

Washington State Behavioral Health Workforce Assessment

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ACCESS THE REPORT AND OCCUPATION PROFILES

The full report "Washington State Behavioral Health Workforce Assessment" can be accessed at:
<http://www.wtb.wa.gov/behavioralhealthgroup.asp>

Individual occupation profiles can be accessed at: <https://depts.washington.edu/fammed/chws/studies/wabh/>

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Washington State Behavioral Health Workforce Assessment

EXECUTIVE SUMMARY

Washington has set the goal of integrating behavioral and physical healthcare by 2020, consistent with national trends. State legislation mandates this integration statewide by 2020. The demand for behavioral healthcare - mental health and substance use disorder treatment - exceeds the availability of services throughout the state. This situation is exacerbated by the growing opioid epidemic, mandates for greater access to behavioral health services, and limited funding to address these needs. While the state has many highly competent and committed professionals working hard to deliver behavioral health services, difficulties recruiting, educating, training, and retaining a skilled behavioral healthcare workforce may harm the state's ability to deliver on its goal.

This report represents the completion of an 18-month project. Phase I culminated in November 2016 with a report of initial findings regarding barriers and short-term solutions to ensure a comprehensive and effective behavioral health workforce. Phase II focused on assembling more detailed information to describe the Washington behavioral health workforce, and refining and updating Phase I recommendations as healthcare providers gained knowledge and experience regarding behavioral and physical healthcare integration. Five stakeholder focus groups that included CEOs, leaders of behavioral health agencies, organized labor, associations, and educators shaped the actionable recommendations in this Phase II report. Nearly 250 individuals participated in the development of the Phase I and Phase II reports via a combination of interviews, large group meetings, focus groups, or written input.

The behavioral health workforce can be found in facilities providing mental health and substance use disorder treatment, physical/medical care delivery locations; and integrated behavioral/physical health services teams. Many occupations involved in delivering behavioral health services are recognizable by name, and detailed profiles of nine of the occupations commonly identified with the behavioral health workforce are attached to this report: psychiatrists, clinical/counseling psychologists, social workers, psychiatric advanced registered nurse practitioners, mental health counselors, marriage and family counselors/therapists, chemical dependency professionals, certified peer counselors, and community health workers. Medical professionals in physical healthcare settings may provide behavioral health services as well, in conjunction with their primarily medical care roles. These professionals are not as easily recognizable as behavioral health providers, complicating the process of quantifying and describing the overall workforce.

To help frame understanding of the behavioral health workforce, this report provides details about:

- the occupations and roles that comprise the overall behavioral health workforce,
- the size and distribution of the workforce,
- measures of workforce demand,
- the education and training pathways connecting to these careers, and
- some new approaches to addressing behavioral health workforce needs in the state.

Policy and practice issues that can affect development and deployment of the behavioral health workforce are also described in this report, including:

- the impact of shifts in payment and policy on behavioral health workforce demands,
- technical skills needed by the workforce,

- the importance of retention and turnover, and
- workforce-related lessons from one of the state’s early adopters of integrated behavioral and physical health care systems.

KEY FINDINGS

As stated in the Phase I report, the challenges to ensuring adequate access to behavioral healthcare are complex. Ensuring Washington’s behavioral health workforce is able to meet the state’s needs will require more than just “turning on the spigot” at education programs across the state. Because the healthcare system is rapidly changing, workforce planning requires that attention be paid to the underlying systemic, structural, and perception challenges that affect the ability to recruit, educate, train, credential, and retain a sufficiently large and adequately skilled workforce to provide needed behavioral health services.

The Phase II report identifies various specific issues that affect the availability and effective functioning of behavioral health occupations. These included issues related to education, regulation, and practice.

Stakeholders throