, Washington, May 2021 <https://data.bls.gov/oes/#/home>

## **Recommendations from the prior reports:**

**R1:** Increase the Medicaid reimbursement rate.

**R2:** Examine the way capitation rates are set to create a rate that better reflects the true cost of care and regional impacts; explore implementation of alternative payment models.

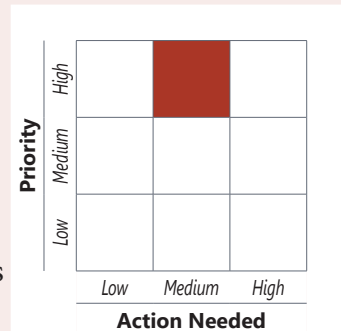
**R3:** Develop and implement a funding mechanism that recognizes and supports community BHAs for performing a significant training function required for behavioral health workers to obtain their educational degree or completion of a registered apprenticeship and their clinical licensure.

**R4:** Expand the list of professions eligible to bill as mental health providers.

# R1: Increases to Medicaid reimbursement

## 2022 Takeaways

The Legislature funded a two percent rate increase in 2021 and a seven percent directed increase on top of that in 2022. Addressing low reimbursement rates has been a key recommendation of the Workforce Board's Behavioral Health Workforce Assessment every year. The rate increase was implemented through a state directed payment, meaning the managed care organizations (MCOs) were required to pass those funds directly on to providers. Some provider stakeholders reported that they have not yet seen the two percent increase. Current law requires the Health Care Authority (HCA) to validate that targeted rate increases are implemented appropriately, and HCA is in the process of doing that now. If there are instances in which it appears funds were not being passed on to providers, HCA will work with the MCOs to ensure those are corrected.



It is important to note that stakeholders overwhelmingly have reported that this combined increase is not enough to counteract the effects of recent inflation and multi-generational underinvestment in Washington's behavioral health system. Low wages for behavioral health service providers continue to affect recruitment and retention. Additional rate increases are necessary to bring wages to a competitive level in the marketplace as well as to address recent inflation.

Originally created in 2017, reissued in 2021 with the same language.

## Summary of Progress to Date

The Legislature provided funds for a two percent rate increase in 2021, and a seven percent increase on top of that in 2022, for all services paid through the behavioral health portion of the Medicaid managed care capitation rates. The two percent rate increase was effective April 1, 2021. The seven percent rate increase will be effective January 1, 2023. Both increases are automatic; behavioral health organizations don't have to apply for them. (Note: Opioid Treatment Program services were excluded from the seven percent increase, as they were eligible for a 32 percent increase.) The rate increases were implemented using a state-directed payment. This is a Centers for Medicare and Medicaid-approved option that allows the state to require MCOs to make certain changes to reimbursement levels. MCOs are required to increase rates paid to providers. How behavioral health service providers choose to use those funds, whether for staff wages increases or other expenses, is outside the control of the HCA.

### Key Successes

The Legislature funded a two percent rate increase in 2021 and a seven percent increase in 2022.

HCA was provided one-time \$100 million in workforce stabilization and relief funds in the 2022 Legislative Session, another top recommendation of the Workforce Board's 2021 report. The funds are intended to provide lump sum payments to eligible community behavioral health treatment providers, including tribal healthcare providers, who are contracting with MCOs or behavioral health administrative services organizations (BH - ASOs). As of October 2022, \$92 million has been offered to various community behavioral health treatment providers. Payments are scheduled in September and October 2022 to providers who return their signed contracts by designated due dates. Some providers reported that they are using this funding as "bridge funding" to provide salaries/benefit enhancements to behavioral health workers while waiting for the seven percent rate increase to take effect in January 2023. (For more information about the workforce stabilization fund please see RR2: Behavioral health career financial support/Pandemic relief on page 26).

### Pending Rate Development Change

At the time of this report drafting, HCA is working with Milliman, Inc., a contracted actuary service, to develop the calendar year 2023 MCO capitation rates. These are the rates that HCA pays to the plans and account. They are not provider rates. Based on updated utilization and cost information, behavioral health MCO capitation rates at a statewide composite level reflected a decrease from calendar year 2022, which has caused considerable concerns for stakeholders. The specific provider impact of changes to the MCO rates will depend on the specific contracting arrangement that provider has with their MCO. As of the submission of this report, November 2022, a final decision remains under development.

### Prior Recommendation and Suggested Actions

Increase reimbursement rates. Adjust reimbursement rates to better support competitive recruitment/retention of skilled behavioral health workforce.

**Suggested Actions:** Implement a minimum seven percent increase to Medicaid reimbursement for licensed and certified community BHAs contracted through managed care organizations

The rate increase shall prioritize staff compensation in all behavioral health non- hospital inpatient, residential, and outpatient providers receiving payment for services contracted through the MCOs.

DSHS and/or the HCA should act on the following recommendations: Prioritize funding levels that keep Medicaid capitation rates high enough to positively influence wages.

**Suggested Action:** HCA shall provide an annual report to the Governor and the appropriate committees of the Legislature detailing how the rate increase was used to improve employee recruitment and retention and, where data are available, information on recruitment and retention of underrepresented populations.

## Areas of Improvement Identified by Stakeholders

Some stakeholders report they have yet to receive the 2021 two percent rate increase. Some MCOs require re-negotiation of contracts for behavioral health providers to receive the increase. Due to the highly competitive job market, some behavioral health providers are temporarily funding wage increases for their workers before the seven percent rate increase becomes available in order to retain staff.

Stakeholders stated that the seven percent was designed to be a starting point, and that it is important that this is not a one-time increase. All partners who spoke agreed seven percent was insufficient to counter historical underinvestment in behavioral health, and that Medicaid reimbursement rates need to increase regularly. Stakeholders said the real

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*"[We need to make sure it is] very transparent that rate increase is supposed to get to the providers. That you can follow that money from the budget that was passed down to the provider."*

— Advocacy Organization

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costs of serving vulnerable populations should be considered. Also, the U.S. Bureau of Labor Statistics' Consumer Price Index has increased 8.2 percent since September 2021, reflecting increased costs for both employers and workers<sup>1</sup>.

Some shared that passing the money through MCOs created lack of transparency. However, due to the laws and regulations that govern Medicaid, MCOs must be involved if the rate is increased. The other option is an arrangement like the provider relief funds described in the recruitment

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*"One managed care partner reached out to me a couple months ago and wanted to fully re-paper our contract to finally implement that two percent ... we still have not seen that two percent increase from at least one managed care partner."*

— Behavioral Health Agency

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and retention section, but that is a one-time payment. Different billing types also caused confusion, as stakeholders were unable to see whether the full seven percent is going to each organization.

Funding for rate increases is appropriated to HCA, who then distributes funding to the MCOs, who in turn use those funds to reimburse behavioral health organizations for provided services. There have been some significant delays in distributing to some organizations, and as noted previously some BHAs have yet to receive the two percent increase, in part due to administrative burden. Stakeholders shared that this causes a cash flow issue.

While stakeholders said they are very supportive of the Legislature increasing the rates paid to the MCOs, they shared that it also causes additional administrative work for the behavioral health providers. A rate increase typically involves contractual amendments or entire new contracts between the MCOs and behavioral health organizations. Reviewing these amended or new documents can consume significant administrative time, particularly if an organization is contracted with all five MCOs. Stakeholders reported that this burden can impact smaller clinics with fewer administrative resources in particular.

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*"Providers shouldn't have to go through five contract negotiations to get what they're supposed to receive based on the Legislature."*

— Behavioral Health Agency

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Stakeholders report some MCOs were quick to make contract changes, but others can take months or even years. Some agencies are negotiating with MCOs as they implement the two percent, by creating flex contracts so that the seven percent will automatically increase in Jan 2023. Not all agencies have the resources to negotiate such complexities.

## Items for Future Consideration

Some stakeholders shared their concerns regarding the distribution process of the seven percent rate increase by MCOs to community providers. To address these concerns, it was suggested that MCOs develop a communication and distribution plan to inform providers of the processes, procedures, timeline, and other requirements for the distribution of funds. The timeliness and administrative burden are of particular concern, as they are barriers to the planning and implementation plans of providers.

While the two rate increases provided by the Legislature are greatly appreciated by stakeholders, the rapid inflation occurring nationally in 2022 undermines the impact as operating costs have increased. Additional increases are necessary to drive needed change.

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<sup>1</sup> U.S. Bureau of Labor Statistics, Consumer Price Index, September 2022

# R2: Medicaid managed care behavioral health rate development and alternative payment models

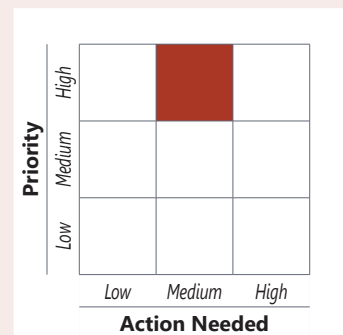
## 2022 Takeaways

HCA is currently working on a study to establish benchmark behavioral health payment rates and a fee schedule that can be used for assessing the costs associated with expansion of services, rate increases, and Medicaid managed care plan state directed payments. The preliminary report is due June 2023.

The Certified Community Behavioral Health Center (CCBHC) model continues to grow in Washington with 17 facilities now funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) expansion grants. HCA is in the process of completing a CCBHC payment model study funded via a budget proviso.

The Washington Council for Behavioral Health (Council) has proposed the following actions to help move the state towards statewide implementation of the CCBHC model, and the Behavioral Health Workforce Advisory Committee (BHWAC) supports this request:

**2022 Recommendation:** Provide continuation funding for planning and development of Certified Community Behavioral Health Clinics. Build on foundational work from FY 2022 to develop a sustainable, prospective payment system for comprehensive community behavioral health services by refining the CCBHC model, pursuing federal demonstration state status, conducting related actuarial analysis, obtaining continued technical assistance from the National Council for Mental Wellbeing, and proposing a pathway for statewide implementation of CCBHCs.



Originally created in 2017, reissued in 2021 with the same language.

## Summary of Progress to Date

There have been two budget provisos that have advanced work on developing benchmark rates and sustainable alternative payment models:

First, under **SB 5092 (2021), Section 2015, Proviso 59: Behavioral Health Comparison Rates**, the Legislature provided \$400,000 in funding for the HCA to contract for a study to establish benchmark behavioral health payment rates and a fee schedule that can be used for assessing the costs associated with expansion of services, rate increases, and Medicaid managed care plan state directed payments.

- HCA is collaborating with Milliman on this Behavioral Health Rates Comparison Project.

- The objectives are to:
  - Develop and publish behavioral health provider payment comparison rates that are consistent with efficiency, economy, quality of care, and access to care.
  - Provide an examination and understanding of the provider resources involved in delivering individual-covered behavioral health services.
  - Provide transparent payment rate benchmarks for use by all stakeholders, including during negotiations between payers and providers.
- The study is also intended to help support HCA in making informed decisions regarding changes to covered benefits, improve transparency in analysis and communications, and evaluate variations in provider payment through comparison of actual payment rates vs. benchmark rates.
- The project kickoff and workgroup engagement started in October 2021. The participants included stakeholders with provider-level program and financial expertise. Three workgroups were formed: mental health outpatient, SUD outpatient, and SUD residential. The study involves a comprehensive evaluation that includes direct/indirect, administration, and other related costs.
- Phase 1 was completed in June 2022.
- HCA will deliver a preliminary report to OFM by June 30, 2023.

### Prior Recommendation and Suggested Actions

Increase reimbursement rates. Adjust reimbursement rates to better support competitive recruitment/retention of skilled behavioral health workforce.

**Suggested Actions:** Examine the way capitation rates are set and address the underlying assumptions in the actuarial study to set a rate that better reflects the true cost of care and regional impacts. The Legislature would need to be more directive with the actuary developing the rates.

Open up the Medicaid state plan to make more services reimbursable such as outreach, patient navigation/management, travel, and care coordination. These services were not CMS-reimbursable as they are not included in the Washington State Plan Amendment.

Provide additional technical assistance and regional salaries data to facilitate transition to Value-Based Payments, particularly to assist community-based facilities who are investing time in identifying their needs and resources.

Second, under **SB 5693, Sec. 215 (106) CCBHC Payment Model Study** in their 2022 budget, the Legislature provided \$600,000 in funding to the HCA to explore the development and implementation of a sustainable, alternative payment model for comprehensive community behavioral health services, including the CCBHC model, which provides for an enhanced Medicaid reimbursement rate based on anticipated costs of expanding services to meet the needs of complex populations. This funding is also intended to be used to obtain actuarial expertise, technical assistance from the National Council for Mental Wellbeing, conduct research into national data and other state models, and engage stakeholders including representatives of community BHAs and MCOs.

## Key Successes

The Legislature provided \$600,000 to HCA to explore the development and implementation of a sustainable alternative payment model for comprehensive community behavioral health services.

More specifically, the study involves:

- Overviews of alternate payment models and options and considerations for implementing the certified community behavioral health clinic model within Washington state.
- An analysis of the impact of expanding alternate payment models on the state's behavioral health systems.

- Relevant federal regulations and options to implement alternate payment models under those regulations.
- Options for payment rate designs.
- An analysis of the benefits and potential challenges in integrating the CCBHC reimbursement model within an integrated managed care environment.
- Actuarial analysis on the costs for implementing alternative payment model options, including opportunities for leveraging federal funding.
- Recommendations to the Legislature on a pathway for statewide implementation.
- The HCA, Milliman, and the National Council for Wellbeing (a national expert on the topic) are collaborating on this project.
  - Two workgroups have been created and are underway: practice work group and payment model work group.
  - The HCA must provide a preliminary report to the Office of Financial Management and the appropriate committees of the Legislature with findings, recommendations, and preliminary cost estimates by December 31, 2022.

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*"This is an area where Washington State needs more investment. Data on national models shows a ROI in terms of growing your workforce due to better compensation packages."*

— Government Agency

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Since 2020, SAMSHA has awarded 17 CCBHC expansion grants to Washington to assist with the start-up costs of becoming CCBHCs and providing 24/7 comprehensive healthcare programs. Stakeholders are optimistic about the workforce opportunity offered by the CCBHC model and appreciative of the support provided by the Legislature so far.

HCA submitted a 2023 decision package to pursue a SAMSHA planning grant to become a new demonstration state beginning in 2024. Demonstration state status is required for state-certified CCBHCs to receive the special Medicaid payment methodology, known as the prospective payment system.

The Council has proposed the following actions to help move the state towards the CCBHC model, and the BHWAC supports this request:

**Recommendation 6:** Provide continuation funding for planning and development of Certified Community Behavioral Health Clinics. Build on foundational work from FY 2022 to develop a sustainable, prospective payment system for comprehensive community behavioral health services by refining the CCBHC model, pursuing federal demonstration state status, conducting related actuarial analysis, obtaining continued technical assistance from the National Council for Mental Wellbeing, and proposing a pathway for statewide implementation of CCBHCs.

Regarding value-based payments, HCA is exploring and considering these payment structures for several clinical programs. Behavioral health is an area of study for future payment re-design and development. CCBHC implementation could serve as a building block for value-based models, where providers can have an opportunity to be paid more when they deliver high quality outcomes.

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*"Fund diversification is built into the CCBHC model, which is one of the reasons it is successful."*

— Government Agency

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## Areas of Improvement Identified by Stakeholders

Community BHAs noted that value-based payments are new to MCOs and there is still a lot of work to do to increase payers' understanding of the model. This is in large part because existing models are not tailored to behavioral health.

HCA noted that the CCBHC model is an area where Washington needs more investment. In order for providers to understand, explore, and do planning to determine if this model will work for their agencies, they need access to utilization data and other relevant information from MCOs.

## Items for Future Consideration

Although it is a huge challenge, HCA should propose having services such as outreach, travel, care navigation, and care coordination qualify for Medicaid program reimbursement in future State Plan Amendment processes with CMS. These services are currently non-reimbursable.

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*"Most providers have a contract and processes, sometimes they're drawn out so we're still negotiating some January 1, 2022, stuff which incorporates some new acuity-based rates and likewise, so there's cash flow problems ... where it's almost September."*

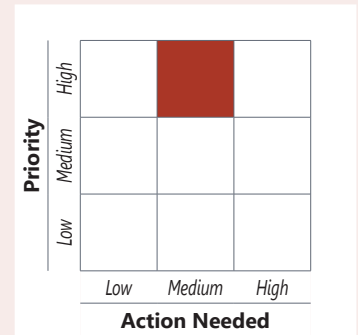
— Practitioner

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# R3: Reimbursement and incentives for student clinical training in community-based organizations

## 2022 Takeaways

Funded by the Legislature, HCA has led a workgroup to develop standards and recognize costs associated with a teaching clinic enhancement. A related project, funded by Ballmer Group, is engaging the Council to conduct a demonstration project that explores funding and training at community BHAs as part of supporting those facilities with their training efforts. Evaluation of outcomes from the demonstration project can help inform future investments.



Originally created in 2017, updated in 2020 and 2021.

## Summary of Progress to Date

HCA received \$150,000 from the Legislature in 2022 to convene a workgroup and work towards developing a recommended teaching clinic enhancement rate for BHAs training and supervising students and those seeking their certification for license.

The report will be going to the Legislature in December 2022 and will address teaching clinic standards and a preliminary teaching clinic enhancement rate. HCA partnered with Mercer Government Human Services Solutions to conduct the actuarial analysis. In order to develop enhancement rate methodologies, they developed and deployed a provider survey, then analyzed the results to better understand current clinical practices, costs, and revenue, based on three different staffing types (interns, trainees, independently licensed practitioners), productivity rates, and related items.

Complementing the state's investment, Ballmer Group provided \$1.1 million in funding to the Council to conduct a teaching clinic enhancement demonstration project, which will include six clinical pilot sites. The project began in the Fall of 2022. The Council will use the preliminary findings of HCA's report to inform its work, which will include testing and refining standards for qualification as a teaching clinic and financial analysis of the cost to providers who engage in education and training of interns and trainees.

Those participating in the program are both students pursuing clinical education (specifically, master's level clinical degrees) and clinicians who have completed their formal education and are paid employees working towards their independent clinical license.

*"I just want to advocate for the incentivization at least trickling down to some extent to the supervisor level."*

— Professional Organization



## Prior Recommendation and Suggested Actions

Support both the student and new-graduate training functions of community BHAs:

- Develop and implement a funding mechanism that supports community BHAs for performing a significant training function required for behavioral health workers to obtain their educational degree or completion of a registered apprenticeship and their clinical licensure.

### Suggested Actions:

- HCA was directed by the Legislature under proviso 74a from SB 5092 (2021) to develop a recommended teaching clinic enhancement rate for BHAs training and supervising students and those seeking their certification/license.
- After recommendations are issued as charged in proviso to the HCA, the Council should further develop the rate via pilot site testing, as previously funded by private philanthropy. HCA must coordinate with the Council throughout the pilot site testing process and may seek supplemental funding from the Legislature if necessary.
- Create a stipend for clinical supervision of students, based on patient encounters lost. Provide a stipend for clinical supervision to incentivize potential or existing sites to provide supervision. Structure it to allow for the tracking of payments used for supervision, including non-billable time dedicated to supervision of student interns, which cost the BHAs potential billable time. Note: this proposal is limited to students, because tracking of student supervision is already required of clinical training sites by education programs and building on this existing structure would not create a new administrative burden for supervisors and supervising agencies.

## Areas of Improvement Identified by Stakeholders

Stakeholders reported significant concerns with the survey structure for the rate enhancement study, including the volume of data required and the confusing nature of its design. One person noted that, “[The survey structure] didn’t understand the variety and complexity and nuance of the type of training that we do in our clinics,” so the data may not be reliable. The survey ultimately received seven responses. Given the limited sample size, stakeholders said it was best that results of the survey be viewed as preliminary.

### Key Successes

Both public and philanthropic investments are being directed towards supporting community BHAs with their role as training institutions.

## Items for Future Consideration

If the teaching clinic demonstration project shows effective outcomes in supporting the training of master’s-level students and post-graduate trainees, consideration should be given to expanding implementation statewide. The model may also prove informative in how to support the clinical training of other essential health professions at a variety of types of facilities.

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*“Low compensation is a huge issue — and we must compensate supervisors well. Direct service staff tend to have higher work satisfaction when they have a positive supervisory relationship — and when their supervisor stays!”*

— Behavioral Health Agency

Stakeholders reported high levels of support for creating a stipend to incentivize potential or existing sites to provide clinical supervision of students. Two philanthropically funded programs are currently providing stipends to sites providing clinical rotations to psychiatric mental health nurse practitioner students and could provide a model. For more information, see recommendation E3, Graduate more behavioral health professionals licensed as prescribers. Some stakeholders also support direct financial incentives for supervisors.

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*"I also think smaller agencies are at a disadvantage to compete with bigger agencies for a competitive stipend for interns. I think a set stipend amount for the state can be great from the equity perspective."*

— Practitioner

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It is important to note that using a rate to support facilities' training functions may create administrative complexity for both BHAs and HCA. Throughout the feedback sessions, regardless of topic, stakeholders expressed frustration with the overall level of administrative work behavioral health facilities must complete as part of fulfilling their mission. Depending on how incentives such as teaching clinic rates are structured, some facilities may choose to not participate because of additional administrative requirements.

# R4: Expand professions eligible to bill as mental health providers

## 2022 Takeaways

The Department of Health (DOH) accepted a rule petition to consider including pharmacists in the definition of mental health professionals. There is not currently a timeline for when this rulemaking will begin.

|        |               |        |      |
|--------|---------------|--------|------|
|        | Low           | Medium | High |
| High   |               |        |      |
| Medium |               |        |      |
| Low    |               |        |      |
|        | Low           | Medium | High |
|        | Action Needed |        |      |

Originally created in 2017.

## Summary of Progress to Date

DOH has accepted a rule petition from the Washington State Pharmacy Association to consider amending **WAC 246-341-0515** to include pharmacists in the definition of mental health professionals. There is not currently a timeline for when this rulemaking process will begin.

There are opportunities to further integrate additional professions that already provide services in mental health settings, such as occupational therapy, into Washington's behavioral health system. The Washington Occupational

Therapy Association is supportive of expanding the use of their profession's specialized services within mental health settings to positively impact the functional behaviors of clients needing interventions.

Two pieces of legislation were put forward in 2022 but did not pass:

- **SB 5884 Establishing behavioral health support specialists** (2022) would have created the behavioral health support specialist position.
- **HB 1865 Addressing the behavioral health workforce shortage and expanding access to peer services by creating the profession of certified peer specialists** (2022) would have created advanced peer specialists and created a different kind of license, allowing peers to work in different settings.

### Prior Recommendation and Suggested Actions

Expand the list of professions eligible to bill as mental health providers.

**Suggested Actions:** Policymakers should request that DOH conduct a Sunrise Review of the professions recommended for an expanded scope of practice to include a greater range of behavioral health services

Policymakers should request that the HCA/DSHS review billing limitations for approved services and consider if other professions such as occupational therapy and speech-language pathologists should be included.

*"If it created new capacity, that would be great. But, if it just slices the pie in more and smaller slices, then I do not think that would be helpful."*

— Provider Network

## Areas of Improvement Identified by Stakeholders

Stakeholders felt that this recommendation was still somewhat relevant. They feel the action items, however, are out of date. The recommendation requires a new approach, one that is aligned with the many changes that have happened with new developments in the field in the past few years, such as peer counselors, and apprenticeships.

Stakeholders raised concerns that creating new occupations without new funding sources will cause harm to the field.

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*"Yes [it is still relevant], but it needs to be done with stakeholder input so as to not disrupt the current system in a negative way."*

— Practitioner

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## Items for Future Consideration

If the Legislature creates new behavioral health professions, or if existing professions, such as pharmacists, are used in new ways, careful consideration must be given to whether changes in reimbursement are needed to allow these professions to bill for services.

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*"I think we need to focus on creating a pathway to a great career in existing professions."*

— Behavioral Health Agency

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# CATEGORY: Education and Training

Educational and training capacity are components that influence who and how many individuals enter the behavioral health workforce. Educational output is greatly affected by shortages of clinical training sites across professions. Across healthcare professions, student clinical training provides a key recruitment tool for employers, as students who have a good experience at a site can be more willing to accept a later job offer.

In the Workforce Board's reports from 2016-2021, behavioral health stakeholders found a series of needs important to supporting the education and training system:

- Increase access to clinical training for those entering behavioral health occupations.
- Support the growth of the peer counselor workforce; increase the ability of behavioral health agencies to accept students by incentivizing and supporting clinical training sites.
- Increase the number of health professionals able to prescribe psychiatric medications and provide medication-assisted substance use treatment.

In addition to generally increasing the size of the workforce, recruiting, supporting, and retaining learners from underrepresented communities is critical to ensuring that the behavioral health workforce reflects the diversity of the communities it services and delivers culturally and linguistically appropriate services.

## Background

Appropriate clinical training prior to graduation from an educational program is necessary not only to effectively teach real-world practice, but also to ensure that the skills that were introduced in school programs are mastered. Staff at behavioral health sites take on additional responsibilities when supervising or precepting students. Backfill arrangements must be made to adequately manage caseloads for clinicians also serving as student supervisors or preceptors. Stakeholders have expressed concern that too few clinical training sites with appropriately trained supervisors or preceptors are available to adequately support existing behavioral health education programs and future expansion, and that the costs of training and supervision need to be covered. Stakeholders requested incentives for training sites and supervisors/preceptors. Additionally, there has been a call to grow registered apprenticeship programs to get people who lack access to higher education into the workforce.

While they do not replace graduate-trained behavioral health professionals, peer counselors can be a critical component and complement to behavioral health treatment teams. Peer counselors and other community health workers in the behavioral health workforce are more likely to reflect the diversity of their communities. Lived experience is often what causes these individuals to become part of the community health workforce. Stakeholders noted that behavioral health service settings

are increasing their demand for peer counselors and other community health workers. During the COVID-19 pandemic a training and testing backlog built up for peer counselors. Health Care Authority (HCA) has expanded training capacity in order to reduce the backlog. As of October 20, 2022, the training waitlist included 700 individuals, down from 1400.

The limited availability of some health professionals able to prescribe psychiatric medications and provide medication-assisted substance use treatment is a barrier to the integration of healthcare. Primary care providers, such as physicians, advanced registered nurse practitioners (ARNP), and physician assistants, are legally able to prescribe both psychiatric and physical health medications, but stakeholders report that many providers working in primary care are not comfortable providing psychiatric medication management for patients with an acute mental health diagnosis. Additionally, depending on the number of patients served, prescribing medication-assisted treatment (MAT) for opioid misuse treatment requires a special training and a federal waiver process for primary care providers. Recent challenges with clinical placements for psychiatric nurse practitioner students are limiting the number of new students that can be enrolled.

The final recommendation was to expand access to Washington's Integrated Basic Education and Skills Training Program (I-BEST) program. I-BEST operates in community and technical colleges, and quickly teaches students literacy, work, and college-readiness skills so they can move through school and into living wage jobs faster. Some I-BEST programs focus on healthcare occupations, and there are a few programs in the state that include a focus on behavioral health. Expanding I-BEST healthcare programs to include more information on behavioral health occupations could provide the state with an untapped resource of diverse entry-level and paraprofessional providers, such as peer counselors, medical assistants with integrative skills, and substance use disorder professionals (SUDPs). These are the most in-demand professions, according to Key Informants and Sentinels participating in the Health Workforce Sentinel Network. Expanding I-BEST to include more behavioral health occupations could also help students from diverse backgrounds to progress toward degree programs and develop additional skills in areas such as psychology, human services, and community health.

## Recommendations from the prior reports:

- E1:** Evaluate the ability and capacity of behavioral health agencies that are providing behavioral health services to implement training programs, including registered apprenticeships.
- E2:** Expand the role for peer counselors in Washington to support emergency services/ first responder departments.
- E3:** Graduate more behavioral health professionals licensed as prescribers.
- E4:** Expand access to Washington's Integrated Basic Education and Skills Training (I-BEST) Program teaching model, and encourage additional programs that include behavioral health occupations.



# E1: Increase the ability of behavioral health agencies to accept students

## 2022 Takeaways

Ballmer Group made several significant investments in training in the state in 2021. The University of Washington (UW) is currently developing a **behavioral health support specialist (BHSS) role** and a separately developed behavioral health support specialist certification is available at Eastern Washington University. The largest investment by Ballmer Group was made at the University of Washington School of Social Work to support the development of a statewide conditional grant program for master's level mental health counseling, marriage and family therapy, and social work students.



Additionally, the SEIU Healthcare 1199NW Multi-Employer Training and Education Fund (the Training Fund) is implementing a new behavioral health registered apprenticeship program, with funding from Ballmer Group via the Harborview Behavioral Health Institute, the state budget (\$1.6 million through the Department of Labor & Industries), and other public funding sources. The apprenticeship program is possible through legislation passed last year and is operated by the Training Fund's Health Care Apprenticeship Consortium. The new program is enrolling its first cohort of apprentices in Fall 2022.

Work is also underway at the HCA on Proviso 74 (2021), which required HCA to convene a workgroup to develop recommendations for a behavioral health teaching clinic enhancement rate. This rate would address behavioral health agencies that are training and supervising students and those seeking their certification or license. The work should include developing standards for classifying a behavioral health agency as a teaching clinic, a cost methodology to determine a teaching clinic enhancement rate, and a timeline for implementation (see Reimbursement Recommendation 3 for more information). This proviso report will be submitted to the Legislature by December 1, 2022.

Originally created in 2017, updated in 2021.

## Summary of Progress to Date

### Apprenticeships

In 2021, the Legislature passed **HB 1311 Authorizing the issuance of substance use disorder professional certifications to persons participating in apprenticeship programs**. This legislation allows an applicant for the Substance Use Disorder Professional (SUDP) certification or a SUDP Trainee (SUDP-T) certification to participate in an approved registered apprenticeship program, as an alternative to the traditional educational pathway. The Legislature also provided \$1.6 million in funding for the program.

In 2022, the SEIU Healthcare 1199 NW Multi-Employer Training and Education Fund (the Training Fund) began a related program, with funding from Ballmer Group. Implementation is led by the Training Fund's Health Care Apprenticeship Consortium, in collaboration with the Harborview Behavioral Health Institute (BHI) and King

County. The Training Fund is managed jointly by SEIU and nine large healthcare systems in Washington. It is an independent nonprofit that works across both groups (i.e., a labor-management partnership).

The goals of the behavioral health apprenticeship program are:

- Help diversify the behavioral health workforce.
- Create additional entry points to the behavioral health field.
- Increase the number of people who provide vital behavioral health services.

The pilot program is funded by various grants, including Ballmer Group. The first cohort began in Fall 2022. Curricula and structured on-the-job training plans have been developed for three apprenticeship programs:

- Behavioral health technician (one year).
- Peer counselor (one year).
- Substance use disorder professional (two years).

The first cohorts of the SUDP and peer counselor apprenticeships began in Fall 2022 with 20 apprentices. Once fully operationalized, the planned scope is to have 20 individuals participating per cohort in each of the three pathways. Recruitment efforts for employers are ongoing, as this is a new program to Washington, and employers aren't yet familiar with apprenticeship for these roles.

The longer-term goal of the apprenticeship program is to provide opportunities for apprentices to articulate their work experience and the college credits they earn during their apprenticeship into a four-year degree program, and possibly beyond. This would increase accessibility and reduce barriers, because apprentices get paid for both their on-the-job training and the related course time. Apprentices in all three of the current apprenticeship pathways participate in accredited college classes through Olympic College.

Reaching underrepresented communities is a primary component of the behavioral health apprentice programs. For employers to take advantage of the grant funding, they must provide a diversity plan. Additionally, when the Health Care Apprenticeship Consortium supports apprentice recruitment, they target apprentices who will reflect the populations they serve.

Tangentially related, in 2022 the Legislature passed **SB 5600 Concerning the sustainability and expansion of state registered apprenticeship programs**. This bill provides structure and resources to further develop apprenticeship programs, although not specifically behavioral health related.

### Prior Recommendation and Suggested Actions

Increase the ability of behavioral health agencies to accept students/trainees by incentivizing and supporting clinical and registered apprenticeship training sites.

**Suggested Action:** Develop and implement a readiness assessment to support behavioral health agencies providing behavioral health services to evaluate their capacity and ability to implement behavioral health training programs. Considerations should include the agency's ability to recruit, support, and retain clinicians/students from underrepresented communities, with potential for sharing best practices among employers.

**Suggested Action:** Promote increased collaboration between universities/colleges and clinics providing behavioral health services for clinical training of behavioral health professions.

### Key Successes

The Legislature passed HB 1311 and provided funding to make a behavioral health apprenticeship program possible. The program began enrolling apprentices in Fall 2022.

## Behavioral Health Support Specialist Training

The University of Washington (UW) is currently developing a **behavioral health support specialist (BHSS) role** at the bachelor's level. This will increase access to evidence-based interventions for the general population through primary care and other behavioral health settings. UW will share their curriculum with any other Washington college or university interested in offering the BHSS specialization. The project is funded by Ballmer Group through 2026 with a goal of training 50 bachelor's level behavioral health support specialists.

Eastern Washington University has developed a 30-credit **behavioral health support specialist certification** through their school of psychology. This certification is available as an add-on for students majoring in psychology, social work, nursing, and addiction studies, as well as an independent certificate for post-baccalaureate students in those areas.

While individuals will be able to receive BHSS training through the programs outlined above, the policy conversation regarding creating the BHSS credential as a separate profession within Title 18 and overseen by the Department of Health (DOH) remains ongoing. **SB 5884 Establishing behavioral health support specialists** (2022) would have created the behavioral health support specialist certification as a profession under Title 18, but it did not pass.

## Grant Program for Master's Level Behavioral Health

Ballmer Group also funded the University of Washington School of Social Work to develop a statewide conditional grant program for master's level mental health counseling, marriage and family therapy, and social work students.

The joint effort is called the Washington State Behavioral Health Workforce Development Initiative. The funds will support 415 conditional grants to students at participating programs through 2026. Twenty different master's programs housed in 13 different universities are participating in the grant work. Following graduation, the grant recipients have a three-year obligation to work at a community behavioral health agency in the state. While the initial cohorts begin training, the Workforce Development Initiative is working closely with the future employers to ensure students will have the education and training experiences they will need to be successful working at community behavioral health agencies.

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*"Conditional grants can play a big role in increasing equity. There are huge structural disadvantages on Persons of Color by assuming that they have family assets or ability to generate credit in order to get a loan. Focusing only on loan forgiveness perpetuates these."*

— Higher Education Institution

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## Online Programs

Several stakeholders from community behavioral health agencies mentioned both benefits and challenges as online master's-level behavioral health programs become more common. Employers spoke of growing numbers of staff and applicants completing these programs and indicated the skills that graduates from most of these programs brought were high quality.

## Areas of Improvement Identified by Stakeholders in 2022

### *Apprenticeships*

Stakeholders are aware of several challenges impacting employer engagement in the apprenticeship program:

1. Reimbursement rates for behavioral health staff are not sufficient, and do not cover the activities needed such as client engagement.
2. Staffing is already shorthanded, so finding someone who can take on the mentor role is challenging. Stakeholders suggested that mentoring in a registered apprenticeship be reimbursable. The new behavioral health apprenticeships include a \$1 per hour increase for staff who serve as an apprentice mentor to help incentivize staff to take on this role.

### *Online programs*

Online programs will most likely continue to grow as learners seek educational programs with greater flexibility. Creating more educational options with the flexibility to allow students to both work and learn at the same time will be key to creating more pathways for advancement. Stakeholders said paying student interns is one potential avenue to resolve this tension. Students can hinder their ability to qualify for Washington licensure if they choose a program that does not include an internship component. For example, individuals seeking a counseling credential have inadvertently attended online psychology master's programs that do not include an internship component prior to graduation. A behavioral health employer said she believed her staff members chose programs without internships because internships are typically unpaid, and these individuals were attending school while working full time. The students could not afford to complete an internship in lieu of working and did not realize the effect of selecting a non-qualifying program on their eligibility for licensure.

### *Readiness assessment*

Regarding the 2021 recommendation made in a prior report to develop a readiness assessment, stakeholders reported confusion around the term “readiness assessment,” which could be misconstrued as a test or a survey. It was intended to mean “a tool to bring down barriers and help them become ready for implementing training programs.” They recommended updating the language for clarity.

## Items for Future Consideration

The overall intent of the recommendation on readiness assessment is to help determine ways to get more people in the workforce. It is a challenge for over-burdened facilities to implement training and education tasks without adequate resources.

### **Key Successes**

The University of Washington is developing a bachelor's-level program funded by Ballmer Group, and Ballmer Group is also supporting master's-level students through a conditional grant program.

For future work, stakeholders suggested restating and/or reframing the recommendation to consider:

- Providing support services and educating facilities to help them understand what is needed to become effective training sites.
- Focusing on agencies' ability to recruit, support, and retain clinicians/students from underrepresented communities; provide examples of best practices in this area among employers.
- Sharing the recommendation with key partners such as the HCA to help guide their efforts.
- Holding feedback forums or soliciting information from existing community meetings such as regional provider meetings, ACHs, etc.
- The impact of changes to college and university behavioral health programs on the behavioral health agencies that rely on students in these programs for their talent pipeline, especially rural areas.

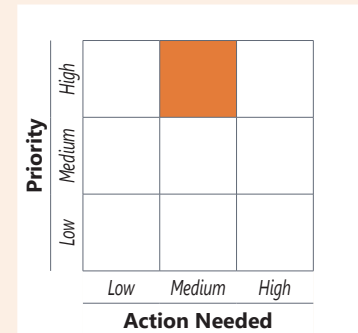
Other potential actions that would further inform behavioral health workforce planning efforts include:

- Conducting an assessment of the capacity of Washington's behavioral health education programs for current and future planning. As a whole, due to the number and different types of institutions involved, Washington lacks a statewide understanding of the entirety of the behavioral health education system. Gaining knowledge about a variety of important factors, such as number of programs, number of seats, entry pathways, application volume, barriers experienced by applicants, and availability of faculty, would assist with centralized, coordinated planning efforts.
- Understanding the extent to which the current supply of Washington's master's level licensed behavioral health providers obtained their behavioral health education outside of Washington and/or through distance learning programs. This could be estimated through a survey of behavioral health providers. This would help quantify the growth of online training programs and better understand how these institutions are contributing to the behavioral health workforce supply in the state.
- Increased support, connections, and collaborations among a variety of post-secondary institutions with behavioral health programs and clinical training sites, including federally qualified health centers (FQHCs) and community behavioral health clinics.

## E2: Peer counselors

### 2022 Takeaways

The role of peer counselors has continued to receive emphasis from the Washington Legislature with several budget provisos and bills. Whether or not to license peers as health professionals through the DOH remains controversial. The HCA included expanded support for community health workers, including peer counselors, in the five-year Washington Medicaid Transformation Project waiver renewal request (1115 Waiver) to the Centers for Medicare and Medicaid Services (CMS). This waiver renewal request is currently in discussion and negotiation with CMS. While negotiation is ongoing, CMS has proposed a three-to-six-month extension of the current Medicaid Transformation Project.



Originally created in 2017, updated in 2020.

### Summary of Progress to Date

One piece of legislation and four budget items recently passed that addressed this recommendation:

- Signed into law: **SB 5644 Concerning providing quality behavioral health co-response services** (2022). The University of Washington (UW), with a co-responder outreach alliance and other stakeholders, will create opportunities for first responders, peer counselors, and behavioral health professionals to engage in training, exchange information, and establish best practices. A state-level assessment and recommendations are due June 30, 2023.
- In 2021, the Health Care Authority (HCA) received \$2 million in the budget for the Community Behavioral Health Program to provide for grants to law enforcement and other first responders to include a mental health professional on the team of personnel responding to emergencies.
- In the 2021-2023 budget, 215 Proviso 40 broadly called to convene a taskforce to examine impacts and changes proposed to the use of

#### Prior Recommendation and Suggested Action

Increase the use of peer counselors and other community-based workers in behavioral health settings, by continuing to expand training capacity and consistency across these occupations. Updated 2020: Anticipate a possible increase in behavioral health workers in emergency services/first responder roles due to the COVID-19 pandemic.

**Suggested Action:** Expand the role for peer counselors in Washington to address any potential increase in demand for workers, as behavioral health workers are needed to support emergency services/first responder departments.

*"What we need is more flexibility and a quicker way of onboarding peers and getting them doing the work they need to do."*

— Practitioner



criminal background checks in employment in the behavioral health setting, with the goal of reducing barriers to developing and retaining a robust behavioral health workforce, while maintaining patient safety measures.

One topic of this proviso was “Expanding the role of peers into emergency services and first-responder roles.” This required an examination of expanding the peer role, a new, state-endorsed certification for peer crisis responders, and continual professionalization of the peer counselor role. Findings and recommendations will be detailed in a forthcoming report.

- **Washington State HCA’s Peer Support Program (PSP)** received \$881,000 in 2021 and 2022 from the state supplemental budget to increase recruitment from Black, Indigenous, and People of Color (BIPOC) communities and educate about peer career opportunities. There had been a backlog of around 1,400 people who applied and were on a waitlist. The HCA is reducing this backlog thanks to this funding. More than 735 people will be able to receive training in 2022. The PSP has also begun conducting train-the-trainer sessions and listening sessions to identify barriers to peer services in marginalized communities.
- **Peer Workforce Expansion Pilot.** HCA also received \$50,000 in 2022 for funding to increase services provided by Certified Peer Support Counselors in the behavioral health workforce in Clark County.

**Additional emphasis on community health workers**, including peers, was included in the 1115 waiver HCA submitted to Medicaid. This waiver review is currently in discussion and negotiation with CMS.

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*“More peer voices need to be involved in the creation of a [peer specialist] bill.”*

— Practitioner

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An additional bill, **HB 1865 Addressing the behavioral health workforce shortage and expanding access to peer services by creating the profession of certified peer specialists**, was put forward but did not pass.

## Key Successes

HCA is successfully reducing the training backlog and is also working to increase recruitment of members of BIPOC communities into the Peer Support Program.

## Areas of Improvement Identified by Stakeholders

Stakeholders are highly supportive of the peer counselor workforce. There was acknowledgment that significant gains had been made, but that these gains aren’t always apparent due to the COVID-19 pandemic’s impact on the workforce. Areas of improvement include:

- More inclusion of peer counselors in developing legislation.
- More clarity on the proposed new certification for peer counselors, and whether it is the same or different from existing ones.
- Concerns about adding training and making careers harder to access if the profession is made a profession credentialed by the DOH under **RCW Title 18**. Many peers are working within their communities, and there is a concern that the addition of training and licensure processes would hinder the work that is already occurring.
- Provide more training opportunities for children and youth peer providers; most available trainings are for adult peer providers.

- Current state rules regarding how and where peers are allowed to work limit their ability to be fully used in crisis response and other settings.

## Items for Future Consideration

The initiative to create the peer specialist profession through **HB 1865 Addressing the behavioral health workforce shortage and expanding access to peer services by creating the profession of certified peer specialists** did not pass the Senate. Stakeholders commented that this topic needs further discussion to:

- Determine the role of peers, the structure of peer support role, and whether they should be classified as healthcare professionals under Title 18.
- If there is an effort to professionalize peer counselors, the legislation development process should include the participation and input of peers and peer-run organizations in the legislation development process.

While HCA has made good progress in reducing the waiting list for the peer counselor certification training program, the Legislature should provide continued support to HCA to fully address the backlog. HCA should consider further expansion of alternative training models, such as train the trainer, to increase access to education.

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*"Students who'd like to become peer counselors, and would like to get trained and certified, can't."*

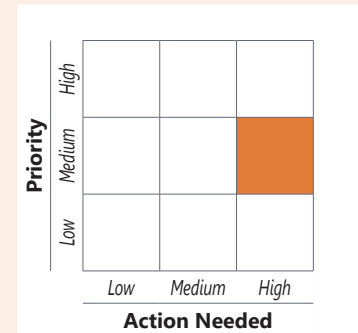
— Behavioral Health Educator

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# E3: Graduate more behavioral health prescribers

## 2022 Takeaways

The original recommendation in 2017 was to create a grant fund to support grants to create or expand psychiatric mental health nurse practitioner (PMHNP) programs. The grant program has not been created. Stakeholders feel this recommendation should be updated and other approaches could be used beyond the idea of a grant program. Stakeholders called attention to clinical placement availability for students, and they noted that since the start of the COVID-19 pandemic, locating clinical placements for PMHNPs has become even more challenging.



Originally created in 2017.

## Summary of Progress to Date

The PMHNP grant program was not created. Stakeholders feel this recommendation should be updated and other approaches could be used beyond the idea of a grant program.

Stakeholders involved in advanced practice nursing education said that finding clinical sites for PMHNP students, while always challenging, has become dramatically more difficult since the beginning of the pandemic. One institution reported that this challenge limited their ability to expand the size of their PMHNP cohort. If placements continue to experience this level of barrier, the program may reduce the number of applicants that it accepts.

Since Fall 2020 there has been success in supporting rural PMHNP training through the UW Premera Rural Nursing Health Initiative (RNHI). The initiative, funded by a \$4.6 million donation from the Premera Foundation, seeks to support training for rural clinical training for nurse practitioner students and the development of rural post-graduate ARNP fellowships. To date, UW Premera RNHI has awarded 76 stipends to students from all six

## Prior Recommendation and Suggested Action

**Graduate more behavioral health professionals licensed as prescribers.** The limited availability of professionals able to prescribe psychiatric medications and provide medication-assisted substance use treatment was identified as a barrier to the integration of healthcare. ARNPs can prescribe both legend drugs and controlled substances, including medications used for behavioral health conditions. Challenges have been reported in both increasing ARNPs' comfort in psychiatric prescribing, and in availability of ARNPs overall, as education requirements increase towards doctoral level.

**Suggested Action:** Policymakers should create a grant program for universities with PMHNP programs in Washington to apply for and receive funds to pay for faculty positions and preceptorship placement. Policymakers should create a grant program to increase capacity in the PMHNP training program. If the (\$5 million) grant program was created, universities could apply for single or multiple \$400,000 grants for a two-to-three-year cycle to educate and train additional PMHNPs and support preceptorships, resulting in approximately 80 additional PMHNPs over the next two to three years. Efforts to help RNs move along career ladders to become ARNPs and PMHNPs should also be explored.

doctorate of nurse practice programs located in Washington. Nine of these awards were to PMHNP students working in rural facilities across the state. UW Premera RNHI works with the clinical placement coordinators and faculty at each university to ensure appropriate rural sites for their stipend recipients. Both the student and the clinical training site receive a stipend from UW Premera RNHI to support the learning experience.

The Washington State Opportunity Scholarship (WSOS) is also providing support to sites where Nurse Practitioner Graduate (GRD) Scholars are completing clinical practicum hours. These students are awarded scholarships to help with the cost of their graduate education and must complete at least 50 percent of their clinical practicum hours in an underserved community. WSOS offers a stipend to both urban and rural underserved community sites training WSOS-awarded ARNP students. In Fall 2021, WSOS welcomed a pilot cohort of eight ARNP Graduate Scholars. Since then, WSOS has awarded seven stipends to five clinics across the state. Three of these stipends were for facilities hosting PMHNP students in an underserved area of Washington. WSOS's goal is for clinical coordinators to be able access new sites or expand capacity at current sites with the offer of the stipend. In Summer 2022, WSOS scaled the program to 19 new Scholars and will continue to work to grow the reach of the stipend program.

Two pieces of legislation related to allowing additional health professions to prescribe psychiatric medications were introduced but didn't pass:

- **HB 1863 Authorizing the prescriptive authority of psychologists** (2022). This bill would have authorized the prescriptive authority of psychologists to help address the lack of mental health prescribers in Washington.
- **HB 2967 Increasing the prescriptive authority of psychologists** (2020). This bill would have granted prescriptive authority for psychologists who obtain additional training. DOH conducted a Sunrise Review in 2020 (amended 2021) that concluded: "The department does not support House Bill 2967 as written because it does not meet the sunrise criteria. Briefly, the criteria state that unregulated practice can clearly harm or endanger public health; the public needs and are expected to benefit from an assurance of professional ability; and the public cannot be protected in a more cost-beneficial manner."

## Areas of Improvement Identified by Stakeholders

Stakeholders still identified an urgent need to provide access to providers who are authorized to prescribe behavioral health medications. They shared various approaches, including expanding the use of:

- Telehealth to maintain/improve access to prescribers.
- Supporting providers' resources such as use of the Partnership Access Lines (PAL).
- Examining the potential expansion of roles of pharmacists for this purpose.
- Strengthening pathways into the Psychiatric ARNP role.

### Key Successes

UW Premera RNHI has supported rural clinical training experiences for PMHNPs across the state.

## Items for Future Consideration

Stakeholders support updating this recommendation, and they continue to pursue grant funding to initiate a program to educate and train additional PMHNPs, as well as creating preceptorships that could result in more PMHNPs. The nurse practitioner scholarship programs are beneficial to the recipients and the sites. An important note for policymakers: these program structures create a precedent of paying preceptors, or their organizations, a fee for precepting an ARNP student, which has not traditionally been the case in nurse practitioner training. This overlaps with stakeholder feedback regarding an overall need for support to behavioral health facilities that provide clinical training experiences for students.

Stakeholders believed there are also other promising ways to manage the shortage of behavioral health prescriber professionals, such as through care integration and technology:

- Expand the use of Partnership Access Lines (PAL) and telemedicine prescribing.
- Expand the competency of other health professionals, such as primary care physicians, to prescribe psychiatric medication.
- Support the existing efforts by pharmacy school(s) to create a pathway to the behavioral health field for post-graduate pharmacists. See Care Integration recommendation C3 for more information.

# E4: Expand access to the Integrated Basic Education and Skills Training Program (I-BEST) model

## 2022 Takeaways

Two colleges in the Washington State Board for Community and Technical Colleges (SBCTC) system are approved to offer Human Services (Behavioral Science) I-BEST programming. The Legislature should continue to fund the expansion of the I-BEST program for behavioral health.



Originally created in 2017.

## Summary of Progress to Date

The I-BEST model is widely seen as successful; it originated in Washington and has since spread to about 18 other states.

Two colleges in the SBCTC system are approved to offer Human Services (Behavioral Science) I-BEST programming. In addition, 22 colleges offer various Human Services certificates and degrees with the potential to expand to the I-BEST model. Unfortunately, Grays Harbor I-BEST human services programs have been canceled due to budget cuts several years ago.

I-BEST is intentionally built to broaden opportunities for Black, Indigenous, and People of Color (BIPOC); it is an equity model because it shortens the pathway for adult learners exiting the basic education programming and allows them to earn dual credit as they're learning workplace and basic skills.

In 2020, SBCTC received funding through a legislative proviso for the development and expansion of I-BEST.

The funds have been awarded to nine colleges, one of which is currently developing their Behavioral Health I-BEST programming (Lake Washington Institute of Technology). It is year two (of three total) of the proviso, and they are

## Prior Recommendation and Suggested Action

Expand access to the I-BEST teaching model and encourage additional programs that include behavioral health occupations.

Washington's Integrated Basic Education and Skills Training Program (I-BEST) quickly teaches students literacy, work, and college-readiness skills so they can move through school and into living wage jobs faster. Expanding I-BEST healthcare programs to include more information on behavioral health occupations could provide the state with an untapped resource of diverse entry-level and paraprofessional providers, such as substance use disorder professionals (one of the occupations most highly in demand, according to Key Informants and Sentinels), medical assistants with integrative skills, and peer counselors. Expanding I-BEST to include more behavioral health occupations could also help students from diverse backgrounds to progress toward degree programs and develop additional skills in areas such as psychology, human services, and community health.

**Suggested Action:** Increased funding support of policymakers for the I-BEST program.



working on curriculum and integration development. There are not yet students in the classes, as it is still under development.

There will also be potential for I-BEST expansion through the Afghan/Ukraine New Arrival funds, as this funding can be used to support I-BEST programming for immigrant and refugee populations.

## **Areas of Improvement Identified by Stakeholders**

There is interest for this from community colleges, but they need financial support and an available workforce. Many postsecondary programs are currently struggling to recruit faculty.

## **Items for Future Consideration**

Continue to expand the I-BEST program for behavioral health.

### **Key Successes**

The I-BEST model is widely seen as successful; it originated in Washington and has since spread to about 18 other states. In 2020, the Legislature provided three years of funding to develop and expand I-BEST.

# CATEGORY: Licensing

In evaluating the number, distribution, and scope of practice of behavioral health occupational licenses and credentials, the Workforce Board's reports from 2016-2021 found that delays in the credentialing and licensing application process, processing background checks, and extensive paperwork requirements were major frustrations for stakeholders. The Workforce Board also found that there were not enough providers with dual training and certification in mental health and substance use disorder (SUD) treatment to meet system needs. Several licensing and credentialing policies, regulations, and costs influence the number, distribution, and scope of practice of the occupations that comprise the behavioral health workforce.

Thus, several items were prioritized as items for further investigation and ongoing work, including dual-credentialing, licensing reciprocity with other states or countries, and licensure paperwork.

Specific goals for the prior licensing recommendations included:

- Providing opportunities for increased integration of mental health services and substance use disorder treatment.
- Allowing behavioral health experts who are relocating to Washington from other states with an existing clinical license to more easily meet licensing/certification requirements in Washington.
- Reducing reporting requirements that take considerable workforce commitment to keep up with the paperwork and to respond to documentation and audit requirements. These processes can be duplicative and inconsistent.
- Reducing several barriers to licensure, including the time it takes to get licensed, and the lack of reciprocity with other states and countries.
- Address limited opportunities for dual-credentialing, and long timelines to receive some types of credentials.

## Recommendations from the prior reports:

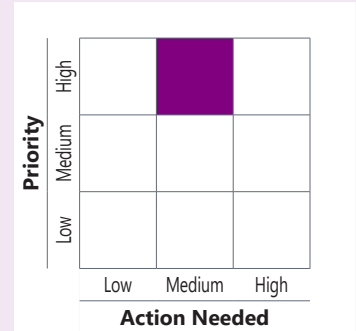
- L1:** Review the incentives for Licensed Mental Health Professionals (LMHPs) to become certified as Substance Use Disorder Professionals.
- L2:** Simplify licensure requirements for established professionals moving to Washington.
- L3:** Engage with and incorporate tribal governments' and tribal providers' perspective regarding licensing reciprocity.

# L1: Substance use disorder dual-credentialing

## 2022 Takeaways

The substance use disorder professional alternative training pathway is in use, and individuals have successfully completed the process. Stakeholders identified some ongoing challenges with dual-credentialing, including the cost of holding two credentials and differing administrative and documentation requirements for those providing both types of services.

The Health Care Authority (HCA) is currently reviewing the possibility of expanding the allowable provider types for SUD services to include social workers and therapists as part of a state plan amendment. The current work is preliminary, and an external stakeholder review is expected to begin in early Winter 2023.



Originally created in 2017.

## Summary of Progress to Date

The Substance Use Disorder (SUD) alternative training pathway has credentialed new practitioners, and this program continues to be relevant. Currently nurse practitioners, marriage and family therapists, mental health counselors, social workers, psychologists, physicians (MD and DO), and physician assistants are eligible for the alternative training pathway. The Department of Health has begun a rulemaking process to consider adding pharmacists as a profession eligible for the alternative path to the SUD-professional (SUDP).

Out of 2,969 SUDPs, 1,994 have the SUDP license only. The remaining 975 (33%) have two or more behavioral health licenses.<sup>1</sup> The most common license SUDP dual combinations are 446 with a Mental Health Counselor License and 219 with a Social Worker Independent Clinical License. Out of 1,467 SUDP-trainees, 319 (22%) hold an additional behavioral health license.<sup>1</sup> It is

## Prior Recommendation and Suggested Actions

Review the incentives for Licensed Mental Health Professionals (LMHPs) to become certified as Substance User Disorder Professionals.

**Suggested Action:** The Department of Health should consider the following actions to address these issues:

Continue with its plan to monitor the use of the new SUD alternative training pathway, working with the CDP Advisory Committee at quarterly meetings, periodically reviewing Department credentialing data, and inviting stakeholders to provide feedback to determine the extent that licensed healthcare practitioners use the alternative training pathway.

**Suggested Action:** Consider requesting funding to bring on a third-party expert from outside the state to identify new ways of approaching this challenge and models that might work in the short-term to incentivize becoming a dual-credentialed provider.

<sup>1</sup> Mental Health Counselor, ANRP/RN, Social Worker or MFT License (Includes Independent, Associate, Probationary or Trainee) Washington State Department of Health, Healthcare Provider Credential Data accessed Oct. 24, 2022 from data.wa.gov.

unknown how many of these dually credentialed individuals used the alternative pathway. It is also common for someone to be initially licensed as an SUDP and go onto complete further training in another behavioral health profession.

**SB 1768 Concerning substance use disorder professional practice** (2019) created Co-Occurring Disorder Specialists as an enhancement available for several types of behavioral health licenses. A person with a co-occurring disorder specialist enhancement may provide substance use disorder counseling services equal in scope to those provided by substance use disorder professionals. The enhancement may be added to the license of a psychologist, independent clinical social worker (LICSW), marriage and family therapist (LMFT), mental health counselor (LMHC), or agency-affiliated counselor (AAC) with at least a master's degree in counseling or a related field and at least two years of experience in treating persons with mental illness or emotional disturbance.

### Key Successes

The Substance Use Disorder alternative training pathway is in use and has credentialed providers.

A piece of relevant legislation did not pass:

**HB 1729 Establishing a streamlined process to increase the capacity of certain mental health providers to offer substance use disorder treatment** (2019), which was aimed at creating pathways to professional competency in the SUD space.

Funding has not been provided for a third-party expert, so the second recommended action has not been completed.

HCA is currently reviewing the possibility of expanding the allowable provider types for SUD services, to include social workers and therapists as part of a state plan amendment. State plan amendments are an extensive process and involve significant scrutiny by the Centers for Medicare and Medicaid Services (CMS), as well as stakeholder input and legislative budget authority. HCA is still reviewing the draft amendment internally and informally with CMS. HCA plans to begin external stakeholder review in early winter, with implementation either January or July of 2024. This work will need to align with the legal scope of practice created in statute for the potential expansion professions.

Dual-credentialing and expanding the Medicaid-billable provider types for SUD services does not increase the absolute number of behavioral health workers in our state. It does create opportunities for greater workforce flexibility.

## Areas of Improvement Identified by Stakeholders

The general consensus of stakeholders is that, while behavioral health providers use the current SUDP alternative pathway, numerous disincentives keep many clinicians from pursuing this option. Licensed providers completing the alternative SUDP pathway are typically completing all training, requirements, testing, and supervision while also working full time. Stakeholders shared their perspective that there is also considerably more administrative paperwork to provide SUD services compared to other types of mental health services. Federal regulations that create additional requirements around the provision of SUD services were also identified as a barrier. Many felt it is time to explore other models that are less resource-intensive (time, money, supervision, paperwork) or find a

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*"The documentation [to provide SUD services] is so much more than if they were just providing mental health services so we had two [clinicians] so far that declined to provide SUD services because of the documentation."*

— Practitioner

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new way to provide SUD services. Also, high fees to obtain the credential has been identified as a disincentive, as providers must pay for two separate license types.

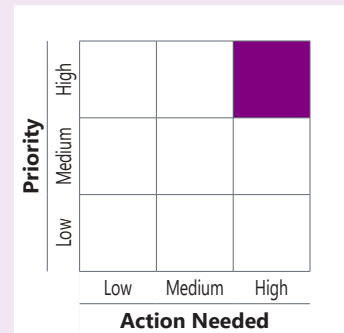
The Co-Occurring Disorder Specialist Enhancement was meant to be a more streamlined version of the alternative pathway that allowed for limited provision of co-occurring services in certain settings by professions that already hold a masters' or doctoral level degree (mental health counselors, social workers, marriage and family therapists and psychologists). However, many stakeholders perceive these professions as already having the ability in their legal scope of practice to provide SUD services and assessments. They view the enhancement as primarily needed to be able to obtain reimbursement for SUD services.

The enhancement law limits the level of SUD services that can be provided by an individual with the enhancement and does not allow for practice outside of behavioral health agencies that provide counseling services, namely federally qualified health centers and hospitals. As of September 29, 2022, no Co-Occurring Disorder Specialist Enhancements have been issued by the Department of Health.

# L2: Simplify licensure requirements for established professionals moving to Washington

## 2022 Takeaways

SB 5054 (2019) streamlined Washington’s licensure processes for experienced behavioral health clinicians licensed in other states and created a crosswalk of portability/reciprocity requirements from other states. The probationary license rules for mental health counselor, marriage and family therapist, social worker, or psychologist have been successfully implemented. However, the resulting process retained more steps and paperwork than stakeholders had hoped. The process could still be streamlined, and behavioral health agencies report applicants can wait months to receive their license.



Department of Health (DOH) has not changed the rule that a behavioral health professional who has been licensed for five consecutive years in good standing is deemed to have met the required post-graduate supervised hours without providing formal documentation. A prior recommendation requested DOH consider lowering the number of years to two or three. DOH has not reduced the rule from five years to two to three years, in part because it could create inequities with those who receive their license in Washington.

The tension between the need to ensure public safety and quality of care of behavioral health services, and the need to ensure enough access to providers, is a persistent issue in the field of behavioral health. To address this issue would require focused, structured engagement between regulators and the licensee community in order to create consistency and simplify licensure requirements.

Originally created in 2020.

## Summary of Progress to Date

Regarding the first action (see prior recommendations on the next page): DOH reports that the change was not made to reduce the rule from five years to two or three years. This was decided because it could create requirement inequities between clinicians training in Washington and those who trained in another state. Washington licensees could still have supervision requirements to fulfill while an applicant coming from another state with a shorter supervision period could be fully licensed. This is because more than two years of supervision is required for some professions in Washington.

Regarding the second and third recommended actions: In 2019, Washington enacted **SB 5054 Increasing the behavioral health workforce by establishing a reciprocity program to increase the portability of behavioral health licenses and certifications**. The goal of this legislation was to streamline Washington licensure processes for experienced behavioral health clinicians licensed in other states. The bill required DOH to establish a streamlined licensure process for applicants licensed in another state as a psychologist, substance use disorder professional, mental health counselor, social worker, or marriage and family therapist. DOH has reported that the probationary



license rules have been successfully implemented. If a practitioner is moving into Washington and has substantial equivalency for both scope of practice and supervision requirements, then they can obtain a full license. If they meet the scope of practice, but not the licensing requirements, then they can apply for the probationary license, which gives them two years to obtain the Washington supervision requirements, during which they are allowed to work at a certain types of facilities. However, the employer is not required to take responsibility for providing supervision; the individual may still need to find supervision on their own.

Practitioners have used the probationary license program to begin their work in Washington.

In 2022, the Legislature passed **HB 1286 Adopting the psychology interjurisdictional compact** (PsyPact), which facilitates telemedicine and allows for 30 days of in-person practice. More compacts are gaining momentum, with active conversations among groups representing mental health counselors and social workers. Compacts can simplify telemedicine offered across state lines, provide for continuity of care for established patients, allow more rapid entry to

### Prior Recommendations and Suggested Actions

1. Continue to support the DOH's work implementing licensing reciprocity. Following the passage of SB 5054 (2019), DOH conducted the work to expand the lists of substantial equivalencies to determine eligibility for a provisional license based on scope of practice for psychologists, social workers, marriage and family therapists, mental health counselors, and substance use disorder professionals. DOH expressed interest in expanding the lists to 50 states. The current lists are based on scope of practice, but similar lists based on comparison of licensing requirements will help behavioral health professionals considering relocation to Washington to identify missing licensure requirements.

Develop a crosswalk of licensing portability/reciprocity requirements. Workers who are relocating to Washington with an existing clinical license need clarity on the licensing/certification requirements based on their degrees/credentials.

2. Reduce paperwork requirements for established professionals. Stakeholders reported difficulty transferring licensure or hiring employees who require licensure reciprocity due to challenges in documenting initial supervision hours and/or academic requirements. DOH's recently-adopted rule provided an exemption in documented supervision hours for out-of-state clinicians who have been licensed for five years in good standing. However, five years was still a burdensome length of time. Stakeholders requested an update of this rule to two to three consecutive years in good standing for eligibility in this exemption.

**Suggested Action:** DOH has a recently-adopted rule providing that a behavioral health professional who has been licensed for five consecutive years in good standing is deemed to have met the required post-graduate supervised hours without providing formal documentation, regardless of the base number of supervised hours required in the other state of original licensure. Reduce the five-year requirement to two to three years.

**Suggested Action:** Adapt the existing provisional license for behavioral health clinicians relocating to Washington, with license of good standing in another state for at least two years but less than five, to delay the requirement for submission of academic transcripts and/or clinical supervision documentation until the end of the initial provisional license period, provided they are employed at a certified Behavioral Health Agency (BHA). The employing BHA shall assume responsibility for the worker, per the specific policies as documented in the worker's provisional license requirements. (Probationary license implemented 2019.)

**Suggested Action:** Support expanding lists of substantial equivalencies based on both licensing requirements (e.g., hours of supervision, years of practice, etc., required for license) and scope of practice (e.g., what the licensee can legally do in practice).

**Suggested Action:** Develop a crosswalk of reciprocal licensing requirements for licensed behavioral health workers moving to Washington.

### Key Successes

The probationary license rules for mental health counselor, marriage and family therapist, social worker, and psychologist have been successfully implemented.

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*"[We] could explore scope of practice and allow SUDP reimbursement in some professions without the SUDP credential."*

— Government Agency

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practice from providers from other states during emergencies, and support licensure portability for military members and their families. The Department of Defense has been active in providing funding support nationally for the development of compacts across a variety of health professions as part of supporting military spouse employment. However, it is important to note that compacts do not increase the net number of available clinicians given that the behavioral health workforce remains in short supply across the United States.

Home-state compact privileges or licenses typically include requirements for a state to conduct an FBI fingerprint background check process for applicants as part of ensuring public safety. How a compact is written, and whether it allows for a single state license option in addition to a compact license, can impact initial home state licensing timelines.

Regarding the fourth suggested action: The crosswalks were implemented as part of SB 5054. They can be accessed on the DOH website for **LICSWs, LMHCs, LMFTs, Psychologists, and SUDPs**. The program is limited in some ways, as those clinicians with probationary licenses are only authorized to work in community behavioral health agencies. Some clinician types are less common in those settings, such as psychologists, with the result that the probationary pathway is less accessible due to employment factors outside the clinician's control.

Related to the topic of licensure portability, DOH recently began a rulemaking process to remove the requirement that the department must verify the coursework of nationally certified SUDP applicants. The department indicated in their rulemaking document that verifying coursework presents a significant and re-occurring barrier for SUDPs coming from other states.

## Areas of Improvement Identified by Stakeholders

Behavioral health agency representatives shared their perspective that SB 5054 seemed to prioritize providers meeting all the existing Washington requirements, which are very high compared to other states, rather than prioritizing bringing in more practitioners during a crisis shortage of workers.

DOH reports seeing an uptick in people coming into Washington from other countries with prior behavioral health training; there is no substantial equivalency or licensing pathway. DOH has begun working with Highline College to explore this. This could be something to examine in the future, and it could support equity goals to serve the communities that they come from.

As of the December 2020 Workforce Board report, the stakeholder workgroup was neutral on the feasibility of interstate licensing compacts. In 2022, some participants expressed interest in compacts if participation would help Washington align with nationally agreed upon standards that enabled licensed individuals to move more smoothly between states.

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*"The idea was that if someone was licensed in another state for a certain period of time (five years, for example) without any adverse actions, Washington would simply issue them a license. Instead, the state wanted to crosswalk with other states to see if their standards were as robust as ours before they would determine whether reciprocity was appropriate, or whether the applicant needed to provide additional documentation to receive a license here. It got very complicated very quickly."*

— Facility Association

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Stakeholders advocated for the SB 5054 legislation so that DOH could create a streamlined licensure process for those already licensed in other states, but it ended up creating more steps and verification of requirements than stakeholders had anticipated. This process could still be streamlined, and is still causing several months of delay.

| Profession Type                 | Total Count of Probationary Licenses Issued Since 2019 | Active Probationary Licenses | Probationary Licenses Issued and Full Licensure Issued | Probationary Licenses Lapsed Without Obtaining Full Licensure |
|---------------------------------|--|------------------------------|--|---|
| Substance Use Disorder Provider | 11   | 3                            | 5  | 3   |
| Marriage and Family Therapist   | 72   | 27                           | 40   | 5   |
| Mental Health Counselor         | 118  | 43                           | 70   | 5   |
| Psychologist                    | 6  | 3                            | 3  | 0   |
| Social Worker Advanced          | 9  | 5                            | 2  | 2   |
| Social Worker Independent       | 67   | 35                           | 32   | 0   |
| <b>Total</b>                    | <b>283</b>   | <b>116</b>                   | <b>152</b>   | <b>15</b>   |

Washington State Department of Health, January 1, 2019 - September 13, 2022

## Items for Future Consideration

Compacts help states align their licensure standards around a common, agreed-upon set of requirements. However, even in a compact environment there will likely remain a need for state-level conversations and potential policy change for Washington requirements that fall within the compact standard, such as how a post-graduate supervision hours requirement is met. The tension between the need to ensure safety and quality in behavioral healthcare and the need to ensure enough providers is a persistent issue in the field of behavioral health. To address this issue would require focused, structured engagement between regulators and the licensee community.

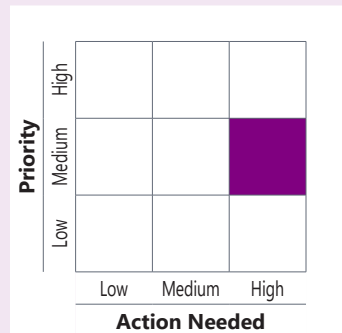
### Key Successes

Substantial equivalency has been determined by the DOH based on scope of practice and supervision hours. The crosswalks are now publicly available for each profession.

# L3: Tribal providers' perspective on licensing reciprocity

## 2022 Takeaways

Due to a lack of funding, this recommendation has not been completed. A key next step would be government-to-government action that includes the Governor's Indian Health Advisory Council, Centennial Accord, Indian Policy Advisory Council, or the Governor's Tribal Social Services Council.



Originally created in 2020.

## Summary of Progress to Date

No funding has yet been made available to convene a summit.

## Areas of Improvement Identified by Stakeholders

The key respondent for this recommendation works with tribal communities, but they do not represent any individual tribes. Their ideas:

- Recommend that this be a government-to-government topic rather than in partnership with ACHs.
- Recommend this be at the Governor's Indian Health Advisory Council, Centennial Accord, Indian Policy Advisory Council, or the Governor's Tribal Social Services Council. Since this topic crosses multiple agencies, it cannot be one agency focused on this topic.

## Items for Future Consideration

Initiate a government-to-government action to discuss Tribal Sovereignty, full faith and credit, and federal laws pertaining to Indian Health Services settings, including Tribal 638 and Urban Indian Health Programs and how these apply to licensing and certification of behavioral health facilities and workforce.

## Prior Recommendation and Suggested Action

Engage with and incorporate tribal governments' and tribal providers' perspective regarding licensing reciprocity. As a community, tribes are acutely affected by behavioral health (BH) concerns at disproportionately high rates compared to non-tribal counterparts; they have specific experience working to improve access to BH services. More expertise is needed on this topic. Convening an initial tribal behavioral health summit in partnership with the Accountable Communities of Health could be a starting point.

**Suggested Action:** Convene a summit of tribal leaders and behavioral health experts to discuss how these nations address challenges of licensing and recognition of BH licensing across boundaries — with a focus on learning from one another about licensing portability that could be tailored to all jurisdictions.

# CATEGORY: Supervision

In the five reports issued by the Workforce Board on the behavioral health workforce between 2016 and 2021, stakeholders reported that obtaining the required, high-quality, supervised practice hours for licensure after graduation from a behavioral health education program remains a barrier to behavioral health workforce development in Washington. Stakeholders were interested in:

- Finding ways to reduce the number of supervised hours required for licensure while maintaining quality of care.
- Funding that is structured to promote new models of supervision that expand the types of occupations and qualifications able to provide post-graduate supervision required for independent practice.
- Exploring the use of tele-precepting/tele-supervision hours to count towards a greater share of supervision hours.
- Identifying the viability of replacing supervision hours with competency-based training or testing.

## Background

Obtaining the post-graduate supervised practice hours required for licensure in many behavioral health professions remains a barrier to the development of this workforce in Washington. Many of the larger challenges with the current supervision paradigm exist because there is not a centrally planned post-graduate training system.

Graduates who wish to pursue licensure must coordinate their own supervision process by finding a position that provides appropriate supervision or paying a supervisor themselves.

Stakeholders have typically highlighted behavioral health facilities and agencies that provide supervision as an incentive for new graduates. Two frequently mentioned stakeholder concerns with the current state of supervision are: 1) assuring high-quality supervision, and 2) training for supervisors. As driven by stakeholder input, the goal of this category was to find ways to reduce the hours required for licensure and independent practice while maintaining quality of care.

### Supervision for licensure

These recommendations are around supervision for Licensure, as opposed to day-to-day clinical supervision. In Certified Community Behavioral Health Agencies, Clinical Supervisors do not need to be licensed. However, they must be designated as a Mental Health Professional (MHP) (typically a master's plus two years full time experience in service provision under the supervision of an MHP), and they are likely to have many years of experience. In some cases, day-to-day supervision will also count toward licensure supervision, but not always. For example, hours will not count towards licensure requirements if:

- The supervision is provided by a supervisor that is licensed in the 'wrong' discipline for an employee, or
- The day-to-day clinical supervision is provided by an MHP who is not licensed.

Current requirements to act as a supervisor for behavioral health professions in Washington vary by profession and credential, but typically include a license or credential under **RCW Title 18** that is: 1) in good standing for a period of time that varies by occupation, 2) in the discipline being supervised or an equally qualified mental health practitioner, and 3) at the level of or higher than the supervisee.

Similarly, there is an interest in understanding why different professions with similar scopes of work require different numbers of post-graduate supervision hours. Stakeholders have expressed frustration at what appears to some as the arbitrary number of supervision hours required for licensure, particularly because of the urgent need for a qualified workforce. The topic remains complex, requiring the inclusion and input of behavioral health, legal, quality assurance, and credentialing experts to identify the origins of such discrepancies, explore any necessity of those discrepancies, and develop consensus regarding recommendations for potentially streamlining supervised hour requirements across occupations employed in similar/overlapping clinical positions.

Since the onset of the pandemic, stakeholders have reported significant increases in use of telemedicine and tele-supervision. They have been unanimous in supporting ways to make tele-supervision hours count towards a greater share of the supervision hours required of both students and candidates for professional license.

This topic has also been prioritized by the Children & Youth Behavioral Health Work Group, demonstrating additional support from stakeholders in the field.

### **Recommendations from the prior reports:**

- S1:** Assess the impact of current supervision requirements on size, distribution, and availability of select occupations in the behavioral health workforce.
- S2:** Expand and incentivize supervision programs, and structure funding to promote new models.
- S3:** Remove barriers to effective tele-precepting for supervision in clinical education and pre-licensure settings.
- S4:** Identify, promote, and support competency-based evaluation methods.

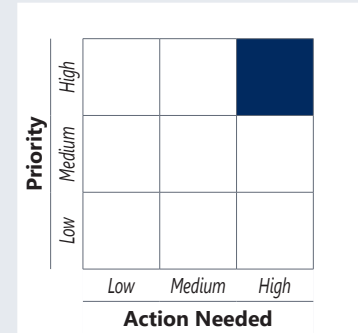


# S1: Behavioral health supervision workgroup & required supervision hours

## 2022 Takeaways

Washington should monitor the impact of the national conversations regarding interstate licensure compacts and look for ways to align supervision hours. This may result in reductions for some professions. The Washington Mental Health Counselors Association convened a series of workgroup meetings around this topic throughout 2022. A report will be forthcoming.

*NOTE: this recommendation overlapped with S2 (supervision models) in some reports.*



Originally created in 2017, updated in 2020 and 2021.

## Summary of Progress to Date

There was significant effort to address this recommendation with two pieces of legislation introduced in 2022, though neither were passed into law. In the Summer of 2022, the Washington Mental Health Counselors Association formed a workgroup to assess the impact of current supervision requirements. They are currently considering all the information they have gathered to make recommendations.

The two pieces of related legislation that did not pass:

**1. HB 2040 Streamlining licensing requirements for certain behavioral health professionals (2022).**

This bill would have created a task force to, among other items, examine reducing postgraduate supervision hours requirements.

**2. SB 5638 Concerning expediting approval for applicants for an associate license as a social worker, mental health counselor, or marriage and family therapist (2022).** While this bill did not address supervision directly, it was intended to shorten the length of time before someone can practice.

### Prior Recommendation and Suggested Action

Assess the impact of current supervision requirements on size, distribution, and availability of select occupations in the behavioral health workforce. Provide recommendations on ways to reduce or standardize the number of supervised hours required for licensure, while assuring clinical competency. Due to the complexity of this topic, changes should involve behavioral health, legal, quality assurance, and credentialing experts. Focus on the following occupations: Substance Use Disorder Professional (SUDP), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), and Licensed Independent Clinical Social Worker (LICSW).

**Suggested Action:** Develop a workgroup to identify discrepancies in the number of supervised hours required for certain clinical licenses and to make recommendations regarding standardizing the number of supervision hours required for clinical licensure across these occupations. The workgroup should include behavioral health professional associations and individuals pursuing clinical licensure.

The permission for **agency-affiliated counselors to practice while their license application is being approved** is in **RCW 18.19.210**, as amended by HB 1907 (2019). SB 5638 (2022) would have extended this to social workers, mental health counselors, and marriage and family therapists. While not directly related to supervision requirements, this bill was also intended to allow quicker entry to practice by allowing practice while the license application is pending.

## Areas of Improvement Identified by Stakeholders

Stakeholders support policymakers forming a workgroup or taskforce to work towards a legislative proposal to alter supervision requirements, but advocate that such a group must:

- Include practitioners who have working/practical experience.
- Consider and align with ongoing compact work being developed nationally.
- Take workforce shortages into account.
- Reconcile the variation in supervision required for licensing among different professions.
- Prioritize public safety and quality of care when proposing supervision changes.

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*"In our rural area we are really struggling with finding clinicians to fill open spots — and the people applying are right out of school and will need extensive training and supervision."*

— Practitioner

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Stakeholders were divided about whether the total number of supervision hours should be consistent across occupations.

There is a national conversation underway within the social work profession involving the development of a social work licensure compact. The proposed supervision requirement for licensed clinical social worker participation in the compact is 3,000 hours. This is 1,000 fewer hours than the current 4,000 required in Washington for licensure. If the compact is introduced in Washington, consideration should be paid to aligning Washington supervision requirements with the compact standard to ensure equity for those receiving licensure in Washington with those practicing in the state through the compact. There is strong interest from the community behavioral health community participating in this project to align Washington's licensed independent clinical social worker supervision hours with the proposed 3,000 hours standard.

## Items for Future Consideration

If policymakers decide to build on this work, they should consider the areas of improvement identified above.

Other input on areas for additional gains on this recommendation:

- As previously recommended, future workgroup(s) should include behavioral health, education, legal, quality assurance, and credentialing experts.
- Stakeholders also strongly suggested including behavioral health agencies and providers in the workgroup to provide perspective in formulating potential strategies and solutions based on practice experience.

- Find a reasonable balance between providing access to quality behavioral healthcare — potentially reducing the number of supervised hours and years required for licensure for some professions — and greater consistency in supervision requirements across professions. To accomplish this, after implementing changes to supervision requirements, the Department of Health (DOH) could monitor the unprofessional conduct complaints it receives and any resulting disciplinary actions to determine if patient safety was affected.
- Workgroups should make specific, actionable requests, such as aligning the number of supervision hours required for three masters level professions, which vary.
- Identify other workgroup(s) or initiatives related to this topic that have been successful, such as the Fair Start for Kids Act that provided funding for reflective supervision in early childhood education. An additional example is the **quality rating and improvement system (QRIS)**, wherein the Legislature has recognized the importance of supervision and funded it.

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*"I think the task force is great idea, but I think that we need to get down to the provider level to understand the barriers that they are facing when it comes to supervision Not only with the workforce shortages, but with the staunch limitations within each licensure that make it really difficult."*

— Practitioner

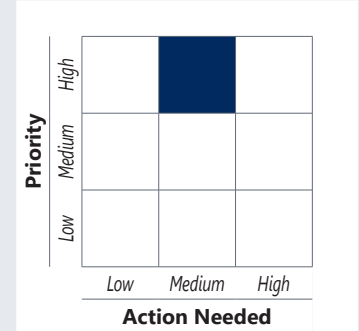
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# S2: Expand and incentivize supervision programs

## 2022 Takeaways

The Health Care Authority (HCA) is managing a supervision program, and is working to design the project in collaboration with Accountable Communities of Health (ACHs). Additionally, HCA is working on a teaching clinic payment study that will be released in Fall 2022. The purpose of the study is to formalize the structures around the teaching clinic model, assess costs associated with the model, and develop Medicaid funding strategies to sustain the model.

The Council for Behavioral Health has received funding from Ballmer Group to develop and implement a demonstration project to support the teaching function of community behavioral health agencies. Ongoing evaluation of the pilot and dissemination of outcomes will be a key next step.



Originally created in 2017, updated in 2020.

## Summary of Progress to Date

Regarding the first recommendation: **HB 1504 Modifying the workforce education investment act** (2021) implemented a **Behavioral Health Preceptorship program**, based on the existing Greater Health Now (GHN, formerly Greater Columbia Accountable Community of Health) model. It provided \$1 million for 19 organizations to replicate and expand the GHN model. The model helps organizations precept students who need clinical hours to complete their certifications but are not in the position to do so due to budgeting, supervision requirements, and lack of training resources, for instance.

The program formally launched in June 2020, and hired more than 50 interns with specialties including counseling, social work, psychology, and substance use disorders. The program initially ran from April of 2020 to June 30, 2021; it was extended for nine organizations until June 30, 2022, due to the COVID-19 pandemic.

This program is a collaboration between the HCA and the ACHs. Components include:

- How the funds are used (recent legislation allows funds to be used to support supervisors and/or student interns/associates).
- Reporting structure (balance minimizing administrative burden while showing impact).
- Increasing the diversity of the workforce.

Information about outcomes is pending.

HCA is working on a report to the Legislature that will provide a preliminary model for the costs incurred by behavioral health agencies supervising interns and new

### Key Successes

The Behavioral Health Preceptorship program is funded at \$1,000,000 and underway.

graduates earning supervision hours toward licensure. The report will include development of standards for classifying a behavioral health agency as a teaching clinic, a cost methodology to determine a teaching clinic enhancement rate, and a timeline for implementation. The Washington Council for Behavioral Health is conducting a demonstration with funding provided by Ballmer Group. Six demonstration sites have been selected, and the project will launch in Fall 2022.

Regarding the second recommendation: Many behavioral health agencies are implementing new supervision models already, or other unique approaches to manage the various aspects and tasks of supervision.

Examples of ongoing grassroots approaches:

- Community behavioral health agencies having a core supervisor, then Continuous Quality Improvement (CQI) helping with licensure tasks.
- Using a mentor for career development tasks, rather than relying solely on a supervisor.
- The clinical director provides administrative supervision as a support.
- Developing a supervisor guide and training to provide supports for supervisors.

Progress on the recommendation to develop a bifurcated supervision model has been accomplished through efforts by behavioral health agencies and related organizations to create a variety of approaches to supervision, both administrative and clinical. The previous recommendation no longer appears relevant in the current policy environment; however, this overall topic remains a high priority because stakeholders report they are experiencing a severe shortage of staff able to provide supervision.

## Areas of Improvement Identified by Stakeholders

Many stakeholders emphasize that interns should be paid. Interns are pre-graduate students completing required clinical training experiences in community settings. While not directly related to the post-licensure supervision issue, payment of graduate-level interns may lead to better retention of this workforce, enable greater diversity of applicants, and create opportunities for the incumbent workforce. Discussion of compensation for

### Prior Recommendations and Suggested Actions:

1. Expand geographical reach of, and scale up, programs that promote behavioral health supervision. Incentivize supervision programs, like the Greater Columbia Accountable Communities of Health (GCACH) Internship and Training Fund. Co-create/fund programs that support quality supervision and training for behavioral health professionals in partnership with regional behavioral health service providers for undergraduate, master's, and post-doctoral behavioral health trainees ("graduated professionals seeking hours of supervised clinical practice required for independent clinical licensure").
2. Structure funding supports to promote new models of supervision that allow for division of labor and multiple pathways to working as a supervisor.

**Suggested Action:** Support evaluation and scaling of quality incentivized supervision programs through increased funding, in cooperation with direct service organizations.

**Suggested Action:** With resources allocated, develop a pilot program to allow behavioral health employers to fund a bifurcated supervision model (i.e., divide responsibilities between clinical vs. organizational). The pilot should:

1. place emphasis on access to employers in rural and underserved regions.
2. provide a stipend to supervisors carrying a full load of direct reports.
3. carefully consider how these roles are defined (i.e., how a "full caseload" is defined).

**Suggested Action:** Determine the feasibility of creating a generalized behavioral health supervisor qualification to oversee training of a variety of behavioral health occupations, possibly an agency affiliated supervisor to support community mental health agencies in their training role.

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*"There is much discussion about this nationally; schools have challenges with placements if sites are required to pay [but] no funding [has been] identified.*

— Professional Association

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interns is also included in the HCA work on the teaching clinic enhancement (proviso 74, 2021).

Many stakeholders advocated for an evaluation of strategies designed to increase supervisor retention and understand what works for retention of supervisors, which was reported to be a major issue. Such a project could capture and distribute best practices, if the evaluation demonstrates impact. Other stakeholders gave feedback that the issues impacting retention of supervisors are well understood and are directly tied to wage and burdensome administrative requirements. They felt addressing increasing wages and decreasing the required administrative tasks involved in supervision would prove effective to increase supervisor retention.

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*"It's antiquated thinking to believe an individual can afford to carry a full-time job and a full time (unpaid) internship. Many universities will not allow interns to be paid. Many students are single parents, or financially struggling and cannot afford internships to be unpaid."*

— Behavioral Health Agency

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## Items for Future Consideration

Regarding the first recommendation: HB 1504 sunsets in June 2023. Future work on this topic should evaluate the outcomes and request ongoing continued funding, if appropriate.

Regarding the second recommendation: There is no formal policy or funding needed to continue using these models. Many behavioral health organizations have their own unique supervision models that work for their specific operations, programs, and services. Providers are encouraged to review current best practices used by other similar/comparable organizations to determine potential models that could improve and enhance their programs and services. Some examples shared by stakeholders include:

- Promoting career development through a mentorship program where the leaders and experienced professionals in the organization serve as mentors to staff members to provide insight and pathways for career and personal growth.
- **CoLab for Community and Behavioral Health Policy** is developing a supervisor guide and training to provide support for supervisors.



# S3: Tele-precepting for supervision

## 2022 Takeaways

All master's level behavioral health professions may now complete supervision virtually. Substance Use Disorder Professional Trainees (SUDP-Ts) remain subject to rules requiring in person supervision. Future work could consider if flexibility to provide off-site, but immediately available, or telehealth supervision, is warranted.

Future work could consider reviewing the outcomes and benefits of HB 1063 (more below) and determine if extending discretion to the Secretary of Health to grant waivers to the associate license renewal limits outside a governor-declared state of emergency is warranted.

|        |     |        |      |
|--------|-----|--------|------|
| High   |     |        |      |
| Medium |     |        |      |
| Low    |     |        |      |
|        | Low | Medium | High |

**Action Needed**

Originally created in 2020.

## Summary of Progress to Date

Washington made a short-term policy adjustment that was later codified into law that allows for tele-precepting for social workers. Social work was the only behavioral health master's profession with a previous limitation on the number of supervised hours that could be fulfilled via tele-precepting. However, SUDP Trainees do still have a requirement to receive all supervision via a supervisor physically at the facility with them.

- **HB 1007 Concerning the completion of supervised experience through distance supervision** (2021) removed the limitations on the number of supervised experience hours that a person pursuing a license as an independent clinical social worker or advanced social worker may complete through distance supervision.

Social workers were the only profession that had limitations on the number of supervised hours that could be virtual. This legislation resolved that all master's level behavioral health professions are now treated the same on this topic. This originally came about due to the COVID-19 pandemic, but the benefits go beyond the pandemic timeframe.

- **HB 1063 Allowing additional renewals for behavioral health professional trainee and associate credentials** (2021) authorized the Secretary of Health to grant a waiver for additional credential renewals due to barriers to testing resulting from a Governor-declared emergency for the following credentials: a) SUD professional trainee (SUDP-T) and b) Social Worker (LWAIC), mental health counselor (LMHCA) and family therapist (LMFTA) associate licenses.

### Prior Recommendation and Suggested Action

Remove barriers to effective tele-precepting for supervision in clinical education and pre-licensure settings. Note: Current laws limit the number of tele-supervision hours which can apply towards clinical education requirements and licensure hours.

**Suggested Action:** Support the increased use of tele-precepting for clinical supervision and licensure requirement, including: a) amending relevant laws and policies and b) making permanent provisional changes to allow increased tele-supervision hours.

## Key Successes

All master's level behavioral health professions may now complete supervision virtually. Due to state rules, SUD profession supervision cannot be completed virtually.

## Items for Future Consideration

Any future work should consider reviewing the outcomes and benefits of HB 1063 and consider whether the Secretary of Health should have the authority to offer a waiver of the renewal limit outside a governor's declared state of emergency.

It may be reasonable to examine the issue of SUDP-T tele-supervision, as it is the remaining behavioral health profession that does not allow for this practice. The goal of this review would be to determine if the benefits of expanding flexibility to have tele-supervision for some portion of the SUDP-T supervision hours outweigh risks to patient safety.

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*"We now have equity amongst the three masters level professions in terms of how they can access tele-supervision"*

— Facility Association

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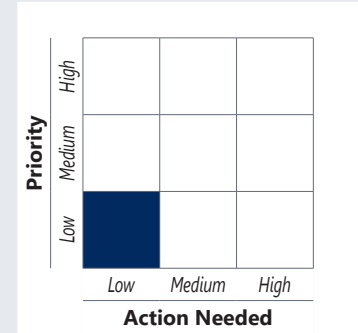
### Associate licensure renewals

During discussion of HB 1063, a stakeholder made the point that the testing required to move from the associate to independent licensure level can be a key barrier for individuals whose first language is not English. Exams in the master's level behavioral health professions are offered in English. Applicants can request accommodations made for extra time. Due to the limit on how many times an associate credential can be renewed, a person who is not able to pass the test can find themselves limited to lower-level roles in the behavioral health workforce. This can occur despite the clear need in the state for a clinical behavioral health workforce that better reflects the diverse population it serves. Nationally, the social work profession is discussing how high-stakes testing impacts the applicant population. Better understanding how such requirements affect Washington's behavioral health workforce and making adjustments could help remove barriers to workforce advancement and retention.

# S4: Competency-based evaluation method

## 2022 Takeaways

No strong champions have emerged during this evaluation for a competency-based supervision model for postgraduate trainees. Without strong interest from the stakeholders this recommendation received a low priority for continued action.



Originally created in 2020.

## Summary of Progress to Date

Shifting from an hours-based to a competency-based model of supervision could potentially shorten the length of time to licensure for some. However, the shift does not have broad support from the stakeholder community currently.

Changing to a competency-based model could impact the ability of Washington clinicians to be licensed in other states. It also could create uncertainty for facilities and trainees about when a person will qualify for full licensure.

## Areas of Improvement Identified by Stakeholders

The interviews and feedback sessions held during the preparation of this report did not identify strong champions in the state for a competency-based supervision model for postgraduate trainees.

## Items for Future Consideration

Using competency-based evaluation methods is a complex issue and stakeholders provided mixed responses on this topic. Future discussion should consider:

- The ramifications of a competency-based approach to postgraduate supervision of behavioral health occupations. While competency-based supervision could reduce the length of time for applicants who

## Prior Recommendation and Suggested Action

Identify viability of adapting certain aspects of Washington's existing education, training, and credentialing evaluation metrics into a competency-based method. Should supervision measure actual competency and clinical skills instead of number of hours? According to Health Workforce Sentinel Network findings, behavioral health counselors continue to be cited as among the positions with exceptionally long vacancies, and it is an occupation which could benefit from such a pilot evaluation. The workgroup also agreed with MHC as a starting place for this evaluation.

**Suggested Action:** The Legislature should identify an academic institution or similar organization to administer a study on competency-based education, training, and evaluation of MHCs, or another behavioral health occupation in high demand in the state.

can demonstrate mastery of concepts, it could also affect portability of a Washington issued license if other states choose not to recognize a competency-based approach. This could also impact Washington's participation in licensure compacts depending on how participation requirements are written.

- If future work is desired in this area, it should include various organizations that have shared interest and experience on this issue. The suggested organizations include Washington State Department of Health (DOH), subject matter experts in the behavioral health education and training system, Washington-based behavioral health professional associations, Washington Council for Behavioral Health, Washington Association for Community Health, community behavioral health agencies, and Washington State Institute for Public Policy.

# CATEGORY: Care Integration

## Background

Washington has made some progress in integrating behavioral and physical healthcare throughout the past five years. Unfortunately, even with improved access to behavioral healthcare services at primary care providers and via telehealth, the demand for behavioral healthcare treatment continues to significantly exceed the availability of services throughout the state. Access to behavioral health services has also been significantly impacted by the opioid epidemic and the ongoing COVID-19 pandemic, which both necessitate the need for even greater access to behavioral health services.

As these needs increase, stakeholders report that there are still too few providers with the prescribing authority needed to efficiently serve the needs of all behavioral health service sites in the state. The need to expand provider capacity to prescribe medication-assisted treatment for opioid substance use disorders and manage psychotropic medications — including continued expansion of telehealth and telepsychiatry networks and billing systems — remains. This is both a supply shortage issue and a recruitment/retention issue.

In addition, several technical and infrastructure issues related to integrated care delivery need to be addressed, including continuing to expand integrated delivery of care models and providing financial flexibility, and developing a single-platform credentialing system to reduce duplication of administrative work.

The Healthier Washington Collaboration Portal (WA Portal), previously called the Healthier Washington Practice Transformation Hub, is a web-based resource. It is intended to provide extensive content related to behavioral health integration as well as practice transformation resources related to readiness for value-based payment, population health, and improving community-clinical linkages. While awareness of the WA Portal was not high among Behavioral Health Workforce Advisory Committee (BHWAC) stakeholders, the WA Portal has remained an available resource after the end of its initial funding period.

### Importance of bidirectional care integration

Prior recommendations of the BHWAC have focused primarily on the integration of behavioral health workforce into primary care settings. However, it is important to also highlight the importance of integrating primary care into behavioral health settings. Individuals with a serious mental illness face dramatic health disparities including life spans reduced by more than 13 years compared to the general population.<sup>1</sup> For some individuals, a community behavioral health agency may be the primary or even only place they interact with the healthcare system. Having primary care services available can be a key support to help individuals living with diabetes, heart disease, and other chronic conditions.

Further exploration to understand the policy conditions that are hindering the expansion of primary care in behavioral health settings and working to remove those barriers must be an important consideration moving forward. Implementing whole-person integrated models of care, such as Certified Community Behavioral Health Clinics (CCBHCs) would be one pathway for increasing access to primary care services for the Serious Mental Illness/Substance Use Disorder population.

<sup>1</sup> [How do ethnicity and deprivation impact on life expectancy at birth in people with serious mental illness? Observational study in the UK - PMC \(nih.gov\)](#)

## Recommendations from the prior reports:

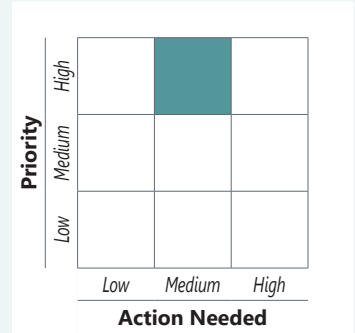
- C1:** Encourage Managed Care Organizations (MCOs)/health plans and Behavioral Health Organizations (BHOs) to contract with credential licensed community behavioral health agencies.
- C2:** Continue to support the use of/expansion of the WA Portal.
- C3:** Increase the confidence of primary care providers, including physicians, Advanced Registered Nurse Practitioners (ARNPs), Physician Assistants (PAs), and pharmacists to use their full prescriptive authority for psychiatric medications.
- C4:** Promote an increase in acquisition of behavioral health competencies among the broader health workforce, with an emphasis on the primary care workforce.



# C1: Single platform credentialing system

## 2022 Takeaways

The Health Care Authority (HCA) implemented the single platform provider credentialing system in the Fall of 2019. MCOs that engaged in the report development are interested in learning more from stakeholders about any challenges in the current roster system to make additional improvements.



Originally created in 2017.

## Summary of Progress to Date

The HCA and its partner agencies have made great strides toward implementing a single platform provider credentialing system. SB 6032 (2018) directed HCA, in collaboration with the Department of Health (DOH), Department of Health and Social Services (DSHS) and other partner agencies, to implement a single platform provider credentialing system. The HCA began planning and implementing the single platform provider credentialing system in Spring 2018 and completed implementation in Fall 2019. Some stakeholders commented that this is one of the best things that the HCA and the MCOs have done together.

## Areas of Improvement Identified by Stakeholders

Stakeholders expressed general enthusiasm around the roster forms, but hope that they become more streamlined, as the forms are still very labor-intensive and require more information than necessary. Several people reported that the MCO roster forms were different for each MCO, and were very time consuming, taking up to several days to complete for each new hire. MCOs who were present shared that they are supposed to be operating under the same roster and that there may be a disconnect here. They indicated that they can work to address this.

### Prior Recommendation and Suggested Action

Strongly encourage payers, MCOs/health plans, and Behavioral Health Administrative Service Organizations (BH-ASOs) to contract with credential licensed community behavioral health agencies.

**Suggested Action:** The Department of Social and Health Services (DSHS) and the HCA should move quickly to identify and implement a single-platform provider credentialing system as directed by SB 5883 and encourage credentialing licensed behavioral health agencies at the organizational level.

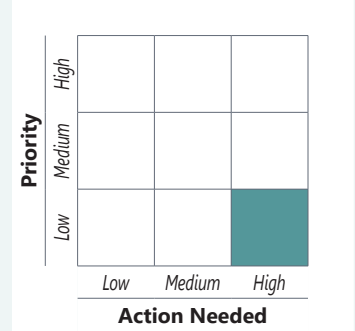
## Key Successes

HCA implemented a single platform provider credentialing system in 2019.

# C2: Healthier Washington Collaboration Portal (WA Portal)

## 2022 Takeaways

The WA Portal is still in use. Behavioral health stakeholders involved in the development of this year's report were not aware of the WA Portal. The DOH could promote greater awareness of the resources on the WA Portal if funding becomes available.



Originally created in 2017.

## Summary of Progress to Date

The Hub is still in use and has been re-named Healthier Washington Collaboration Portal (WA Portal). WA Portal is a digital platform that supports knowledge-sharing and collaboration among public health, social service, and community-based organizations in Washington.

## Areas of Improvement Identified by Stakeholders

No one at the stakeholder meeting reported using the WA Portal. Several were unaware of it and would like to know more.

## Items for Future Consideration

Information-sharing and advertising about WA Portal would promote awareness and participation among health providers.

*"We would like more information regarding the Portal."*

— Practitioner

## Prior Recommendation and Suggested Action

Continue to support the use and expansion of the WA Portal<sup>1</sup> efforts to promote adoption and training for team-based integrated behavioral health and primary care.

Develop a sustainability plan to support the WA Portal after the conclusion of the Healthier Washington initiative and funding period in 2019.

<sup>1</sup> Formerly the Healthier Washington Practice Transformation Hub

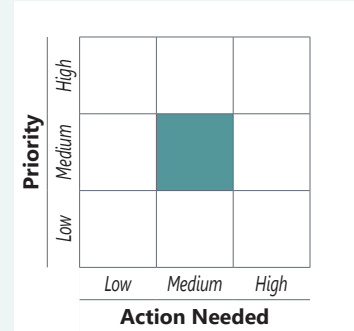
## Key Successes

WA Portal is still in use.

# C3: Primary care providers and prescriptions

## 2022 Takeaways

The Children and Youth Behavioral Healthcare Work Group (CYBHWG) helped support the creation of a permanent funding model for the four Partnership Access Lines (PALs): the original PAL, Mental Health Referral Services for Children and Teens, Perinatal Psychiatry Consultation Line for Providers, and the Psychiatry Consultation Line. The Legislature passed permanent funding in 2020 and the four lines remain a key consultative resource for primary care providers.



Originally created in 2017.

## Summary of Progress to Date

In 2017 the Legislature passed two relevant bills:

- **SB 5436 Expanding patient access to health services through telemedicine by further defining where a patient may receive the service** (2017). This law expanded the definition of origination site to any site of the patient's choosing.
- **Engrossed HB 1713 Implementing recommendations from the children's mental health work group** (2017), which includes a provision requiring BHOs to reimburse providers for the use of telemedicine to deliver medically necessary services to Medicaid clients.

In 2019, the following three programs launched:

- Seattle Children's Hospital began a two-year pilot program, Mental Health Referral Service for Children and Teens, to connect patients and families with available evidence-based outpatient mental health services in their community.

### Prior Recommendation and Suggested Actions

Increase primary care providers' (physicians, ARNPs, PAs, pharmacists) confidence to use their full prescriptive authority for psychiatric medications.

**Suggested Action:** Provide resources and billing codes for those who manage care, outreach, etc., to be able to bill as part of a telehealth delivery team.

**Suggested Action:** Expand MCOs/BHOs providing telepsychiatry networks for contracted provider networks.

**Suggested Action:** Review and consider implementation of the recommendations made by the Collaborative for the Advancement of Telemedicine, a workgroup created by SB 6519 (2016).

**Suggested Action:** Continue support for psychiatrist training through the University of Washington (UW) Integrated Care Training Program and consider expansion of this program to support all psychiatric prescribing providers (e.g., ARNPs, PAs), with a plan for ongoing investment in such training beyond 2018.

*"[PAL for Moms] has significantly improved the care and outcomes for maternal depression."*

— Practitioner

- UW began the Perinatal Psychiatry Consultation Line for Providers (PAL for Moms), a two-year pilot program that supports providers caring for patients with behavioral health disorders who are pregnant, postpartum, or planning pregnancy.
- UW also began the Psychiatry Consultation Line (PCL) to provide 24/7 support to prescribing providers from primary care clinics, community hospitals, emergency departments, substance use treatment programs, evaluation and treatment programs, and municipal and county jails caring for adult patients with mental health and/or substance use disorders.

In 2020, the Legislature passed **HB 2728 Implementing a sustainable funding model for the services provided through the children’s mental health services consultation program and the telebehavioral health video call center**. This bill provided a permanent funding mechanism put in place for the original PAL line, mental health referral service for children and teens, PAL for Moms, and PCL. This bill also requires reporting on the usage of these services.

As of 2022, The UW Integrated Care Training Program is still active, and has expanded beyond just psychiatry to all psychiatric prescribing providers. It is free for anyone in Washington.

In 2022, the Joint Legislative Audit and Review Committee (JLARC) completed a [study of the PAL lines](#). They found that providers were satisfied with the consultation lines, which they said have improved patient access to mental and behavioral health care. The referral service has helped families find outpatient care, but it has struggled to meet timeliness goals and achieve statewide participation. The evaluation found that 97 percent of families using the referral service lived in western Washington counties.

Other achievements related to this area include:

- In 2022, UW received \$505,000 from the general fund to create two residency training positions and one behavioral health faculty to create a residency program focused on behavioral health at their teaching hospital for psychiatric pharmacist residencies.
- In partnership with UW School of Pharmacy, the WSU College of Pharmacy and Pharmaceutical Sciences (CPPS) will create a pathway to provide post-graduate training of pharmacists in assessment and management of behavioral health conditions including mental health, substance use disorders, and psychiatric conditions. Graduates of this program will provide primary behavioral healthcare to meet the needs of patients in their communities throughout rural Washington. These specially trained pharmacists will provide expanded access to vital behavioral health services, which are not adequately available in the state. Funds will be used to hire faculty and to develop and support psychiatric residency training for pharmacists.

The final recommended action around telemedicine is considered outdated, following the changes in practice brought about by the COVID-19 pandemic.

## Key Successes

The original PAL hotline and three new ones have been permanently funded by the Legislature.

## Areas of Improvement Identified by Stakeholders

Stakeholders expressed a lot of support for the PAL lines; they are considered well used, useful resources.

There is enthusiasm for the Mental Health Referral Service for Children — PAL for Kids — though the downside is it would have a two to three week wait for accessing services (this is a referral service, not direct service).

Stakeholders shared some general comments around the variety of the action items under a single recommendation, and the heavy focus on telehealth.

One way a stakeholder currently meets this goal, which could be another approach: have a psychiatrist who consults with the others on the healthcare team once a month and is available for calls.

Stakeholders expressed that care coordination is highly impactful, but rarely reimbursed. This is an antiquated fee for service billing model. This was a particular concern for those serving pediatric patients where care coordination services have been implemented using grant funds. Grant funds are typically not a sustainable long-term funding mechanism.

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*"I think that's the most important piece with this topic, because so much of this was planned before COVID... Once COVID hit... everybody moved very quickly to make it possible for us to use telehealth, and then... so many circumstances changed throughout those two and a half years."*

— Managed Care Organization

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# C4: Training for primary care behavioral health competency

## 2022 Takeaways

A project is underway around care integration for children and youth: the Legislature provided approximately \$2 million to the HCA to fund behavioral health integration in 10 primary care clinics statewide. This topic still needs attention, as primary care clinics continue to encounter challenges in hiring behavioral health staff due to the overall need for behavioral health workers, as well as licensing issues.



Originally created in 2020.

## Summary of Progress to Date

The original recommended action called for funding for the Allied Health Center of Excellence to create a clearinghouse of behavioral health training opportunities. The Allied Health Center of Excellence has this clearinghouse created in their work plan but has not received funding to complete it.

The Allied Health Center of Excellence provided \$5,000 of seed funding in 2022 to Lake Washington Institute of Technology's Substance Use Disorder program to develop an online statewide certificate program. This will develop a full SUD treatment program online within next year. Any community and technical college (CTC) will be able to use the course.

*"Families love to be able to go to the place that they're already familiar with and getting [primary] care [to get behavioral health care]."*

— Provider Network

## Prior Recommendation and Suggested Action

Promote an increase in acquisition of behavioral health competencies among the broader health workforce, with an emphasis on the primary care workforce. Following the state's integration of behavioral health and physical healthcare systems, providing behavioral healthcare in primary healthcare settings has increased. Physical healthcare providers are not sufficiently trained in providing behavioral health services. Currently, there are resources available to provide training in behavioral health competencies, but identifying and accessing adequate resources can be a barrier. Developing a clearinghouse of these resources, and conducting outreach to provider organizations that could utilize these resources, would help streamline access issues.

**Suggested Action:** With resources allocated, the Allied Health Center of Excellence which serves as a resource to all 34 community and technical colleges, K-12 Health Science, business/industry partners, and identified government entities should develop a clearinghouse of behavioral health continuing education opportunities and work with the relevant provider organizations to educate their workforce about available courses.



In 2021, the Legislature provided approximately \$2 million to the HCA, at the recommendation of the CYBHWG Behavioral Health Integration subgroup, for start-up costs for a 10-clinic behavioral health pediatric clinic integration project. The April 2022 subgroup update shared that:

- Funding has been approved for approximately \$200,000 per clinic.
- The goal is to provide behavioral health integration funds to ten clinics statewide.
- The start-up program will prioritize clinics with a substantial Medicaid population.
- Start-up funding will prioritize clinics with demonstrated readiness to implement effective integrated programs.
- UW is currently developing a **behavioral health support specialist (BHSS) role** at the bachelor's level (as described in recommendation E1 of the Education and Training chapter). The BHSS role would serve in primary care settings.

## Areas of Improvement Identified by Stakeholders

Regarding care integration broadly, stakeholders have seen a lot of progress, and behavioral health practitioners are enthusiastic. More primary care providers want to bring in behavioral health, but can't due to the challenge of hiring behavioral health workers. There are also challenges around which settings can bill for the services of different provider types with federally qualified health centers being limited by their alternative payment model.

Stakeholders want to ensure that different professions are trained to work with one another, and there is not just one-directional training.

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*"We do have some primary care practices that are interested in starting behavioral health services within their practice. They want to do this work, but it is hard to find behavioral providers to work in these settings."*

— Provider Network

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# Appendices A, B, & C

## Supplemental Reports

# Appendix A

## **Washington State's Behavioral Health Workforce: Examination of Education and Training Needs and Priorities for Future Assessment**

# Washington State’s Behavioral Health Workforce: Examination of Education and Training Needs and Priorities for Future Assessment

July 2022

Susan M Skillman, MS, Ben Dunlap, MPH

## KEY FINDINGS

This qualitative study sought to identify stakeholders’ concerns and related recommendations regarding the education and training of Washington’s behavioral health workforce. Conducted in Spring 2022, key findings include:

- New graduates in behavioral health occupations tend to be more prepared for private practice than for work in community settings.
- Case management is an important skill in community settings, but is often not well developed in new graduates.
- Frequently, specific practical skills and knowledge are weak or lacking among new hires.
- Functioning effectively in integrated care settings remains a formidable challenge for both new and existing staff.
- While some employers are hiring more bachelor’s-level workers, there is potential to expand this workforce.
- Supervision, mentorship and general staff support are needed for both the new and incumbent behavioral health workforce.
- Increasing numbers of providers are obtaining their education through online learning.

### Education and training priorities include:

- More qualified behavioral health job applicants are needed, particularly with master’s-level credentials.
- Pathways into different behavioral health roles need greater clarity.
- New behavioral health education approaches and occupations are generally welcome, if financially viable.
- Increased behavioral health education program capacity and improved access are needed.
- More applicants dually trained in counseling and substance use disorder treatment, with training in social determinants of health, could better serve those populations with higher incidence of co-occurring disorders and poverty.

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## KEY FINDINGS *continued*

- Early experiences to help behavioral health occupations students identify career goals could increase graduates' job match success.
- High quality supervision and mentorship support is needed for both new and mid-career professionals.

Areas for further investigation suggested from this study include obtaining more input about behavioral health workforce demand from the Health Workforce Sentinel Network, surveying education programs to describe barriers to program expansion, analyzing data on education output over time, and surveying Master's level professionals about factors affecting their professional paths and future plans.

# Washington State's Behavioral Health Workforce: Examination of Education and Training Needs and Priorities for Future Assessment

## BACKGROUND

Since 2016, Washington State has supported intensive assessments of the state's behavioral health (BH) workforce in order to identify barriers and recommend solutions to meeting the behavioral health needs of its population.<sup>1,2</sup> These assessments and subsequent work identified a need to better understand stakeholder concerns and related recommendations regarding the education and training of the behavioral health workforce, in-demand skills that are difficult to fill from current applicant pools, and factors related to education and training requirements that may be contributing to the high levels of behavioral health workforce vacancies and turnover in the state.

Objectives of this examination include:

1. Understanding the range of education and training backgrounds of the behavioral health workforce in various settings in Washington, and which positions are the most difficult to fill;
2. Identifying how the education and training preparation of behavioral health occupations meet the needs of employers and clients, and areas that could be improved;
3. Discussing barriers and facilitators in policy and practice which may assist or impede workforce training and education for Washington's behavioral health workforce.

To meet these objectives, we spoke with individuals who held roles as behavioral health care employers, clinicians, educators, and from policy and practice organizations (key informants) about the critical needs of the workforce, especially those related to the education and training preparation of the workforce as well as strategies to address them. This assessment is intended to provide information to help formulate future activities and recommendations for policy and practice to strengthen Washington's behavioral health workforce.

## METHODS

Staff at the University of Washington's Center for Health Workforce Studies (UW CHWS) conducted 16 interviews with key informants purposefully selected from a variety of behavioral health service delivery settings, behavioral health clinicians, organizations involved in funding and contracting with behavioral health service sites, and education institutions. Potential interviewees were contacted by email, and those willing to participate (nearly all contacted) were interviewed using videoconference software (Zoom).

This study was determined to not be human subjects research according to institutional review board (IRB) policies and therefore did not require IRB review. All key Informants were informed that their participation was voluntary, and that interview data would be kept confidential. All interviewees agreed to participate.



An interview guide developed for this study included questions exploring the following topics:

- behavioral health team composition,
- education requirements,
- current behavioral health workforce demand,
- recruitment and retention challenges,
- adequacy of education and skills preparation of newly hired individuals,
- education and training needs/desires of the incumbent behavioral health workforce, and
- recommendations for changes to behavioral health professions education and training or related policies and regulations.

The questions used to guide key informant interviews varied depending on the informant's role and type of organization with which they were affiliated. Interviewer notes and transcripts were reviewed by the study team to identify themes and illustrative quotations.

In addition, findings from the Spring 2022 data collected for the Washington Health Workforce Sentinel Network from responding behavioral health care facilities in the state were used to supplement interview findings.<sup>3</sup> Quotes cited below are from key informants unless otherwise indicated.

## FINDINGS

### BEHAVIORAL HEALTH WORKFORCE COMPOSITION AND HIRING CHALLENGES

Behavioral health service organizations may employ a variety of licensed, credentialed, as well as unlicensed/uncredentialed occupations to provide a wide variety of services. These services may be provided in settings such as private practices, community-based ambulatory clinics, inpatient and residential facilities, and mobile crisis response units, among others. The organizations and employers we spoke with typically made distinctions between various behavioral health services and programs within their organizations, as these programs often had specific professional types and skills required to meet a variety of criteria including: requirements set by reimbursement or funding requirements (e.g. state Medicaid plan requirements), other state regulatory and licensing requirements, and population needs. For example, key informants mentioned that community behavioral health agencies typically receive much of their reimbursement for services through Medicaid, and are less likely to be in a position to bill Medicare or private insurance. Because facilities employ the provider types that their reimbursement model supports, similar services can be delivered in different settings by occupations with different amounts of training and clinical experience, as well as license/credential status. Administrators among the key informants emphasized that they felt they were maintaining service quality even when they had to modify their team structures in response to recruitment and retention issues (especially master's-level counselors), although this was not without difficulty. Some types of services, however, were reported to not be available to clients specifically due to a lack of some advanced-degree occupation types. In addition, as one key informant reported:

“...the bottom line is that, through the years of working together, there comes a synergistic capacity [among staff], that is just outstanding and they get tremendous clinical outcomes...it's this constantly churning of new people coming in that compromises the integrity of our services.”

Because of staffing variations among behavioral health providers and due to the impact of the pandemic and ongoing workforce recruitment and retention challenges, our interviews sought to obtain general descriptions of interviewees' current health workforce configurations and areas of greatest demand, prior to discussing education and training needs and priorities for those occupations. Following are examples of typical occupations and demand issues from the key informants interviewed for this study and from the Spring 2022 Washington Health Workforce Sentinel Network:

## ■ Community Behavioral Health Agencies (CBHAs), typically serving many high acuity clients:

- Master's-level counselors (clinical social workers, mental health counselors, marriage and family counselors)
  - Reported by nearly all key informants and in responses to the Sentinel Network as being extremely difficult to recruit  
"...master's level therapists are difficult to recruit and once licensed, to retain. Some of this is due to an insufficient number of candidates for the community need but for [this organization] it has (until recently) been due to low salaries." (Spring 2022 Sentinel Network)
- Agency affiliated counselors (AACs), who are licensed to work as counselors in licensed CBHA settings only.
- Care coordinators/navigators
  - Services often not reimbursable, but may be paid with block funding or other sources.  
"...masters level clinicians and...bachelor's level care coordinators...Those are the two areas where we have the greatest number of vacancies where we lose staff."  
"...we are now also experiencing challenges and difficulty recruiting for bachelor's level care team assistance and then also ... difficulty even finding high school graduate positions to get filled."
- Peer counselors/Certified Peer Counselors
- Behavioral health technicians, typically serving inpatient/residential settings.
- Prescribing providers: e.g. psychiatrists and/or psychiatric advanced registered nurse practitioners (psych ARNPs).
  - Some CBHAs report "sharing" a psychiatrist and/or a psych ARNP to reduce the cost of employing a full-time prescriber.

## ■ Integrated physical and behavioral healthcare settings (e.g., Community Health Centers):

- Psychologists
- Master's-level counselors, such as mental health counselors and licensed independent clinical social workers (LICSWs)
- Substance use disorder professionals (SUDPs)
  - Key informants from some community settings reported that they thought they could offer better services with less loss-to-follow up care if they had more applicants with both a master's-level clinician license, as well as a substance use disorder professional (SUDP) license, in order to more efficiently treat the co-occurring mental health and substance use disorders they are encountering in their patient population.
- Medical assistants with behavioral health screening training
- Community health workers (CHWs), if funding source is available (not a billable service under fee-for-service reimbursement).  
"Starting wage for this role = \$16.75/hr. Very few applicants are applying." (Spring 2022 Sentinel Network)
- Psych ARNPs
  - One key informant said having providers with pediatric or child psychology expertise would be ideal, but are hard to find.

## ■ Substance use disorder (SUD) treatment organizations:

- Master's-level counselors  
"Dually credentialed [e.g. mental health and substance use disorder] professionals are very difficult to find, more than any other professional except psychiatrists and psychiatric ARNPs." (Spring 2022 Sentinel Network)
- Substance use disorder professionals (SUDPs) and Trainees (SUDPTs)  
"It is exceptionally difficult to attract SUDP/Ts. There is a dearth of these professionals with a high need within the community" (Spring 2022 Sentinel Network)
- Bachelors level care coordinators
- Psych-ARNPs (prescribers for medication assisted treatment)

- Registered nurses (RNs)
  - One key informant noted that some detox facilities were forced to close due to lack of nurses interested in SUD treatment work during pandemic:

“Finding nurses who care about alcohol and persons with alcohol and drug problems is very difficult, and when you get a good one, you have to just really hang on. And we don’t have the funding to pay them competitive wages, with the hospitals, so that is really killing us on the nursing side, and we have detox programs, and each program needs about 12 nurses to function... I closed one [detox facility] in 2020, both because of COVID and because I couldn’t get any nurses. ”

Overall, most key informants agreed that master’s-level clinicians (with or without a license), i.e. social workers, mental health counselors, and marriage and family counselors, are the occupations most in demand at this time:

“In 2018, we had 9% vacancy rate for master’s positions in outpatient. 2020, 20%, now we are 50% vacancy for master’s positions. We are going to move to relying more on bachelor’s-level trained staff. We’re not going to see the light at the end of the tunnel with getting more master’s. We’re doing our own training for the bachelor’s level people so they can do some of the master’s level skills.”

Key informants reported a variety of responses to difficulties hiring master’s-level counselors including scaling back some services or training up and using bachelor’s trained individuals to provide services in community behavioral health settings. Employers using more bachelor’s-level occupations reported the need to reclassify certain positions and rewrite job descriptions so they were suitable for individuals with a bachelor’s degree. At least one agency commented that this change has likely reduced the services available because the “...higher level of expertise that typically is required for people with serious mental illnesses, we are lacking in the workforce to meet that need...”. In another example, Wraparound with Intensive Services (WISe) programs (an approach to helping children, youth, and their families with intensive mental health care)<sup>4</sup> typically employ a licensed master’s-level clinician as an integral part of the WISe clinical team. At least one key informant at a community behavioral health agency, however, reported hearing from other WISe programs that they were hiring bachelors level staff and then training them in WISe specifically because no licensed master’s level applicants could be recruited to their positions.

Some key informants also mentioned difficulty and acute need for prescribing providers, such as psychiatrists and psych ARNPs, though others mentioned that it has recently become easier to find psych ARNPs.

Key informants argued that case management roles, which can be performed by individuals with less than a master’s degree education, should be more widely reimbursed or supported financially in other ways because they play important roles in assuring access to and continuity of care. In some community behavioral health settings, master’s trained clinicians may be doing more behavioral management for seriously mentally ill individuals (through brief encounters, helping clients find or maintain shelter or food, and other basic needs) rather than using their in-depth counseling skills. Most key informants mentioned that difficulty filling positions has forced them to be creative with staffing, albeit while meeting regulatory and standard of care requirements. One employer reported:

“[the drop in master’s-level clinician applicants led to redesign of] our outpatient clinical services almost completely to where we’re going to be reliant much more heavily on bachelor’s-trained staff because we see... no light at the end of the tunnel ... even if we get more money, we’re not going to see the supply chain of master’s-trained clinicians catch up to what the historical model has been, when you can picture almost a 50% vacancy rate that just - it’s not sustainable”.

Peer counselors and certified peer counselors were cited by some key informants as being difficult to keep employed, perhaps

in part due to their ongoing lived experience condition qualifying them as “peers”, possible past trauma, and the high acuity of patients they typically see:

“We have 35-38 peer support specialist positions. These are also difficult to recruit, though not as hard as master’s level positions. They might find other higher paying jobs as a peer support specialist. Appears to not be enough people [available to be hired] as peers. Peer counselors often have significant lived experience...[and]...many of them are not ‘all done’ with their symptoms.”

Other key informants, however, indicated that the supply of peers was ample to meet their needs.

In inpatient settings, behavioral health technicians, many of which may have associate degrees, may also have high turnover and be somewhat challenging to replace.

Wage pressures affecting workforce stability were also reported by some key informants. For example, one employer reported that during the pandemic they had implemented what they described as unsustainable but necessary wage increases to retain staff so that services could continue, with the hope that some relief is coming which could make the raises sustainable.

Exacerbating these problems, the COVID-19 pandemic simultaneously reduced the size of the behavioral health workforce while increasing demand for behavioral health services. As described by one key informant:

“With [the] pandemic, we had a 15% increase for outpatient services requests in 2020, combined with a 55% vacancy rate in positions [vs. 10-12% typical vacancy rate pre-pandemic]”.

## ADEQUACY OF EDUCATION AND SKILLS PREPARATION

Key informants spoke positively about the behavioral health workforce, but identified areas where educational preparation and skills could be improved. Across behavioral health settings, key informants said that they assume they will need to provide additional training for new staff when hired, even for master’s-level providers who have completed a practicum or internship as part of their training. The training arrangements for new hires described by key informants varied from formal 100-hour training regimens for all new hires, to trainings that address necessary competencies and attitudes as well as awareness and appreciation for organization-specific values and goals. Some key informants emphasized ongoing professional development for all staff, though only one mentioned that their organization pays tuition for select staff demonstrating promise or skill as counselors and who want to pursue formal training.

The following themes surfaced from our interviews with key informants:

**Graduates tend to be more prepared for private practice than for work in community settings.** Multiple key informants described that graduate-level education programs typically focus on educational theory, and the treatment methods used in private practice, but less often provide students with the skills needed in community settings where client acuity is generally higher. Key informants working in care settings serving populations facing poverty and/or socio-economic marginalization often mentioned that new employees frequently do not have a sufficient understanding of the populations served, the barriers faced by these populations in accessing needed services, and how this shapes the role of the behavioral health agency working with these populations. Without experience serving these clients, who often present with severe mental illnesses, as are common in community settings, new graduates often leave community settings and seek either private practice where clients are generally easier to manage, or leave the clinical setting entirely. The following statements represented common themes we heard from key informants:

“Academic programs are not preparing clinical staff to work in community settings,”

“Some patients are homeless, struggling with life, have an SUD, and don’t always show up for appointments, and new staff are sometimes not prepared for this.”

**Case management is an important skill in community settings, but is often not well developed in new graduates.** Several informants also reported that behavioral health program graduates often lack adequate case management skills. In community settings, these skills are needed to, for example, track down a hard-to-reach client. While case management roles can be performed by individuals with less than a master's degree, typically the case management "chase" is not a billable service and therefore goes unfilled in some settings, reducing treatment access and effectiveness. In one integrated care setting, a clinician reported working for months to locate and connect the right specialty resources in the community for a single patient's specific behavioral health need. The lack of a case manager to help with this work was attributed to the fact that, in the fee-for-service environment, there are no billing codes for case managers who could carry out this role and enable the clinician to spend more time providing direct client care.

**Frequently, specific practical skills and knowledge are weak or lacking among new hires:** Examples of specific skills mentioned by key informants that new graduates frequently lacked include:

- Proficiency with using an electronic health record (EHR) system
- Ability to use the diagnostic and statistical manual (DSM)  
"those of us in the field don't feel like they're getting the training and education, they need to do a good diagnosis, to work with the DSM."
- Knowledge of how to make a treatment plan for a patient
- Ability to use evidence based practices (EBPs) in a clinical setting
- Ability to adapt interventions to meet patients' needs (e.g. some patients may benefit more from brief evidence-based interventions, such as SBIRT, rather than traditional 60-minute counseling sessions)
- Humility, particularly among new master's-trained staff, regarding the limitations of their skills and knowledge
- Awareness of the population served by the facility, and cultural humility toward unfamiliar populations, their history and customs

**Functioning effectively in integrated care settings remains a formidable challenge for both new and existing staff:** Key informants reported that many behavioral health workers, even those with extensive education, lack training that enable them to work effectively in clinically-oriented teams. An observation was shared that often there is not a clear, shared understanding of roles in specialist behavioral health team settings or integrated care settings, nor is there adequate knowledge of the roles of the other types of professionals in these settings. This can be exacerbated by differences in jargon or technical language commonly used by different health profession disciplines. One key informant mentioned that achieving care that is truly integrated, with high-functioning clinical teams, is "not rocket science, it's harder than that!"

**While some employers are hiring more bachelor's-level workers, there is potential to expand this workforce:** Some key informants argued that there is an untapped pool of workers who have completed a bachelor's degree in psychology, social work, or another social services degree, who are not being recruited sufficiently into behavioral health, or not being trained and supervised sufficiently to encourage both recruitment and retention of these workers. One key informant pointed out that:

"There is nothing new about bachelor's level people doing direct care. ...A third of our services by master's staff were things that bachelor's level people could do. And, we assessed that about one half of the services could, with training, be done by bachelor's instead of master's [trained individuals]."

**Supervision, mentorship and general staff support benefit both the new and incumbent behavioral health workforce:** Retaining experienced senior staff in settings where they can provide supervision and mentorship is critical to both workforce development and retention. Educating and training new behavioral health professionals is dependent on having qualified professionals able and willing to serve in those roles. However, experienced staff in community settings are reported to often leave

for private practice's higher pay, the ability to be selective about patients, and have generally less arduous working conditions. In addition, regulatory burdens for experienced clinicians and administrators may be driving senior staff away from community settings where they might otherwise supervise or mentor newer professionals:

“We had 14 audits in 16 months from WISE, MCOs, EQRO [CMS external quality review organization], the state, trying to make sure we are following all of the process requirements. And, we had no corrective actions. All of this is driving our 12 veterans in our org out of admin positions and into private practice.”

Rural settings often have fewer opportunities for trainees to find quality, or even adequate, supervision towards licensure, and this problem may be compounded by perceived overly-restrictive supervision requirements which bar cross-disciplinary supervision for master's-level license seekers (e.g. social workers, marriage and family therapists, and mental health counselors) and thereby further limit the availability of supervision-for-licensure in rural areas. More general staff support for these roles, as well as regular mentorship meetings and resources, were cited as important retention factors which have helped to bring some staff back to community health settings after they left for higher paying positions.

**Increasing numbers of providers are obtaining their education through online learning:** Key informants with knowledge of the education paths of their new and incumbent workers agreed that growing numbers are obtaining their education through distance and online education programs, and this trend was occurring even before the onset of the pandemic. One key informant mentioned that about a third of new master's hires completed their degree online, citing the benefits of avoiding commuting time and lower costs compared to some in-state “brick and mortar” programs. Interest among workers in specific online programs was reported to have been encouraged through the positive experiences of their colleagues who had attended the programs. Some of these distance education programs may be based in-state, but it appears that a considerable number of these training programs may be out of state, in a variety of institutions with a range of reputations – including highly respected ones.

Key informants tended to speak favorably about the education provided through these online programs, indicating most seemed to provide comparable preparation to brick and mortar programs, but all still required good preceptorships and supervised practice to fully prepare an individual for practice. The exceptions, however, are educational programs without appropriate internships which were described as leading some students to behavioral health career dead-ends because completing a master's program without an internship or practicum does not meet Washington's licensing standards for master's level clinicians. Several informants raised concerns that some students may not be able to afford an unpaid internship and may not be adequately aware of which programs meet the accreditation and the internship or practicum requirements for Washington licensure.

## **EDUCATION AND TRAINING PRIORITIES TO IMPROVE THE ADEQUACY AND QUALITY OF THE BEHAVIORAL HEALTH WORKFORCE**

Overall, based on responses from these interviews with key informants and from recent responses to the Sentinel Network, more behavioral health workers in general are needed around the state as well as more entrants to the field who are ready and have the skills needed for practice.

**More qualified behavioral health job applicants are needed, particularly with master's-level credentials:** Our interviews consistently found that there are currently not enough qualified master's-level applicants applying for work in behavioral health settings. This problem is long-standing, and may be getting worse: for example, one employer in eastern Washington reported that vacancy rates in positions moved up from 9% in 2018, to 12% in 2019, then 30% by the end of 2021, to 50% by April 2022. Several employers reported similar problems, and some added that they are now having difficulty finding applicants for bachelor's-level positions as well.



**Pathways into different behavioral health roles need greater clarity:** There was consistent concern expressed by employers and clinicians that new workers in behavioral health, including those with advanced degrees, may not be prepared for some elements of behavioral health care, particularly in integrated or community settings. For example, new master's level therapist graduates may be well-prepared for 60-minute one-on-one therapy sessions in private practice with mildly symptomatic patients, but frequently are not prepared for work in community behavioral health and in other community settings that require greater case management skills, preparation for work with high acuity patients, and the ability to effectively address the social determinants of health that influence treatment effectiveness. Multiple key informants recommended that students be provided with early experiences and program options that enable them to develop the skills and competencies needed for the type of practice where they are most likely to find professional satisfaction and success.

**New behavioral health education approaches and occupations are generally welcome, if financially viable:** Entry into behavioral health work through on-the-job training and apprenticeship, as well as associate and bachelor's degree programs, would help to both fill needed roles in behavioral health settings and provide individuals with experience in behavioral health care without making the long-term and often expensive commitment of committing to a master's degree program.

Key informants who were aware of apprenticeship models for behavioral health roles such as those developed through the University of Washington's Behavioral Health Institute (for behavioral health technicians, substance use disorder professionals, and peer counselors) generally expressed support, while others were interested in learning more about them. A few key informants expressed some skepticism of apprenticeship approaches to education and training.

The only new role discussed was the behavioral health support specialist (BHSS), an undergraduate certification designed to prepare individuals to work in integrated settings. Some key informants reported that some employers in community behavioral health settings have expressed concern that new roles like the BHSS might pull their workers away from community settings to more lucrative jobs in primary care or hospital settings. Several key informants either expressed, or mentioned hearing concerns from community behavioral health agencies, that allowing individuals with an associate's or bachelor's degree to bill for services may make it even harder for community behavioral health employers to hire and retain associate's and bachelor's level staff, for example as Agency Affiliated Counselors, as this change would potentially create more opportunities for these workers outside of community settings. A minority of interviewees raised concerns that new profession types, such as the BHSS, or expansion of work available to peers, for example, is causing more competition between professions and making the behavioral health treatment landscape more confusing.

While not entirely new occupations, informants were generally supportive of peers and community health workers as potentially helpful for addressing workforce issues, with some caveats regarding appropriate roles (e.g. exercising caution if considering placing peers in crisis support teams).

It was suggested that in some settings, by employing individuals who are not master's trained, the employer could better address patients' immediate needs, such as finding food or housing resources, or doing brief interventions, rather than focusing on traditional 60-minute counseling sessions which are sometimes emphasized in master's-level training programs.

There was general support for new occupations and roles, although questions remained about how they would be deployed and paid for in different settings. Being able to deploy different occupations and pay for their services depends on a variety of criteria that can vary by facility type (e.g. federally qualified community health center vs. community mental health center vs. primary care clinic), even when the facilities are offering similar behavioral health services. Key informants expressed concern that for the introduction of new occupations to be effective, and for effective and consistent use of the wide array of behavioral health occupations currently available, there needs to be funding/reimbursement mechanisms to employ them in the settings where they are the most needed and useful. Regarding the BHSS occupation, one key informant said:



“There are lots of ways that I think we could use those kinds of people under the supervision of a master’s level person, the problem is under our payment methodology [as a community health center] we don’t get paid for bachelor’s level people.”

**Increased behavioral health education program capacity and improved access are needed:** Key informants and Sentinel Network respondents consistently voice support for behavioral health programs in the state. Maintaining and, when possible, increasing education and training output are seen by respondents and key informants as vital to health workforce development in the state:

“We’d like to see more attention paid to the local colleges. It is not a short term fix, but we need to embrace that this situation didn’t just happen...it’s been brewing for years. We need better pay for clinical instructors, more slots for clinical students and more resources to employers to provide quality clinical experiences.” (Spring 2022 Sentinel Network)

Distance education appears to be an increasingly attractive option for entry into the behavioral health workforce and for professional development.

“A lot of people are doing their degrees online for master’s programs”

Distance education allows students to continue working while pursuing education goals because courses could be completed during evenings and weekends, and often at less expense than at brick and mortar schools. More effective marketing, more convenient online class schedules for working individuals, and lower costs were seen by key informants as possible avenues for accredited in-person and online in-state programs to better compete for students in the broader online degree marketplace.

A concern expressed by several key informants was that some students might complete an online behavioral health program that does not meet the requirements for Washington state licensure because it does not include a practicum or internship. Because behavioral health occupations students such as master’s level clinicians frequently carry high student debt loads and face low earnings, informants recommended finding a solution that could help those individuals who have completed a master’s program lacking a practicum to overcome this issue, perhaps based on their clinical work completed post-master’s or through some other avenue, so they are able to advance to licensure.

**More applicants dually trained counseling and SUD treatment, with training in social determinants of health, could better serve those populations with higher incidence of co-occurring disorders and poverty:** For example, community health centers reported needing more counselors who also have SUD training or SUDP licensure, and more understanding and training in social determinants of health. Among the benefits of employing dually trained providers expressed by key informants was reducing client loss-to-follow-up when they are referred to separate clinicians for mental health and SUD treatment.

**Early experiences to help behavioral health occupations students identify career goals could increase graduates’ job match success:** Key informants from community settings indicated that many new-hires’ expectations for their careers is often inconsistent with community-based work. Education objectives and experiences frequently do not prepare students for settings where patient acuity, need and social determinants of health make accessing care more difficult, or for settings where there are significant cultural differences between staff and patients. On the other hand, key informants also pointed out that some students and workers thrive on attending to more acute situations and social mission-oriented work. A recommendation that arose from our interviews was to encourage education programs to provide students, early in their academic careers, with information and experiences that will help them to identify if their career goals (and likely future professional satisfaction) are more aligned with a community behavioral health or an individual counseling pathway.

**High quality supervision and mentorship support is needed for both new and mid-career professionals:** Having good supervision at the start of one’s career, as well as into mid-career, was mentioned as an important determinant for retention in the behavioral health workforce by multiple key informants. Several mentioned the importance of good supervision and mentorship in their own clinical careers, and emphasized that high-quality supervision and ongoing general staff support can improve care quality and reduce workforce turnover.

Prior assessments<sup>1,2</sup> found that removing barriers to high-quality supervision was an important topic among Washington stakeholders with an interest in behavioral health workforce development, and that some stakeholders would like to see existing supervision training, typically designed to meet the WAC requirements for clinical supervisors, also include ways to improve the quality of supervision beyond WAC requirements.<sup>5</sup> Additionally, requirements that supervision for licensure hours be conducted by providers of the same license type were cited as reasons for some recent graduates to leave some settings so they can find the right supervisor:

“Because whether you’re getting a counseling degree or a social work degree or a psychology degree ultimately you’re working with individuals and families and have to be able to relate to them and provide them with good service and that’s going to depend a lot on the supervision to me and less about the degree.”

Recent support for an “add-on” rate for supervision in community settings was mentioned by key informants as an important way to improve access to supervision for licensure. Another example of positive support for supervision and mentorship was the apprenticeship programs’ payments to mentors for the extra work of supervising apprentices.

## AREAS FOR FURTHER INVESTIGATION

Based on the findings from this assessment, following are potential activities that could provide additional useful information about the education and training, as well as recruitment and retention, of Washington’s behavioral health workforce that could help to inform planning and policy.

**Obtain more input from behavior health facilities/employers using the Health Workforce Sentinel Network.** Based on findings from this assessment and input from the Sentinel Network Advisory Committee, develop a short set of questions to be asked of facilities employing behavioral health occupations across the state to further explore education and training needs for this workforce. These questions would be included as part of the Fall 2022 Sentinel Network data collection period and results reported on the Sentinel Network interactive findings dashboard and in a short Findings Brief posted on that dashboard.

**Assess barriers to effective behavioral health workforce education and training.** To expand understanding of the education and training issues identified by key informants interviewed this assessment, conduct interviews or surveys of behavioral health education programs in Washington to describe issues affecting the alignment of programs with employer demand.

**Conduct analyses to describe behavioral health education and training program completions in Washington.** To better understand in-state production of new behavioral health workers, obtain and analyze data from the U.S. Department of Education’s Integrated Postsecondary Education Data System (IPEDS) to describe recent completions and changes over time from behavioral health education and training programs in Washington.

**Conduct surveys of Washington’s master’s-level behavioral health professionals.** A survey of Washington’s master’s-level counselors (mental health counselors, clinical social workers, marriage and family counselors) and SUDPs would provide valuable information about what influences recruitment and retention of these critical behavioral health providers. A survey is the most effective data collection tool to obtain information about factors contributing to these professionals’ career decisions, including

education and credentials, supervised training experiences, experience practicing in sites serving underserved populations, effects of education debt on practice decisions, future career plans, and other factors that contribute to retention and career changes, as well as key demographic characteristics. Data collected would include information about the state(s) where providers obtained their professional education and training which would improve understanding of the percentage of Washington’s behavioral health workforce who were educated in-state, the percentage who attended on-line programs, and barriers to licensure they may have experienced. Surveying the workforce to understand the supply-side characteristics of this workforce and challenges to their recruitment and retention would complement the available demand-side information obtained by this key informant assessment and the Washington Health Workforce Sentinel Network, thereby improving our ability to identify barriers and develop more effective workforce solutions.

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# Appendix B

## **Behavioral/Mental Health, Substance Use Disorder (SUD) Clinics and Residential Treatment Facilities**

# Washington's Health Workforce Sentinel Network

## Findings Brief:

### Behavioral/Mental Health, Substance Use Disorder (SUD) Clinics and Residential Treatment Facilities

Washington's Health Workforce Sentinel Network links the state's healthcare industry with partners in education and training, policymakers, and other workforce planners to identify and respond to emerging demand changes in the health workforce. Every six months, employers ("Sentinels") from across the state and from a wide range of healthcare sectors share their top workforce challenges. This report highlights findings reported by Sentinels providing behavioral health services in the spring and fall of 2022, including in-depth reporting on educational preparation of entrants to Washington's behavioral health workforce. More in-depth findings from 2022 and prior years may be viewed at [www.wa.sentinelnetwork.org/findings](http://www.wa.sentinelnetwork.org/findings).

### Employer Perspectives: Workforce Staffing

Since its inception, the Sentinel Network has tracked the occupations that are reported to be experiencing exceptionally long vacancies. The table below shows the occupations that employers at behavioral health facilities have indicated were the hardest to hire. As the figure shows, many of the same occupations have been reported as experiencing exceptionally long vacancies since at least spring 2019, indicating that these occupations have been in high demand for many years at facilities providing behavioral health services.

**Figure 1. Behavioral Health Facilities\***  
**Occupations with exceptionally long vacancies: 2019-2022**

| Rank | Spring 2019                               | Fall 2019                                 | Spring 2020                               | Fall 2020                                 | Spring 2021                         | Fall 2021                           | Spring 2022                         | Fall 2022                          |
|------|---|---|---|---|-------------------------------------|-------------------------------------|-------------------------------------|------------------------------------|
| 1    | Mental health counselor                   | Mental health counselor                   | Mental health counselor                   | Mental health counselor                   | Mental health counselor             | Mental health counselor             | Mental health counselor             | Mental health counselor            |
| 2    | Chemical dependency professional (SUDP)** | Chemical dependency professional (SUDP)** | Chemical dependency professional (SUDP)** | Chemical dependency professional (SUDP)** | Substance use disorder professional | Substance use disorder professional | Substance use disorder professional | SUDP                               |
|      |   |   |   |   |                                     |                                     |                                     | Registered nurse                   |
|      |   |   |   |   |                                     |                                     |                                     | Peer counselor                     |
| 3    | Social worker                             | Peer counselor                            | Social worker                             | Social worker (Mental Health/SUDP)        | Psychiatrist                        | Social worker (Mental Health/SUDP)  | Social worker (Mental Health/SUDP)  | Social worker (Mental Health/SUDP) |
|      |   |   |   | Social worker                             |                                     |                                     |                                     |                                    |
| 4    | Marriage & family therapist               | Marriage & family therapist               | Peer counselor                            | Registered nurse                          | Peer counselor                      | Peer counselor                      | Marriage & family therapist         | Marriage & family therapist        |

← Most cited

\*Includes behavioral/mental health, substance use disorder clinics, residential treatment facilities, designated crisis responder services, mobile crisis outreach teams, and other residential and out-of-facility behavioral health services.

\*\*Occupation title changed to Substance Use Disorder Professional (SUDP).

Note: Findings prior to spring 2019 not shown due to space constraints – see the Sentinel Network dashboards at [wa.sentinelnetwork.org](http://wa.sentinelnetwork.org)

## Behavioral Health Facilities (2022)

### Reasons for vacancies reported by Behavioral Health facilities

The reasons cited for these exceptionally long vacancies were often low salary, high cost of living in the area around their facility, wage competition, lack of qualified applicants and other recruitment issues, and a general workforce shortage of behavioral and mental health professionals.

*“[There are] no applicants for open positions. Those that do apply want [...] high rates of pay [...]. Most individuals either want full-time with benefits - or only want to work special schedules that are not in alignment with our needs.” – Substance Use Disorder Residential Treatment Facility, Fall 2022*

*“Current [insurance reimbursement] rates do not support competitive compensation [...], which has resulted in dramatic decrease in the number and qualification of potential candidates.” – Behavioral/Mental Health Clinic, Fall 2022*

### Reasons for Retention and Turnover Problems Reported by Behavioral Health Facilities

Respondents highlighted a variety of reasons for worker retention and turnover problems, including employees leaving for higher pay, more flexibility in their work schedule and/or location, and improved work-life balance. Others noted that the COVID-19 pandemic has left their clients with higher needs and reduced staff to care for these patients, leading to burnout and turnover among incumbent employees. Some facilities reported that their employees were choosing not only to leave their organization, but also to exit the industry.

*“Increased stress caused by the pandemic, higher needs of clients and staff shortages have led to burnout and turnover. We are seeing employees not only leave our organization but leave the industry.” – Behavioral/Mental Health Clinic, Spring 2022*

*“Competitive salaries being offered at other agencies in the community. High caseloads, burnout of working with client population.” – Behavioral/Mental Health Clinic, Spring 2022*

*“Staff leaving for positions that pay them an exceptional rate of pay or they can work from home. Also, leaving to take positions that are higher in pay, full-time, or have benefits. As mentioned, our reimbursement rate for our services from funders prevents us from offering exceptional pay, full-time, with benefits for all positions. And, due to the nature of our business (open 24/7), we do not have much flexibility in schedules and cannot work from home.” – Substance Use Disorder Residential Treatment Facility, Fall 2022*

### Responses to Staffing Problems Reported by Behavioral Health Facilities

To cover worker absences and vacancies, many respondents asked current employees to expand their roles, but fear potential burnout among their current workforce, while others have had to implement patient waitlists or reduce the number of appointments for each patient to help manage their current employee’s workloads. Others reported that their current staff worked overtime, took less time off, reduced the number of clients seen or hours spent per client, resulting in staff experiencing increased stress.

*“Less time off by other staff; some clients not seen as often. Staff have become more stressed due to having less time to see clients due to vacancies.” – Behavioral/Mental Health Clinic, Spring 2022*

*“With staffing shortages, [we] have had longer wait times, high census, [and] multiple people filling multiple roles [leading to] burnout.” – Designated Crisis Responder Services, Fall 2022*



### Employer Perspectives: Possible Policy Solutions

When asked about what employee benefits are, or would be, the most helpful in improving retention of their facility's current workforce, respondents indicated that childcare, enhanced medical coverage and family leave, behavioral health services, increased pay and wages, and flexible schedules would be among the most helpful. Respondents indicated that many employees like telehealth as it offers greater flexibility, but it is not always possible depending on the patient population.

*"Childcare would be an amazing benefit to offer, but would be too costly for our company to provide to our employees." – Behavioral/Mental Health Clinic, Spring 2022*

*"Flexible schedules, better pay, lower caseloads [would help with retention]." – Behavioral/Mental Health Clinic, Spring 2022*

*"Medical and dental coverage for family members of staff would make a substantial difference for staff retention." – Behavioral/Mental Health Clinic, Spring 2022*

#### Data Highlight – External factors that affected staffing

In fall 2022, 15 Behavioral Health Sentinels provided feedback on external factors that impacted staffing at their facilities. Nine (60%) indicated that a lack of childcare, 10 (67%) said housing availability, and 6 (40%) said transportation difficulties (expense or lack of public options) affected staffing decisions. This indicates that, based on a small number of responses from across the state, policies and funding directed toward factors such as these could be beneficial.

When asked of their top workforce needs that could be alleviated by policies, regulations, and payment rules, respondents often highlight credentialing and licensing requirements, educational incentives, and payment increases as priorities for many employers. Some respondents indicated that the licensing process can be too long for new and out-of-state employees. Others highlighted the need for increases to public and private insurance reimbursement rates to allow employers to offer competitive benefits and salaries, as well as expanding benefits to cover other behavioral health needs.

*"Private insurance [should provide] reimbursement for group therapy, peer support, and/or case management to reduce pressure on MHP [mental health professionals] for all behavioral health needs." – Behavioral/Mental Health Clinic, Spring 2022*

*"The licensing process for an out of state employee is exceptionally long. It is long for people within the state at times." – Behavioral/Mental Health Clinic, Spring 2022*

### Supplemental Questions About Education Preparation of Entrants to Washington's Behavioral Health Workforce – Fall 2022

Recent efforts to address behavioral health workforce development in Washington have highlighted areas where applicants' and newly hired employees' qualifications often do not fully meet some employers' needs. During the fall 2022 Sentinel Network data collection period, Sentinels were asked to assess the preparation of their existing and recently hired workforce in a variety of areas. These questions were drawn from other examinations of the knowledge and skills preparation of the behavioral health workforce in the state, including:

Skillman SM, Dunlap B. Washington State's Behavioral Health Workforce: Examination of Education and Training Needs and Priorities for Future Assessment. Center for Health Workforce Studies, University of Washington, Jul 2022. <https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2022/11/WA-BH-Education-Training-Assess-FR-2022.pdf>

Feedback from Behavioral Health Sentinels is summarized below, based on 20 responses representing 13 behavioral-mental health clinics, 4 designated crisis responder services, 4 mobile crisis outreach teams, 5 other out-of-facility behavioral health services, 3 residential treatment facilities, 3 substance use disorder residential treatment facilities, 4 community health centers, and 2 "other" hospitals. One respondent could reply for multiple facility types. Respondents represented facilities that provided services in one or more of all nine Accountable Communities of Health in Washington. Because response numbers were relatively small and included "don't know" and "not applicable" answers, these findings merit further investigation.

- 85% of respondents reported licensed behavioral health occupations hired in recent years were, in general, **somewhat prepared or not well prepared** for practice in their type of facility (e.g., prepared for their facility's practice style, client acuity, client load)
- Skills and knowledge areas where the highest percentages of respondents reported applicants and new hires were **well prepared** included:
  - social justice and equity (45%)
  - maintaining healthy boundaries with clients and other providers (42%)
  - adherence to accepted ethical and behavioral standards of the profession (42%)
  - clinical assessment (36%)
  - motivational interviewing (33%)
  - appropriate treatment for behavioral health (33%)
  - creating a therapeutic and helping relationship with the client (33%)
- Skills and knowledge areas where the highest percentages of respondents reported applicants and new hires were **not well prepared** included:
  - interdisciplinary team-based care (55%)
  - working with high utilizers/high need populations (50%)
  - documentation (42%)
  - motivational interviewing (42%)
  - solution-focused brief therapy (40%)
  - substance use (36%)
  - crisis de-escalation (33%)
  - serving diverse clients (33%)
  - research-informed practice (33%)
  - relevant law (33%)

## Behavioral Health Facilities (2022)

### Supplemental Questions About Education Preparation of Entrants to Washington's Behavioral Health Workforce – Fall 2022 (cont.)

Behavioral health facility respondents were also asked about their level of agreement of three statements about behavioral health education that were identified previously as common themes in interviews with select behavioral health workforce key informants across the state:

- **Behavioral health education programs should provide students with early exposure to, and experiences with, different client populations that they may serve in their careers.** Students in behavioral health education programs should be provided with early experiences and program options that enable them to develop the skills and competencies needed for the type of practice (e.g., in safety net facilities, private practice, integrated behavioral health/primary care practice) where they are most likely to find professional satisfaction and success.”
  - 92% agreed (including 54% who strongly agreed)
- **New behavioral health education approaches and occupations are welcome, if financially viable.** Entry into behavioral health work through on-the-job training and apprenticeship, as well as associate and bachelor's degree programs, can help to both fill needed roles in behavioral health settings and provide individuals with experience in behavioral health care without making the long-term and often expensive commitment of committing to a graduate degree program.
  - 84% agreed (including 46% who strongly agreed)
- **Distance education improves access to behavioral health education and increases workforce supply.** Distance education through institutions in Washington and other states is a growing option for behavioral health education and is an important component of health workforce development in the state.
  - 77% agreed (including 46% who strongly agreed)

### About the Washington Health Workforce Sentinel Network

The Health Workforce Sentinel Network links the healthcare sector with policymakers, workforce planners and educators to identify and respond to changing demand for healthcare workers, with a focus on identifying newly emerging skills and roles required by employers. The Sentinel Network is an initiative of Washington's Health Workforce Council, conducted collaboratively by Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies. Funding to initiate the Sentinel Network came from the Healthier Washington initiative, with ongoing support from Governor Inslee's office and the Washington State Legislature.

#### Why become a Sentinel? *As a Sentinel, you can:*

--Communicate your workforce needs and ensure that the state is prepared to respond to the transforming healthcare environment.

--Have access to current and actionable information about emerging healthcare workforce needs.

--Compare your organization's experience and emerging workforce demand trends with similar employer groups.

To view an interactive summary of findings and to provide information from your organization:

[www.wa.sentinelnetwork.org](http://www.wa.sentinelnetwork.org).

Contact: [healthworkforce@wasentinelnetwork.org](mailto:healthworkforce@wasentinelnetwork.org)

Operations Director: Benjamin Stubbs, Research Scientist, UW Center for Health Workforce Studies [bstubbs@uw.edu](mailto:bstubbs@uw.edu)

Program Director: Susan Skillman, Senior Deputy Director, UW Center for Health Workforce Studies [skillman@uw.edu](mailto:skillman@uw.edu)

# Appendix C

## **Behavioral Health Workforce — Building & Sustaining Career Pathways**

# Behavioral Health Workforce - Building & Sustaining Career Pathways

October 31, 2022

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Mikel Poppe, Henedina Tavares, Jenée Myers Twitchell, and Jayme Shoun*

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Washington STEM is pleased to submit this summary report on the status of the work completed to date on the Behavioral Health Building and Sustaining Career Pathways Data Project in partnership with the Workforce Education and Training Coordinating Board (WTB or the Workforce Board throughout). This progress report reflects the agreed-upon goals and milestones for the project approved by WTB, the activities accomplished for each milestone to date, as well as the continuing and planned activities for the milestones for the rest of the project this year.

### Project goals:

1. Provide regional supply data and partnership to drive an expansion of high-quality behavioral health workforce in Washington.
2. Provide Data & Measurement for current career pathways or degree programs providing credentials for each behavioral health and related occupations.
3. Develop a Credential Opportunities by Region and Industry tool to highlight what credentialing opportunities exist (or do not exist) in every region of the state in order to

help with targeted expansion of both programs in post-secondary and career exploration experiences in K-12.

4. Identify gaps and barriers to participation and completion of programs that lead to high demand behavioral health occupations.
5. Develop an interactive dashboard and series of regionalized reports for current supply and demand of behavioral health and related occupations. This may enable advocacy and education efforts to expand access to behavioral health.

## Industry-Approved Behavioral Health Occupation and Job Title List

It is generally understood that the field of behavioral health has a number of jobs with high numbers of openings and a need for filling out the workforce. At the same time, in approaching this project, Washington STEM also understood that there was no agreed-upon or proposed list of behavioral health-specific occupations or job titles to which one could look for purposes of prioritizing need, openings, or combating systemic workforce barriers. Furthermore, traditional job projection data (demand) and higher ed/training data (supply) mask the hiring (and retention) crisis within many occupations in the behavioral health sector. In order to identify behavioral health-specific demand, Washington STEM determined which jobs exist within the traditional occupation groups and used this to generate job projections. In other words, in order to be able to provide and analyze “supply” barriers—barriers to supporting, providing credentials for, or retaining the individuals needed to fulfill the workforce openings—Washington STEM would first need to identify the jobs that were behavioral health-specific.

In order to identify behavioral health-specific occupations and job titles, Washington STEM gathered and analyzed data from the Washington State Employment Security Department, the federal Bureau of Labor & Statistics, Washington State Labor and Industries, individual apprenticeship programs, the Workforce Training and Education Coordinating Board, and key stakeholders and generated a list of initial occupation groupings that are related to behavioral health. Because the Behavioral Health Workforce has many occupations that have specific credential and training requirements, the initial data source Washington STEM used was the ESD [Occupations-industry matrices](#), used to identify the occupations typically found in the behavioral health and related industries. The resulting list of occupations is broken down into two categories: Occupations exclusively found in behavioral health industries, examples include Psychiatrist, Social Worker, and Psychologist; and occupations found in multiple industries including behavioral health, examples include Registered Nurse and Physician.

Overall, occupations were defined using the U.S. Bureau of Labor Statistics (BLS) [Standard Occupation Classification \(SOC\) system](#), and typical credentials and work experience required to enter an occupation are provided by [U.S. Bureau of Labor Statistics \(BLS\) Occupational Characteristics](#). The list of occupations available for consideration was then matched to [occupational projections](#) provided by the Washington State Employment Security Department (ESD). The list of occupations included in the Washington State occupational projections are limited to the 6 digit “detailed occupation level” and do not include all occupations included in the SOC system, as a result some occupations are combined. An example of combined occupation projections would be “21-1014 Mental Health Counselors” which do not have an occupational projection and are instead included in “21-1019 Counselors, All Other.”

The list of occupations was then expanded to include job titles specific to behavioral health. This was initially accomplished using a list of behavioral health professions provided by stakeholders and sources such as the [Washington State Department of Health Behavioral Health Professions, Facilities, and Agencies](#). From there, [O\\*Net OnLine](#) was then used to match these

job titles with occupations. O\*Net OnLine provides a searchable list of reported job titles associated with occupations found in the SOC system. Unique job titles also represent the variation in credentials and work setting experience required for each. The below snapshot is a portion of the occupations first identified as being related to behavioral health, the full initial list includes 60 total occupational groupings.

| SOC code | Occupational title                                  | Projected Job Openings |
|----------|---|------------------------|
| 31-1120  | Home Health and Personal Care Aides                 | 8,181                  |
| 21-1093  | Social and Human Service Assistants                 | 1,353                  |
| 21-1019  | Counselors, All Other                               | 1,083                  |
| 21-1021  | Child, Family, and School Social Workers            | 996                    |
| 31-1131  | Nursing Assistants                                  | 957                    |
| 11-9151  | Social and Community Service Managers               | 589                    |
| 21-1094  | Community Health Workers                            | 486                    |
| 21-1015  | Rehabilitation Counselors                           | 352                    |
| 29-1141  | Registered Nurses                                   | 315                    |
| 21-1023  | Mental Health and Substance Abuse Social Workers    | 302                    |
| 31-9092  | Medical Assistants                                  | 279                    |
| 21-1022  | Healthcare Social Workers                           | 248                    |
| 19-3039  | Psychologists, All Other                            | 206                    |
| 29-1125  | Recreational Therapists                             | 166                    |
| 11-1021  | General and Operations Managers                     | 161                    |
| 29-2053  | Psychiatric Technicians                             | 149                    |
| 21-1099  | Community and Social Service Specialists, All Other | 148                    |
| 21-1091  | Health Education Specialists                        | 130                    |

Washington STEM worked with representatives across a large group of stakeholders to review the occupations list, refine it, and make naming and other decisions about the jobs on the list. Washington STEM engaged with over 150 stakeholders to obtain feedback in crafting the list and the tools. This engagement produced a much more accurate and relevant list of behavioral health-specific jobs that reflects the field, and prepared the list for use in a behavioral health labor market projections tool. This produced a comprehensive draft list of behavioral health occupations and job titles that accurately reflects the field and the contexts of the work; followed by screenshots as examples of the job titles that more accurately reflect the BH industry in Washington: <https://washingtonstem.box.com/v/BH-Job-Titles>

Stakeholder feedback was provided by the following organizations:

|   |  |
|---|--|
| Workforce Training and Education Coordinating Board (WTB) staff | Children and Youth Behavioral Health Work Group (CYBHWG) |
|---|--|



|  |  |
|--|--|
| Behavioral Health Workforce Advisory Committee (BHWAC)               | Health Workforce Council   |
| Healthcare Authority (HCA)   | Washington State Hospital Association                                |
| Washington Association of community health centers                   | Sentinel Network, UW   |
| Behavioral Health Institute, UW                                      | SEIU Healthcare 1199NW Multi-Employer Training and Education Fund    |
| Kaiser Permanente  | Behavioral Health Northwest  |
| Sound Mental Health  | Catholic Community services  |
| Downtown Emergency Services  | Skagit Behavioral Health group (led by Rep Paul)                     |
| Behavioral Health Workforce Task Force (convened by Rep Frank Chopp) | Association of Advanced Practice Psychiatric Nurses                  |
| Comprehensive Life Resources   | Cascade Community Healthcare   |
| Lake Washington Institute of Technology                              | Molina Healthcare  |
| Washington State Department of Health (DOH)                          | School of Nursing, UW  |
| Greater Columbia ACH   | Lifeline Connections   |
| DSHS   | Kitsap Mental Health Services  |
| Lummi Indian Business Council  | Frontier Behavioral Health   |
| Telecare Corp  | Dept. of Veterans Affairs  |
| Discovery Behavioral Healthcare                                      | Evergreen Recovery Centers   |
| National Association of Social Workers - Washington Chapter          | Amerigroup   |
| Valley Cities  | Sunrise Services, Inc.   |
| Greater Lakes Mental Healthcare                                      | Coordinated Care   |
| Yakima Valley Farm Workers Clinic/Behavioral Health                  | Eastern Washington University  |
| Swedish Edmonds Behavioral Health Inpatient Unit                     | Coalition Ending Gender Based Violence                               |
| Council of Presidents  | Association of Alcoholism and Addiction Programs of Washington State |
| Washington State Employment Security Department                      | South Central Workforce Council                                      |
| Sea Mar Community Health Centers                                     | State Board for Community & Technical Colleges                       |
| WA State Psychological Association                                   | Children's Home Society of Washington                                |
| Washington Association for Community Health                          | Elevate Health Pierce County ACH                                     |
| Elevate Health Pierce County ACH                                     | School of Social Work, UW  |

|   |  |
|---|--|
| Washington State Nurses Association                   | Workforce Development Council Seattle -King County |
| North Sound Behavioral Health Administrative Services | Washington State Labor & Industries                |
| Nursing Care Quality Assurance Commission             | Washington State Office of Financial Management    |
| Health Care Apprenticeship Consortium                 |  |

Washington STEM then worked with a smaller group of representatives from key stakeholder organizations to assign percentages of sub occupations to job projections groups. This included meetings with the Workforce Board staff, and with Melody McKee who is the Program Director for the Behavioral Health Training, Workforce and Policy Innovation Center, Harborview Medical Center - Behavioral Health Institute. The following is an example of how the assignment of percentages of sub occupations to a job projections groups work:

- For occupations found primarily in the behavioral health industry Washington STEM assumed 100% of projected job openings are distributed among the job titles identified. While the weighting of job projections has not yet occurred, here is an example of how it will be done:
- Washington STEM identified 5 unique job titles that fall under the occupation of “Social Worker, All Other.” The occupation is projected to have 100 job openings statewide. With input from key stakeholders Washington STEM estimated projected job openings. A *draft example* of how these may be distributed follows:

| <b>Job Title</b>                                    | <b>Weighting</b> | <b>Projected Openings</b> |
|---|------------------|---------------------------|
| Certified Affiliate Sex Offender Treatment Provider | 5%               | 5                         |
| CORF Social Worker/Psychologist                     | 10%              | 10                        |
| Licensed Advanced Social Worker (LASW)              | 30%              | 30                        |
| Licensed Independent Clinical Social Worker (LICSW) | 25%              | 25                        |
| All Other Social Workers                            | 30%              | 30                        |
| <b>Total Projected Job Openings</b>                 |                  | <b>100</b>                |

On November 12th, 2021, Washington STEM released a draft Tableau dashboard that aimed to accurately reflect the behavioral health occupation landscape and the projected job openings in that landscape, by sub-occupation and by region. This tool is a BH industry-specific version of Washington STEM’s more general Labor Market Data Dashboard (<https://washingtonstem.org/labor-market/>). The draft-version of Behavioral Health Labor Market Data Dashboard can currently be found here: [https://tableau.strivetogogether.org/t/GraduateTacoma/views/BH\\_LMD\\_2021/JobTitle-Details?:showAppBanner=false&.display\\_count=n&.showVizHome=n&.origin=viz\\_share\\_link](https://tableau.strivetogogether.org/t/GraduateTacoma/views/BH_LMD_2021/JobTitle-Details?:showAppBanner=false&.display_count=n&.showVizHome=n&.origin=viz_share_link)

Building on the data and feedback collected throughout 2021 to generate a list of behavioral health occupations, and job titles specific to behavioral health within those occupations (<https://washingtonstem.app.box.com/v/BH-Job-Titles>), Washington STEM then generated and collected input on which workplace settings these job titles appear. Input was provided by the Workforce Training and Education Coordinating Board and University of Washington Behavioral Health Institute. Based on this input 13 workplace settings were identified:

- Hospitals
- Schools
- Social Services Agency
- Psychiatric Inpatient
- Involuntary Treatment
- Community Mental Health /Behavioral Health Agency
- Private Practice /Individual Family Services
- Substance Use Disorder /Residential
- Substance Use/Outpatient
- Withdrawal Management
- Peer Services
- Community Based Organizations (CBO)
- State & Regional Agency

Input was then gathered on which of the 13 workplace settings each of the 153 behavioral health jobs previously identified typically appear. The below snapshot is a portion of this list, the full list can be found here: <https://washingtonstem.box.com/v/BH-Job-Settings>.

| Job Titles   | Hospitals | Schools | Social Services Agency | Psychiatric Inpatient | Involuntary Treatment | Community Mental Health /BHA | Private Practice /Individual Family Services | Disorder /Residential | Substance Use | Use/Outpatient | Substance Management | Withdrawal | Peer Services | Community Based Organizations (CBO) | State & Regional Agency |
|--|-----------|---------|------------------------|-----------------------|-----------------------|------------------------------|--|-----------------------|---------------|----------------|----------------------|------------|---------------|-------------------------------------|-------------------------|
| Social Service Coordinator   |           |         | Y                      |                       |                       |                              |  |                       |               |                |                      |            |               |                                     |                         |
| Social and Community Service                                       |           |         | Y                      |                       |                       |                              |  |                       |               |                |                      |            |               |                                     |                         |
| Case Manager   | Y         |         | Y                      |                       |                       | Y                            |  |                       |               |                |                      |            |               | Y                                   |                         |
| Behavior Specialist  |           | Y       |                        |                       |                       |                              |  |                       |               |                |                      |            |               |                                     |                         |
| Behavioral Health Support Specialist                               |           |         |                        |                       |                       |                              |  |                       |               |                |                      |            |               |                                     |                         |
| Certified affiliate sex offender treatment provider                |           |         |                        |                       |                       | Y                            | Y  |                       |               |                |                      |            |               |                                     |                         |
| Child and Adolescent Psychologist                                  | Y         | Y       |                        | Y                     | Y                     | Y                            | Y  | Y                     | Y             | Y              | Y                    |            |               |                                     | Y                       |
| School Psychologist  |           | Y       |                        |                       |                       |                              |  |                       |               |                |                      |            |               |                                     |                         |
| Psychologists, All Other   | Y         | Y       |                        | Y                     | Y                     | Y                            | Y  | Y                     | Y             | Y              | Y                    |            |               |                                     | Y                       |
| Infant Mental Health Therapist                                     | Y         |         |                        |                       |                       | Y                            | Y  |                       |               |                |                      |            |               |                                     |                         |
| Marriage and Family Therapists                                     | Y         | Y       | Y                      | Y                     | Y                     | Y                            | Y  |                       |               |                | Y                    |            |               | Y                                   |                         |
| Employment specialist / Employment advisor / Vocational Specialist |           |         | Y                      |                       |                       | Y                            |  |                       |               |                |                      |            | Y             | Y                                   |                         |
| Rehabilitation Counselors  |           |         | Y                      |                       |                       | Y                            |  |                       |               |                |                      |            | Y             | Y                                   |                         |
| Agency Affiliated Counselor  | Y         | Y       | Y                      | Y                     | Y                     | Y                            | Y  | Y                     | Y             | Y              | Y                    | Y          | Y             | Y                                   |                         |
| Case Manager   | Y         |         | Y                      | Y                     | Y                     | Y                            | Y  | Y                     | Y             | Y              | Y                    | Y          | Y             | Y                                   |                         |

To finalize the weighting and distribution of job openings across occupations, Washington STEM developed a survey for behavioral health-specific human resources/talent/workforce experts to ensure that previous data collection was vetted by in-field professionals. The survey can be found here:

[https://uweducation.co1.qualtrics.com/jfe/form/SV\\_b1NTB1HpY6Aocle?utm\\_campaign=BH\\_Survey](https://uweducation.co1.qualtrics.com/jfe/form/SV_b1NTB1HpY6Aocle?utm_campaign=BH_Survey).

In total, 17 respondents completed the survey, garnering information that allowed us to adjust the projected weighting/assignment of percentage of openings by job title, ensuring that average regional wage is accurately reflected for each job, and ensuring that projected openings by region are accurately reflective of the field.

The screenshot shows the Washington STEM logo at the top, followed by instructions to estimate the percentage share of projected openings for various job titles. The current section is for 'Healthcare Social Workers (486 projected openings statewide)'. It lists three job titles with input fields for their percentage share: 'Outreach Specialist' (0%), 'Healthcare Social Workers, all other behavioral health job titles not listed above' (0%), and 'Total' (0%). Navigation arrows are visible at the bottom.

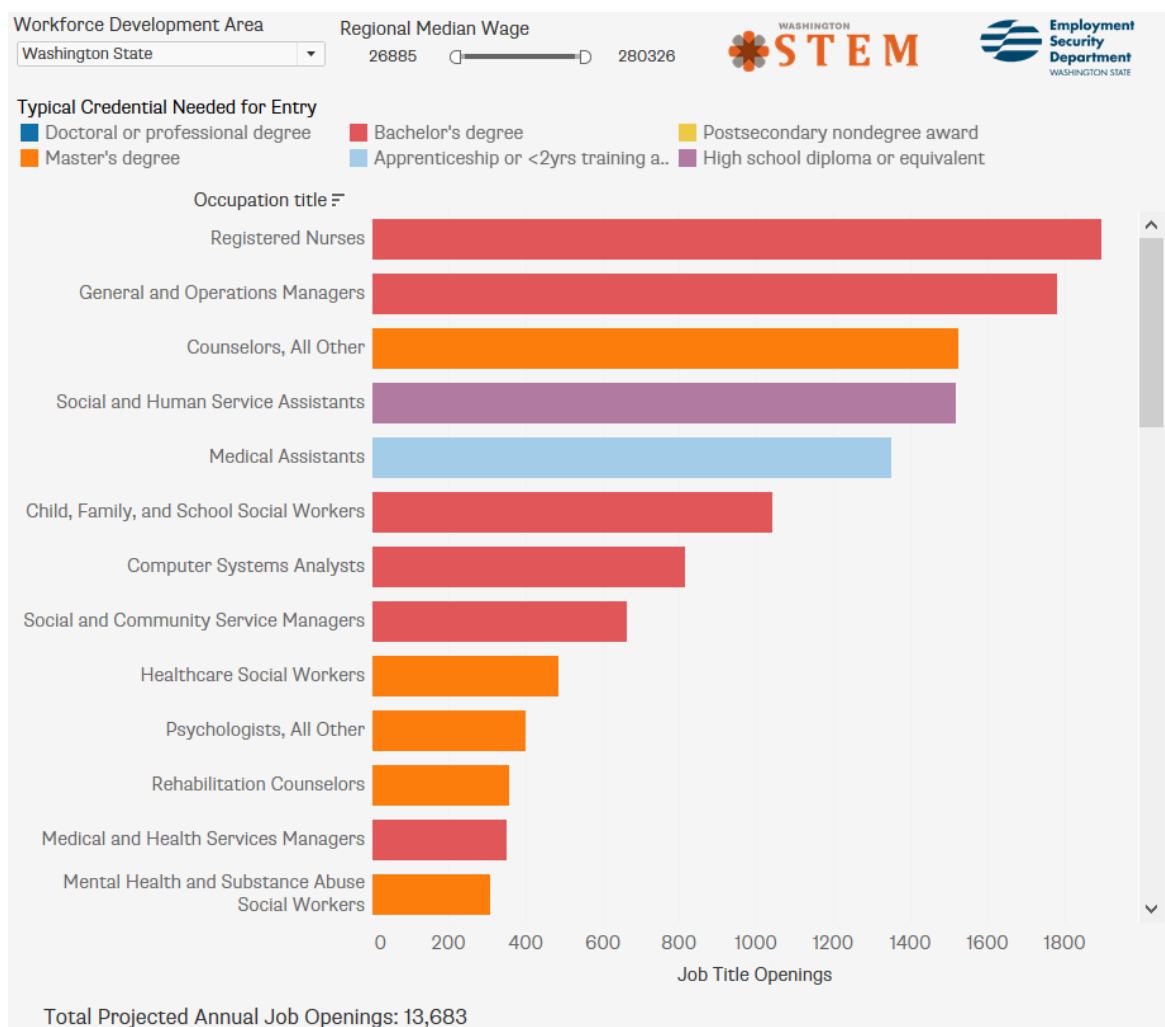
| Job Title  | Percentage |
|--|------------|
| Outreach Specialist  | 0 %        |
| Healthcare Social Workers, all other behavioral health job titles not listed above | 0 %        |
| Total  | 0 %        |

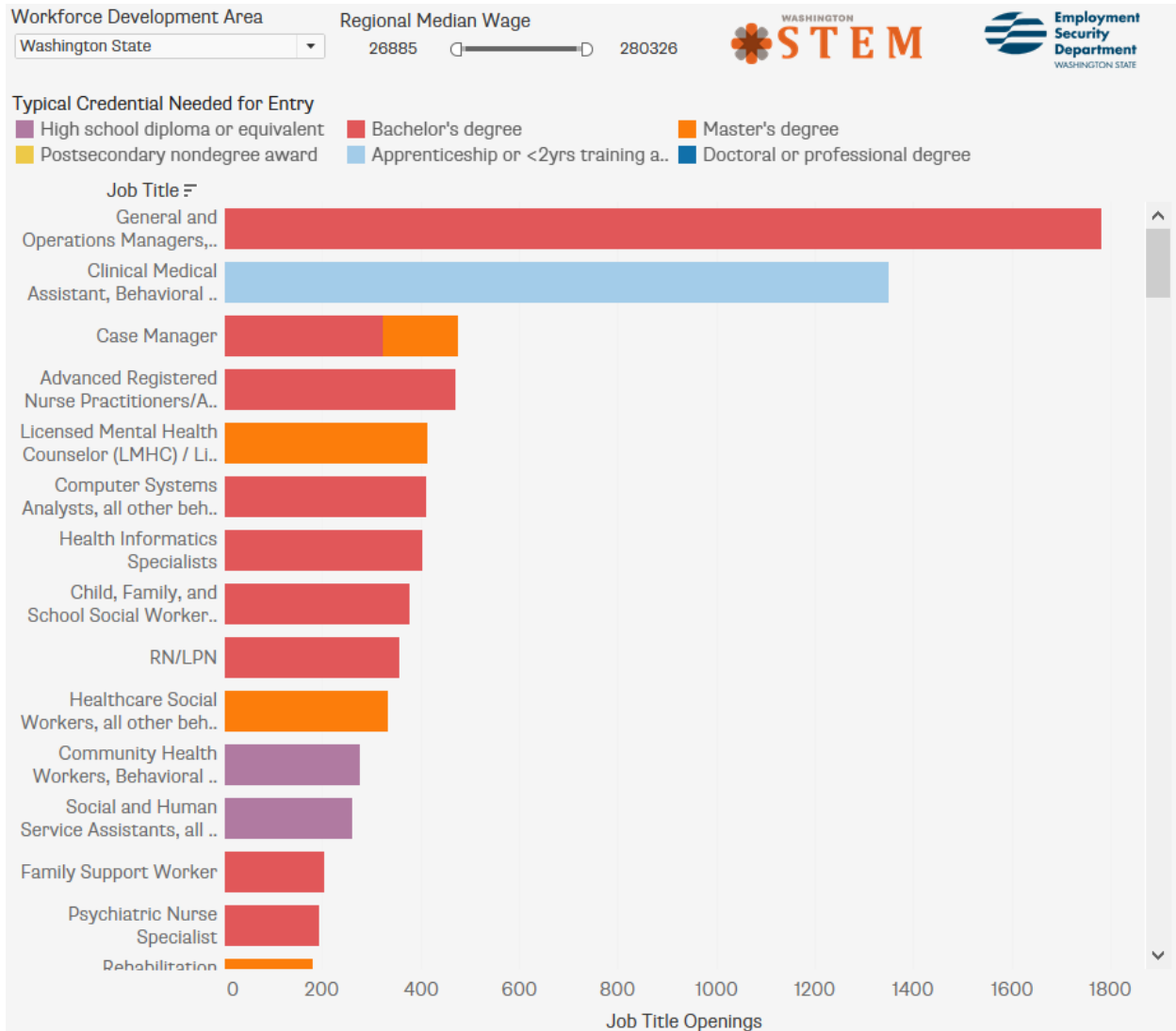
## Creation of Initial Behavioral Health Labor Market Data Dashboard (BH LMDD)

Using all data, stakeholder input, individual conversations with experts, and final survey results, Washington STEM produced the Behavioral Health Labor Market Data Dashboard: [Behavioral Health Labor Market Data Dashboard](#). The dashboard allows users to see projected job openings in behavioral health-specific occupations for the state of Washington and 12 workforce development regions. Projected job openings are defined as new openings due to occupation

growth or exits resulting from either retirement or a worker changing occupations. Projected job openings do not consider turnover within an occupation, as this has a net zero effect on job openings.

- The first chart in the dashboard offers total projected BH job openings for occupations as defined by the Standard Occupation Classification (SOC) Code system (see Image #1, below, “Job Projection - Occupations”).
- The second chart shows projected BH job openings using the BH specific job titles. These job titles are sub-occupations and their associated job openings represent a percentage share of occupation projections based on survey results (see Image #2, below, “Job Projections - Job Titles”).





**Identification of credentials, licensures, and pathway milestones for behavioral health occupations (July to September 2022 completion)**

In order to determine the “supply” side of the project and to identify the barriers to that supply, between May and October of 2022, Washington STEM began to identify and define all of the credentials, licensure, or other training/education requirements for each of the behavioral health jobs, beginning with analyzing behavioral health-specific job titles. For those job titles that align with licensing and training requirements defined by the Washington State Department of Health (DOH) Washington STEM was able to clearly state the minimum postsecondary credential required. For those job titles that do not have postsecondary requirements according to DOH licensing requirements, the Bureau of Labor Statistics (BLS) provides typical credentials required for an occupation. This information was used to limit the investigation of available postsecondary programs to those offering credentials that match or exceed those required by each job.

The next step was to align behavioral health jobs, and the more broad Standard Occupation Classification (SOC) codes, with postsecondary fields of study, defined by the Classification of

Instructional Programs (CIP) code. The CIP SOC crosswalk, a joint effort by the National Center for Education Statistics (NCES) and BLS, is the best tool for matching postsecondary programs to the behavioral health jobs they lead to.

The Integrated Postsecondary Education Data System (IPEDS) provides annual postsecondary credential completions for each institution in the state. Washington STEM grouped these institutions by location and direct enrollment patterns to estimate the number of students accessing each behavioral health-specific credential pathway from each of the 11 regions in the state. Direct enrollment in postsecondary by Washington State high school graduates is provided by the Education Research and Data Center (ERDC).

### **Creation of draft BH Credential Opportunity by Region Index (BH CORI) and Detailed Barriers to Credentialing Priority List (July to September 2022 completion)**

After identifying the necessary credentials, licenses, and training needed for each behavioral health-specific job, Washington STEM was then able to investigate any possible barriers for individuals to pursue and complete those credentials, licenses, and training that could be determined through quantitative data analysis. While there are many possible barriers to completing or pursuing postsecondary pathways, two quantifiable barriers are postsecondary and licensing capacity constraints and full-time salary relative to pathway/degree intensity (oftentimes this is referred to as postsecondary payoff<sup>1</sup> or investment payoff<sup>2</sup> in higher education literature). The credential opportunities and capacities are provided for all behavioral health-specific jobs and the detailed barriers are provided for the 15 highest demand entry-level jobs and can be found at the BH CORI dashboard here:

[https://tableau.strivetgether.org/#/site/GraduateTacoma/views/BH\\_LMD/WorkforceBarriers](https://tableau.strivetgether.org/#/site/GraduateTacoma/views/BH_LMD/WorkforceBarriers)

#### *Postsecondary and Licensing Capacity Constraints*

Bringing together the behavioral health job opening estimates generated by the BH LMDD with the postsecondary credential completions that lead to those jobs, Washington STEM identified where postsecondary capacity constraints exist in the workforce pipeline. Washington STEM was then able to quantify the capacity constraints by matching job openings for a specific behavioral health job title to the number of postsecondary awards produced each year that meet the postsecondary credential requirements of the job.

An example of a behavioral health-specific job that requires multiple credentials or licenses is Licensed Mental Health Counselor. This example is detailed below:

Licensed Mental Health Counselors (LMHC) must have a master's or doctoral degree in mental health counseling, or a behavioral science field relating to mental health. According to the CIP to SOC crosswalk there are 5 credentials that most often lead to entering the job of LMHC, those include Mental Health Counseling, Counseling Psychology, Social Work, Clinical/Medical Social

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<sup>1</sup> Wickersham, K. R. (2019). Where to Go From Here? Toward a Model of 2-Year College Students' Postsecondary Pathway Selection. *Community College Review* 48:2.

<https://doi.org/10.1177/0091552119880941>

<sup>2</sup> Coles, A. (2013). The Investment Payoff: Reassessing and Supporting Efforts to Maximize the Benefits of Higher Education for Underserved Populations. *Institute for Higher Education Policy. Pathways To College Network Report Series*. <https://files.eric.ed.gov/fulltext/ED585282.pdf>



Work, and Pastoral Studies/Counseling. In 2018-19, Washington State produced 755 master's degrees in the 5 fields of study identified. With 1,034 entry level job openings estimated each year, the capacity of these postsecondary programs does not meet the labor force demand. In addition to job openings for LMHCs, there are 2,767 annual job openings estimated for the occupation of "Counselors, All Other" of which LMHC is a subset. Those additional openings will further increase demand for the qualified workers entering the workforce. This data along with additional analysis can be found in the Workforce Barriers example in the next section.

### *Payoff: Full Time Salary Relative to Pathway/Degree Intensity*

Wages can also limit the availability of workers in behavioral health. Regional average wage for occupations is provided by the Washington State Employment Security Department (ESD) Occupational Employment and Wage Statistics (OEWS). To consider the impact wages may have on each job, Washington STEM looked at two factors. The self-sufficiency standard, which Washington STEM has adjusted to account for inflation, tells us the wages required to support a family of one working adult and one infant. For Washington, two working adults must each earn at least \$46,000 to support two adults, one infant and one school age child, for a total household income of \$92,001. The second factor to consider is wages paid to individuals with similar credentials across all occupations. Washington STEM looked at average wage for each behavioral health job, and compared that to the average wages paid to all workers with similar credentials. As an example, Licensed Mental Health Counselor (LMHC) requires at least a Master's degree, in Washington State an LMHC has an average wage of \$58,700, the average wage for all jobs typically requiring a master's degree is \$89,100.

In addition to Department of Health licensing requirements for postsecondary credentials, Washington STEM considered the requirement of supervised postgraduate experience. Supervision hours are identified as a constraint on the behavioral health workforce pipeline for three reasons:

- 1) Wages are lower for associate level, or unlicensed, workers
- 2) The availability of supervisors to fulfill the hours required
- 3) The potential burden on workers to pay for supervision hours

The below example from the Detailed Barriers, found in the draft dashboard, is a summary of behavioral health career pathways and barriers. In addition to the research done to compile this information, Washington STEM worked with regional STEM networks to identify regional partners with knowledge of behavioral health education pathways and workforce demand to review the findings. The Workforce Training Board reached out to members of the Health Workforce Council seeking feedback on the findings. Washington STEM sought feedback by sharing the findings for the highest demand behavioral health jobs in the form of a survey. Survey participants will be asked if they are aware of any additional barriers specific to each job title and to provide any feedback on the barriers Washington STEM identified.

Region: Washington State | Job Title: Licensed Mental Health Counselor (LMHC) / Licensed Mental Health Counselor Associate (LMHCA) / Licensed Professional C...

**Behavioral Health Job Title:**

Licensed Mental Health Counselor (LMHC) / Licensed Mental Health Counselor Associate (LMHCA) / Licensed Professional Counselor (LPC) / Co-occurring disorders clinician / Licensed independent clinical social worker (LICSW) / Marriage and Family Therapists (LMFT)

Typical Credential Required for Entry: Master's degree

Annual Job Openings: 1,034

Annual Postsecondary Credentials Awarded: 755

Postsecondary Credential Shortage: -278

Related Occupation: Counselors, All Other

Additional Job Openings in the Related Occupation: 2,767

**Barriers to Meeting Workforce Demand:**

Postsecondary credentials lead to a qualified associate role. Availability of supervision is a barrier to qualification as a Licensed Independent Social Worker.

Annual postsecondary credentials awarded do not meet the demands of the selected job.

Related jobs may target similar credential earners, increasing the deficit in credentials produced.

Average annual wages for this job are less than wages paid to workers with similar postsecondary education attainment.

**Washington State Postsecondary Credentials Produced 2018-19**

| Institution                       | Credential Type | Credential Title                                      | Credentials Awarded |
|-----------------------------------|-----------------|---|---------------------|
| Antioch University-Seattle        | Master's degree | Mental Health Counseling/Counselor                    | 38                  |
| Bastyr University                 | Master's degree | Counseling Psychology                                 | 21                  |
| Central Washington University     | Master's degree | Counseling Psychology                                 | 4                   |
| City University of Seattle        | Master's degree | Counseling Psychology                                 | 20                  |
| Eastern Washington University     | Master's degree | Counseling Psychology                                 | 11                  |
|                                   |                 | Social Work   | 185                 |
| Faith International University    | Master's degree | Mental Health Counseling/Counselor                    | 6                   |
|                                   |                 | Pastoral Counseling and Specialized Ministries, Other | 0                   |
| Northwest University              | Master's degree | Counseling Psychology                                 | 41                  |
|                                   |                 | Mental Health Counseling/Counselor                    | 26                  |
| Northwest University-College of.. | Master's degree | Mental Health Counseling/Counselor                    | 4                   |
| Seattle University                | Master's degree | Pastoral Studies/Counseling                           | 15                  |
|                                   |                 | Social Work   | 26                  |
| The Seattle School of Theology .. | Master's degree | Counseling Psychology                                 | 61                  |
| University of Washington-Seattle  | Master's degree | Clinical/Medical Social Work                          | 0                   |

**Identification of K-12/secondary readiness and barriers (July to September 2022 completion)**

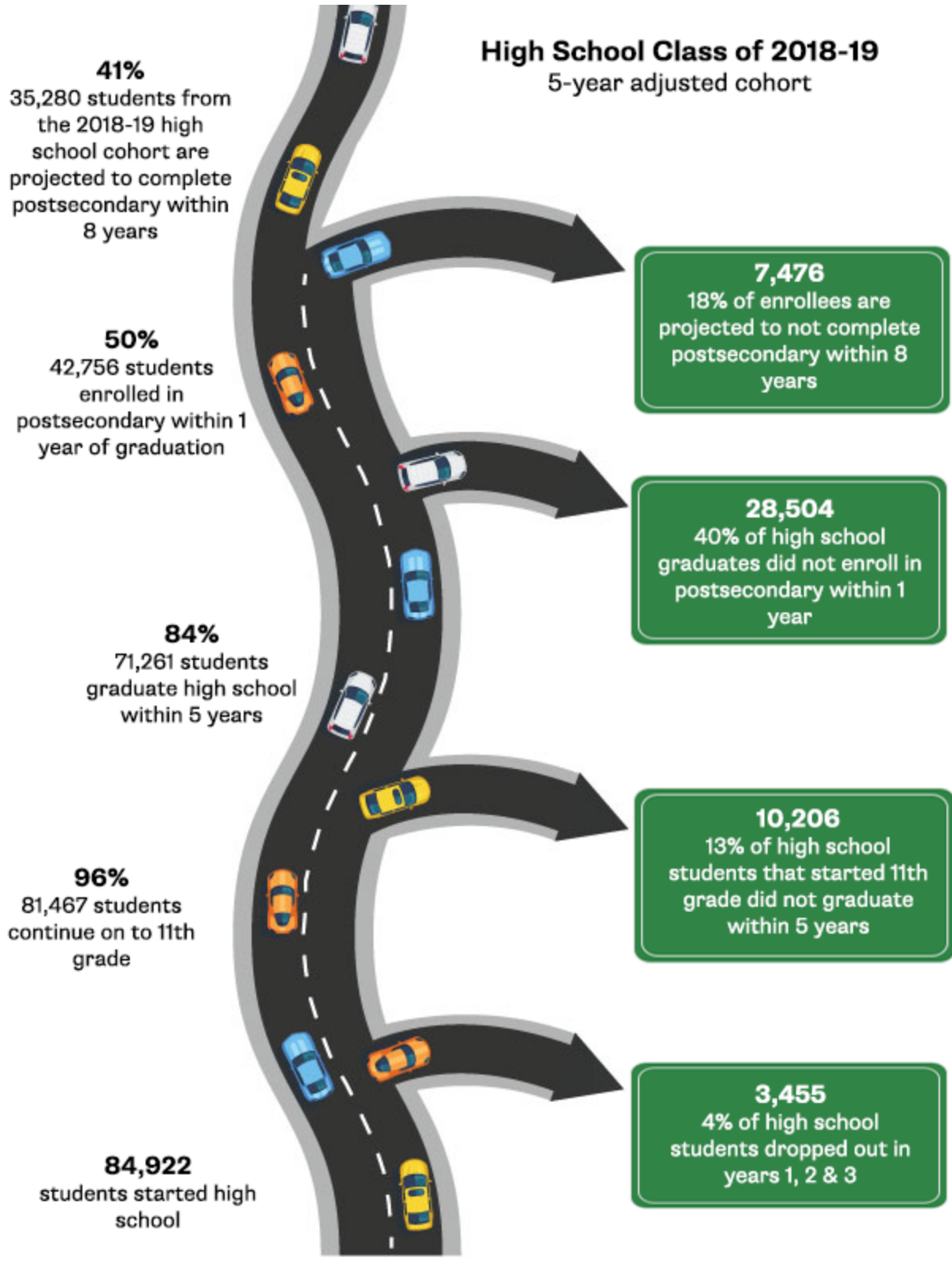
Using the BH LMDD, one can see that the average annual number of job openings among behavioral health-identified occupations is 21,978, including high numbers of openings in the following job titles:

- Licensed Mental Health Counselors
- Child and Adolescent Psychologists
- Behavioral Specialist
- Health Informatics Specialists

Of all of the annual job openings in behavioral health, 60% (13,238) each year are entry-level jobs, meaning that while they may require a postsecondary credential or licensure, they do not require prior job experience. These jobs are ideal for first-time job seekers, those fresh out of high school or fresh out of an initial degree, credential, or licensure.

At the same time, among Washington state K-12 originators (those students whose [at minimum] final portion of K-12 was spent in Washington State public K-12 schools), between 70 and 80% stay within a 50- to 100-mile radius of their home address to seek out postsecondary education/training and/or their first full-time job. Washington STEM, with adjusted data from the Education Research and Data Center, has determined that among those K-12 originators, only about 40-41% of recent high school cohorts are on track to earn any form of postsecondary degree or credential by the time they reach age 29. These data include the high school students who do not end up graduating from high school and therefore provides a complete picture of all high school attendees, not just those who earn a high school diploma (this is different from other sources of enrollment rates such as Washington Student Achievement Council reports which often rely on the Education Research and Data Center [ERDC] High School Graduates Outcomes dashboard, which reports only on the outcomes of high school graduates, not on entire high school cohorts regardless of graduation status).

Washington STEM has determined that of all entry level job openings in the state, 82% require a postsecondary degree or credential and that a total of only 38% of those jobs will be able to be filled each year by homegrown talent. Furthermore, the majority of those jobs require a STEM degree or STEM literacy—including all of the occupations and job titles identified in this body of work.



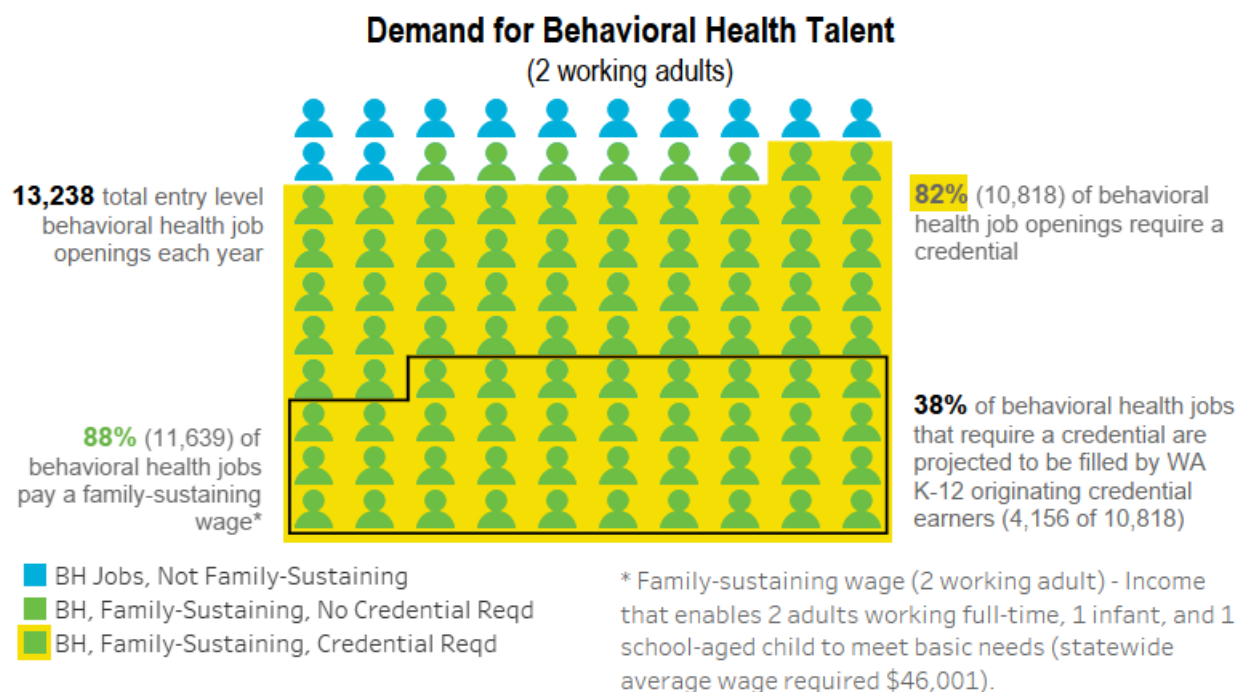
The high school class of 2018-19 5-year adjusted cohort are those students who entered 9th grade, in a Washington State public K-12 school at the beginning of the 2015-16 school year. By 2020 84% of students in the 2018-19 cohort had graduated high school within 5 years. Within 1 year of graduating high school 25% of students enrolled in a 4yr postsecondary institution, while 21% enrolled in a 2yr institution. To estimate 8-year postsecondary completion rates Washington STEM considered enrollment and completion rate trends for the classes of 2005 thru 2012, the most recent year completion rates are available.

Taking all of this data together and focusing on behavioral health jobs specifically, Washington STEM estimates that given the 13,238 annual entry-level job openings in behavioral health-specific occupations, and given that 78,732 annual students complete a postsecondary credential overall, with 4,156 completing a relevant and related behavioral health credential, on 38% of the behavioral health jobs in the state can currently be filled by the supply of K-12 originators (local talent) in our state.

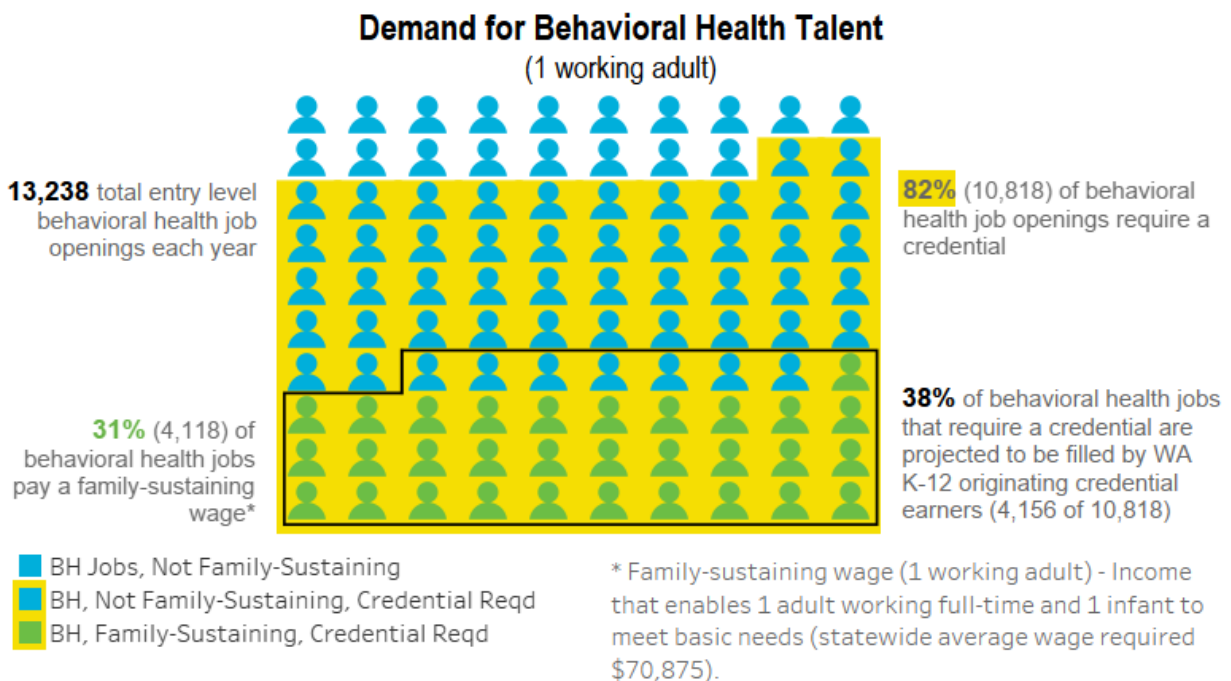
### Demand for Behavioral Health Talent: Compensation & Credentialing

One thing to consider for those seeking behavioral health jobs is the relative investment payoff in terms of salary and other factors compared to the credentialing necessary to obtain many of the projected open behavioral health jobs. When considering wages that will meet standards related to self-sustaining and family-sustaining wages, if an individual is in a household with two full-time working adults, both adults would need to be making \$46,001 for a total household income of \$92,001. At that wage level, 87% of the projected job openings would pay enough to sustain a household with two dependents. However, if either adult lost their job, had a decrease in pay, or had an economic-impacting event, the household would fall below the threshold and would likely need government support to stay afloat.

*Please review both Demand for BH Talent charts below for comparison of family-sustaining wage household needs:*



Meanwhile, for those households that rely on one full-time working adult with just one dependent, the working adult would need to be making \$70,875 on average in order to sustain the household. At that wage level, one can see that only 31% of behavioral health jobs could sustain a family with that makeup. Furthermore, 82% of those jobs require a postsecondary credential (or multiple credentials) while not paying enough to sustain a family/single dependent without government support. Finally, many of the individuals who pursue the credentials and degrees necessary to fulfill behavioral health jobs will incur debt in order to complete those credentials, yet they will be in jobs that pay at or less than family-sustaining wages, making it difficult to pay off student loans, or conversely, the student loan debt may force them to leave the field altogether in order to pay off a credential that they may ultimately not use for lack of adequate wages.



In order to calculate the demand for behavioral health talent relative to the average wages earned and in comparison to the percent that require postsecondary credentials, Washington STEM gathered data found in the Behavioral Health Labor Market Data Dashboard, which includes job title openings, self-sufficiency wages, and average annual wages paid by occupation. This data is then combined with the credentials produced typically leading to behavioral health jobs in order to estimate the number of jobs that could be filled by K12 originating credential earners. These charts can be found at: [https://tableau.strivetgether.org/t/GraduateTacoma/views/DemandforBHTalent/1workingadult?showAppBanner=false&:display\\_count=n&:showVizHome=n&:origin=viz\\_share\\_link](https://tableau.strivetgether.org/t/GraduateTacoma/views/DemandforBHTalent/1workingadult?showAppBanner=false&:display_count=n&:showVizHome=n&:origin=viz_share_link)

### Secondary Readiness and Supply Investigation

Outside of the barriers directly related to behavioral health credential and licensure access, capacity, constraints, and related issues (see section above on BH CORI), there is an overall undersupply of students in Washington State K-12 schools who are being supported to pursue



postsecondary credentials in general—an undersupply of those who could choose to take postsecondary pathways that lead to behavioral health occupations.

In order to better understand this undersupply, Washington STEM and regional STEM Network partners conducted analyses related to high school/secondary-based preparation, knowledge, and environments that do/don't support students in enrolling in and pursuing postsecondary credentials or degrees. Washington STEM identified key beliefs, barriers, and needs expressed by secondary students and by secondary staff (teachers, administrators, counselors, and other certificated staff) related to better preparation for postsecondary enrollment overall. Washington STEM also identified promising new programming that has been developed that opens up pathways for careers in behavioral health, related to the Career Connect Washington initiative, and have identified the need for expanding these program efforts.

### *Methodology*

Washington STEM worked with five STEM Networks across the state to identify public, comprehensive high schools who were ready to investigate their postsecondary readiness supports and ecosystem. One Network also identified a high school that was able to participate in a 9-month multimethod investigation. The multimethodology included examining dual enrollment course-taking patterns and postsecondary outcomes, administering staff and student surveys, and conducting student empathy interviews. The other four high schools participated in student and staff interviews and were supported in doing other methodologies on their own. In total, Washington STEM examined the course-taking and postsecondary outcomes records of nearly 2,000 high school students, surveyed 6,136 high school students, surveyed 397 certificated educators/high school staff, and conducted nine in-depth, one- to two-hour student empathy interviews with students from grades nine through 12.

Using a research and data justice framework, Washington STEM ensured that the participating high schools had the right to the research process including co-developing and providing feedback on staff and student surveys. School staff—counselors, teachers, coaches, and others working directly with students—completed a survey administered via SurveyMonkey to help school partners understand how educator knowledge and perceptions influence students' beliefs about the affordability of postsecondary education, knowledge of scholarships and financial aid, and course-taking patterns. Similarly, student surveys helped schools understand student awareness of the steps needed to enact postsecondary goals. The project team was able to elicit responses from 70% of educators and 70% of students, with an equal distribution of educators and students across grade levels. Washington STEM conducted statistical analysis on all survey data using cross-tabulation as well as text analysis. For interviews, Washington STEM conducted thematic analysis and multi-point applied analysis with staff to check for understanding and meaning-making.

### *Findings*

#### Postsecondary Beliefs:

The aggregated survey results showed a significant discrepancy between student aspirations for postsecondary plans compared with staff perceptions of student aspirations. That is, K-12 professionals believed, on average, that 48% of students aspired to attend postsecondary education or training compared to 88% of students who indicated they intended to go into higher education (see figure below). While there was not a significant difference in aspirations rates across racial and grade level demographics, there was a difference based on gender. Female

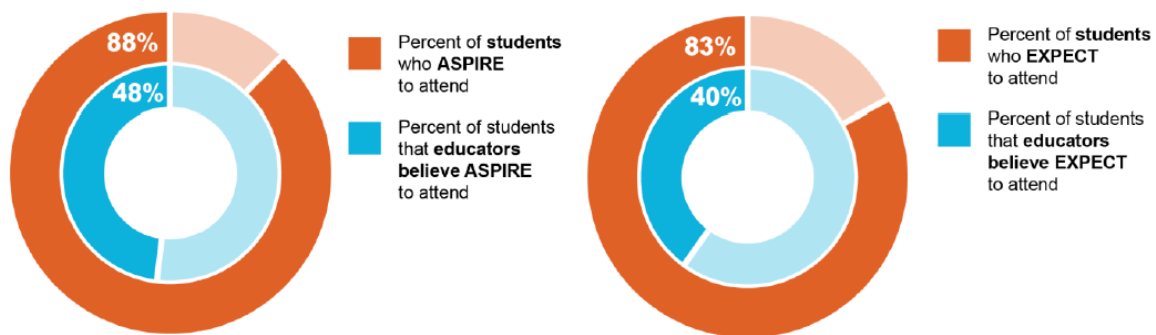


students had higher aspirations, 91%, than male students' aspirations, 84%, for obtaining a postsecondary education.

It is significant to note that so many students intend to pursue postsecondary education and training of some form, given that so many of the behavioral health high-demand jobs require a form of post-high school education. Washington has an interested and aspiring group of youth across the state who could fulfill many of the jobs that are open in behavioral health, but the adults in their lives do not hear about or understand many students' aspirations and so 40% of those who want to pursue postsecondary credentialing may be getting the wrong signals, wrong support, or wrong information about how to act on their interests.

## POSTSECONDARY ASPIRATIONS

### Aspiration vs Expectation



### Educators' Knowledge about Requirements for Postsecondary Pathways:

Relying mostly on personal experience to provide information about postsecondary requirements to students, educators on average specified being more knowledgeable about the requirements to be admitted into a 2-year and 4-year college program than a 1-year certificate or apprenticeship program. Given that most certified K-12 educational roles require advanced education, it is not unusual that staff had a greater understanding of 2- or 4-year degree programs. However, male educators were more knowledgeable about the requirements for 1-year certificate programs and apprenticeship programs than female educators.

This finding is also salient to the behavioral health supply-demand landscape, given that 29% of behavioral health high-demand jobs do not require a 4-year college degree. These non-baccalaureate pathways lead to jobs in behavioral health such as Clinical Medical Assistant, Substance Use Disorder Professional (SUDP), Licensed Practical Nurse (LPN) that pay annual salaries of \$47,300-\$63,250. Given the mismatch between educators' understanding of student aspirations and students' actual interest in pursuing postsecondary credentials, it is important to consider educators' knowledge of non-baccalaureate pathways that lead to behavioral health jobs. Improving their knowledge of such pathways could dramatically increase the numbers of students who pursue Clinical Medical Assistant, Substance Use Disorder

Professional (SUDP), Licensed Practical Nurse (LPN) and similar jobs in our state as they exit high school and step into postsecondary credentialing.

#### Students' Knowledge about Requirements for Postsecondary Pathways:

Mirroring educators' understandings, students were more knowledgeable about the admissions requirements to a 2-year and 4-year college program than a 1-year certificate or apprenticeship program. Male students were more knowledgeable about the requirements for 1-year certificate programs and apprenticeship programs than female students, however, female students were more knowledgeable about 2-year and 4-year college programs than male students. Overall, students in higher grade levels had more knowledge about the requirements for different postsecondary programs than students in earlier grades.

As mentioned above, given that 29% of behavioral health high-demand jobs do not require a 4-year college degree, it is important that our systems support students' knowledge of certificate, apprenticeship and other non-baccalaureate pathways. Early awareness of these pathways as well as providing the supports necessary for pursuing them could increase the supply of students who pursue jobs such as Clinical Medical Assistant, Substance Use Disorder Professional (SUDP), Licensed Practical Nurse (LPN) as they exit high school and step into postsecondary credentialing.

It is also important to note disparities in knowledge about various pathways by racial group. Across racial student demographics, Asian American students were more knowledgeable about the requirements to be admitted into a 4-year college program than all other racial groups. Whereas Latinx students were more knowledgeable about 1-year certificate requirements than other racial groups, and Black students had the least knowledge about 2-year and 4-year admissions requirements than any other racial group.

These data mirror the outcomes related to who fills jobs across the healthcare sector broadly in our state and illuminates how early the knowledge and support gap begins in the process of pursuing postsecondary education. As mentioned above, there was no difference in students' *aspirations* for pursuing postsecondary credentials across racial demographic groups, however students' knowledge of the various pathways varied significantly already as early as ninth grade. This means that students' access to or exposure to pathways is already skewed along racial lines and will perpetuate inequitable postsecondary and career outcomes if left unattended.

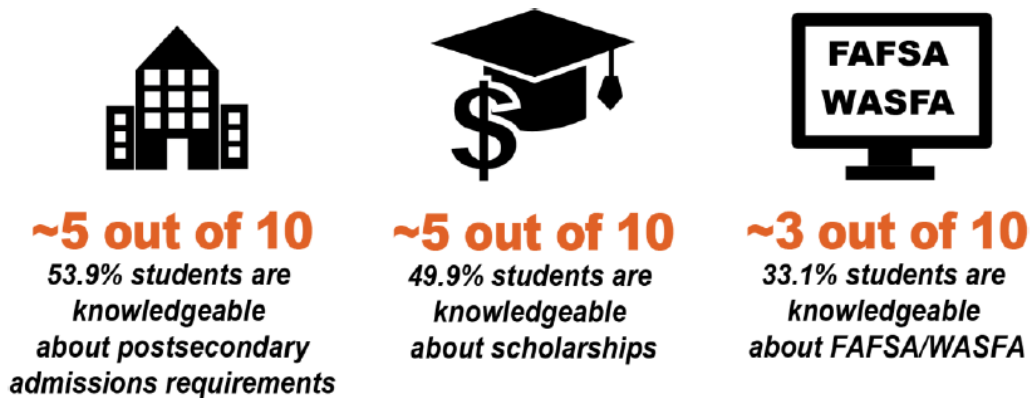
#### Knowledge of Financial Aid and Beliefs on Affordability:

With the complexity of paying for postsecondary education, students rely on teaching staff to help navigate the financial aid process. In the sample size, Washington STEM learned that 6 out of 10 educators were knowledgeable about the Free Application for Federal Student Aid (FAFSA)—financial aid from the federal government to help for post-secondary education through grants, scholarships, federal or private loans, or work-study and other programs. Washington STEM also learned that 5 out of 10 educators were knowledgeable about scholarships and that only 3 out of 10 educators had knowledge about the Washington

Application for State Financial Aid (WASFA)—state financial aid for DREAMers (students who are undocumented or who do not have recognized US citizenship).



While most students in the sample intended to go into higher education, Washington STEM learned that 5 out of 10 students were knowledgeable about postsecondary admissions requirements including knowledge about college entrance exams (SAT/ACT), writing college application essays, or grades in academic courses. Similar to educators, 5 out of 10 students were knowledgeable about scholarships, and 3 out of 10 were knowledgeable about FAFSA or WASFA.



With escalating tuition costs in recent years and the impacts of COVID-19, only a little over 50% of educators believed that students could afford to attend an apprenticeship program, 1-year vocational program, and 2-year college program, but less than 45% of educators believed that students could afford to attend a 4-year college program. Mirroring educator beliefs, over 50% of students believed they could afford to attend an apprenticeship program, 1-year vocational program, and 2-year college program, while 45% of students believed that they could afford to attend a 4-year college program.

In contrast, across student demographics, over 50% of Asian American students believed they could afford to attend a 4-year college program; all other racial groups have less than a 45% belief that they can afford to attend a 4-year college program. Female students believed they could afford to attend a 2-year and 4-year college program at significantly higher rates than

male students. Lastly, students in 9th and 10th grades have lesser belief rates than students in higher grades that they could afford to attend any type of postsecondary program.

#### Students Receiving Information about Dual Credit:

Student survey results show students across all grade levels rely on teaching staff the most for learning about dual credit course opportunities, this is particularly true for Students of Color. However, in comparison to the overall 71% of student responses that indicated someone from school had provided information about dual credit information. For instance, only 55% of Black students reported that they were given information about any type of dual credit program. In contrast, 73.5% of White and 75.5% of Asian students reported having been provided information about dual credit programs.

Student survey findings also point to inequities in receiving dual credit information along lines of gender and grade level. Over 75% of female students indicated having received information about the various types of dual credit compared to less than 65% of male students. Except for Career and Technical Education (CTE) dual credit courses, female students were more aware than male students of the three different types of dual credit programs offered in school. Students in higher grades such as 11th and 12th grade indicated having been spoken to about the different types of dual credit more so than students in earlier grades such as 9th and 10th grade. For instance, 82% of seniors (12th grade) reported having been provided information about dual credit by school staff compared to 58% of freshmen (9th grade).

### Student-Generated Calls to Action

#### *Provide In-Depth Postsecondary Readiness Supports Early and Often in High School*

For many students without access to postsecondary readiness knowledge and career preparation at home, and in particular for students who have been historically excluded from higher education, school staff serve as conduits for postsecondary information and guidance. This was reflected in the overall student responses about wanting teachers to provide comprehensive support on college-going knowledge and readiness, including access to rigorous coursework, support with college planning, financial aid, and navigating college life. Students indicated that one designated school space, such as an advisory period (sometimes called homeroom period), to learn about postsecondary options was not sufficient in both the delivery of information and length to provide college knowledge.

*“As someone who only has few [sic] knowledge about these things, maybe conduct a seminar for students to learn about advanced coursework”*

*“Teach us about the steps to take to go to college or other things like that instead of just expecting us to know. And, if we are meant to be learning about that stuff in advisory, then have advisory more often instead of for 15 minutes once a month.”*

## Provide Accessible Postsecondary Information

While school partners informed the research team that postsecondary information to attend vocational and career schools, two- and four-year colleges, and universities was provided to students through various means—school website, advisory sessions, college, and career fairs—students still felt that the information available was not accessible. Namely, students drew attention to the dominance of English in communicating information about college resources with limited regard to other home languages. Students also felt overwhelmed by the disarray of information provided through multiple platforms rather than a centralized location. Additionally, students shared that a stand-and-deliver approach to learning about postsecondary requirements was not effective, instead, they preferred interactive learning in which teachers modeled how to complete college applications and fill out other postsecondary-related forms.

*“I think that the [postsecondary] information should be a lot **more organized and simple to access**. The directions, information, and requirements are spread out across what seems like a hundred different websites, documents, and videos. It would be really nice if there was **one document with instructions and information** and an index or something to all of the other resources and explanations...Currently, it **feels like a big mess**.”*

“If I could give any advice to adults in my school about how they could better support my learning about **rigorous courses** and achieving my postsecondary goals, I would say to start teaching us about them **as early as possible** so that we have more time to learn and be more knowledgeable about them.”

## Provide Information about Postsecondary Requirements in Earlier Grades

Contrary to what several staff believed about students in earlier grades not having an interest in learning about college and career requirements, especially as they still have four to three years before graduation, freshman and sophomores indicated that they wanted postsecondary information provided to them from the onset. Even though most of them were unclear on the exact profession they wanted to pursue, they shared that a good foundation early on would place them in a valuable position to

make informed college and career choices as a senior. They emphasized the importance of financial literacy and developing skills to make informed financial decisions about postsecondary education and training.

*“Share more about **scholarships even to students who are not juniors or seniors**. It is a big stress on students even before senior year to plan out college and future plans when you have no idea on how financially stable you are or if you can even plan out your future if you live in a low-income house.”*

*“I wish there was a **financial health or real-world class that was a graduation requirement**. This class would go through all these things: **post-secondary**”*

*options, budgeting, financial aid, HS dual credit options, etc. This class would be taken in 9th grade and would help explain all this stuff to us kids.”*

## Provide Information about Rigorous Course-Taking in Earlier Grades

Students understood the value of enrolling in high-level, rigorous courses such as Advanced Placement (AP), College in the High School, Running Start and other dual enrollment courses. They recognized that these rigorous courses could help them develop college-level academic skills and career skills such as critical thinking and problem-solving. Yet, they also understood the value of learning about these courses *early on* as they lead to better college and career preparation. As with postsecondary information, students in earlier grades felt that their high schools targeted juniors and seniors by providing information about high-level coursework while little attention was paid to students in freshman and sophomore grades.

## Promising Career Connected Learning Projects

Over the past several years, the Career Connect Washington initiative has supported and funded the creation and expansion of over 133 programs that aim to connect youth in Washington State to high-demand careers via meaningful experiences, including paid work time, and credentialing. The initiative has codified three levels of experiences that youth should have in order to be prepared for and connected to high-demand jobs across various sectors in Washington State: Career Explore, Career Prep, and Career Launch. These levels of experiences are described below, from the CCW 2021 Legislative Report.

**Career Explore:** Programs designed to expose students to many career options and pathways, beginning as early as elementary or middle school. These programs allow students to learn about future jobs and industries through activities such as career fairs, worksite tours, job shadowing, guest speaker presentations, and other similar activities.

**Career Prep:** Programs designed to deepen understanding of a specific industry or career. These programs begin in high school and provide students with hands-on training and knowledge to help prepare for future work and decide whether a given career path is a good fit. Career Prep programs are longer and more intensive than Career Explore programs and can include a series of CTE and/or skills center courses (e.g., CTE concentration), summer internships, and pre-apprenticeship programs.

**Career Launch:** Programs which combine meaningful, supervised, paid, on-the job experience with aligned academic instruction. Career Launch completers earn an industry-recognized and/or postsecondary credential (or at least 45 credits towards a postsecondary credential) and are competitive candidates for a real job. Career Launch can begin as early as high school. Career Launch programs can be state registered apprenticeships, as well as CTE sequences or postsecondary credential programs that include robust, paid work-based training. Upon successful completion of a Career Launch program, students can choose to continue academically, seek additional career training, or start their career. Please see diagram on next page for more details on Career Launch.



Among those programs that were recently initiated or expanded with funding and support from the Career Connect Washington initiative, there were at least seven programs that focused on supporting K-12 students or students directly out of K-12 to explore, prepare for, and/or enter into healthcare and related fields or into behavioral health jobs specifically. These programs are meaningful examples of how to smooth the transition between secondary and postsecondary and into the credentials needed to fill the most high-demand behavioral health jobs in our state. The following is a sample of programs:

- Foundation for Youth Resiliency and Engagement (FYRE)'s Youth in Community Health program, Okanogan, SkillSource.
- Washington Alliance for Better Schools (WABS)'s Healthcare Career Launch program, with College Success Foundation, Seattle/King County.
- Washington Alliance for Better Schools (WABS)'s Healthcare Industry Leadership Table Career Explore program, with College Success Foundation, Seattle/King County.
- Washington Alliance for Better Schools (WABS)'s Healthcare Nursing Career Launch program, with College Success Foundation, Seattle/King County.
- Washington State University - Elson S. Floyd College of Medicine (WSU Spokane)'s Healthcare Career Prep program, with Eastern Washington Partnership Workforce Development Council, Stevens County & greater Spokane.
- Washington State University - Elson S. Floyd College of Medicine (WSU Spokane)'s Stevens County Healthcare Mentorship program, with Eastern Washington Partnership Workforce Development Council, Stevens County & greater Spokane.
- Whatcom Community College (WCC)'s Behavioral Health Career Launch Program, with Future Workforce Alliance, Island County.

One particular example from above that will increase the supply of skilled and credentialed individuals going into behavioral health jobs is the Whatcom Community College (WCC)'s Behavioral Health Career Launch Program. Details on the program, directly from WCC,<sup>3</sup> include:

### ***Bachelor of Applied Science Social Work (BASSW)\* - New Project***

WCC is building upon its current substance use disorder professional (SUDP) associate of applied science degree by developing a Bachelor of Applied Science degree in social work\*, launching fall 2023, pending approval. Students that continue on from the SUDP program into the bachelor's degree at WCC will be eligible to be certified and work as SUDP in the field during the entirety of the degree. WCC's bachelor of applied science in social work\* will serve place-bound and other students in northwest Washington state – who have limited options to further their education in this field – with an accessible, affordable, and accelerated pathway.

### **Project Timeline**

Fall 2021-Spring 2022: WCC and State curriculum approval.

Spring 2022: Applying for career launch endorsement for BASSW program.

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<https://www.whatcom.edu/about-the-college/business-community-partnerships/career-launch-industry-partnership/career-launch-projects>



Spring 2022: Spring 2023 - Curriculum and course development.

Spring 2023: Accepting student applications for BASSW.

Fall 2023: BASSW program launch\*.

Fall 2024: First cohort of BASSW students in paid internships.

\*Pending approval from the State Board of Community and Technical College and Northwest Commission on Colleges and Universities

## **Draft Conclusions and Recommendations for Consideration for Policy and Advocacy**

Washington STEM's work to support the investigation of Behavioral Health workforce pathways, barriers to credentialing, and overall supply of qualified and diverse individuals has led to a number of conclusions. Summarized below are Washington STEM's conclusions and recommendations for consideration of the Workforce Training and Education Board and the larger bodies of leadership around the Behavioral Health Workforce in Washington State.

### **Address Capacity Constraints for Behavioral Health Credentialing**

Washington STEM identified significant barriers to accessing and completing the degrees, credentials, and licenses required to obtain many BH occupations, including capacity constraints in many postsecondary programs as well as the issue of investment payoff—that there is little payoff in salary and quality of career relative to the costs of the credentialing needed for the jobs.

Credentialing Capacity Constraints: Using the BH CORI, Washington STEM found that 41 behavioral health-specific jobs have postsecondary capacity constraints. Examples include:

- Licensed Mental Health Counselor (LMHC)/LMHCA/LPC/LICSW/LMFT/Co-occurring Disorders Clinician
  - Job openings 914; additional related job openings 2,887; capacity 786
- Rehabilitation Counselor
  - Job openings 279; additional related job openings 270; capacity 8
- Health Informatics Specialists
  - Job openings 456; additional related job openings 2,336; capacity 487
- Behavioral Specialist / Licensed Behavior Analyst
  - Job openings 497; additional related job openings 1,248; capacity 234

Washington STEM recommends investing in and supporting the expansion of several of the postsecondary programs above, including:

- Licensed Mental Health Counselor (LMHC)/LMHCA/LPC/LICSW/LMFT/Co-occurring Disorders Clinician requires an additional 3,015 master's degree completions each year in the following fields of study:

- Mental Health Counseling
- Counseling Psychology
- Social Work
- Clinical/Medical Social Work
- Pastoral Counseling
- Rehabilitation Counselor requires an additional 541 bachelor's degree completions each year in the following fields of study:
  - Vocational Rehabilitation Counseling
- Behavioral Specialist / Licensed Behavior Analyst requires an additional 1,511 master's degree completions each year in the following fields of study:
  - Psychology
  - Applied Behavior Analysis
  - Behavioral Sciences
  - Experimental Psychology
  - Child development
  - Research Psychology
  - Comparative Psychology
- Health Informatics Specialists requires an additional 2,305 bachelor's degree completions each year in the following fields of study:
  - Information Technology
  - Computer and Information Sciences
  - Computer Systems Analysis

### Address Cost and Debt for Behavioral Health Credentialing

As mentioned above, for those individuals who choose to pursue a behavioral health job as a sole provider and full-time working adult with just one dependent, they would need to be making \$70,875 on average in order to sustain the household. At that wage level, one can see that only 31% of behavioral health jobs could sustain a household in that situation. Meanwhile, 82% of those behavioral health jobs require a postsecondary credential and many of the individuals who complete the necessary credentials for those jobs will incur debt in order to complete those credentials. Then yet they will most likely be in jobs that pay at or less than family-sustaining wages, making it difficult to pay off student loans, or conversely, the student loan debt may force them to leave the field altogether in order to pay off a credential that they may ultimately not use for lack of adequate wages.

In order to support individuals in completing the necessary credentials to obtain open jobs in behavioral health, Washington STEM recommends taking steps to subsidize, provide scholarships or conditional scholarships, and loan forgiveness to a wider number of individuals in the field and to make access to those funds and forgiveness steps easier to navigate. Given the findings from the BH LMDD and the BH CORI above, Washington STEM recommends deepening and expanding subsidies, scholarships, and loan forgiveness especially for individuals who have pursued and completed the following postsecondary credentials:

- Doctoral Degree in Psychology
- Doctoral Degree in Behavioral Sciences
- Master's degree in Mental Health Counseling
- Master's degree in Counseling Psychology
- Master's degree in Social Work
- Master's degree in Clinical/Medical Social Work
- Master's degree in Pastoral Counseling
- Master's degree in Psychology
- Master's degree in Applied Behavior Analysis
- Master's degree in Behavioral Sciences
- Master's degree in Experimental Psychology
- Master's degree in Child development
- Master's degree in Research Psychology
- Master's degree in Comparative Psychology
- Bachelor's degree in Information Technology
- Bachelor's degree in Computer and Information Sciences
- Bachelor's degree in Computer Systems Analysis
- Bachelor's degree in Vocational Rehabilitation Counseling

### Work to Increase the Salary and Other Benefits of High Demand Behavioral Health Jobs

As mentioned above, one can see from the Demand for Behavioral Health Talent dashboard that only 31% of behavioral health jobs could sustain a household with a single working adult, and yet 82% of those behavioral health jobs require a postsecondary credential. These individuals, who are often coming into behavioral health jobs with multiple credentials and/or licenses, are also often coming into their jobs with debt from those programs, and are already not able to sustain a household or a dependent (like a child) without government subsidies/aid. While increasing scholarships and loan forgiveness are important steps, Washington STEM recommends also investing in policies that can ensure better salaries for those jobs outlined in the section above.

### Support Investments in K-12 Frameworks & Programs for Postsecondary & Career Readiness

Washington STEM recommends support for system investments to improve access, usability, and data collection of the High School and Beyond Plan and Graduation Pathways. These are frameworks and graduation requirements to connect career interests with courses connect career interests with courses and courses with career pathways or college majors; and identify the steps needed to reach postsecondary goals. There is an overall undersupply of students in Washington State K-12 schools who are being supported to pursue postsecondary credentials in general—an undersupply of those who could choose to take postsecondary pathways that lead to behavioral health occupations.

Washington STEM also recommends investment in behavioral health-specific and healthcare career exploration-type career connected learning programs like those funded by and created by the Career Connect Washington initiative and named in the section above. These programs that start in K-12 or directly after K-12 ensure that students know about pathways, careers, and credentials in the behavioral health workforce.

### Support Dual Credit and Postsecondary Readiness

Washington STEM recommends support for a comprehensive approach to ensuring equitable access to dual credit and making credential attainment more affordable for high school students and their families and will pursue additional policy recommendations to ensure equitable articulation of those credits. Dual credit plays a critical role in increasing the enrollment of students by preparing students for the transition from high school to multiple pathways after graduation including in the behavioral health field. Research points to extensive evidence of the advantages of students earning dual credit as a significant accelerator of momentum towards postsecondary degree attainment.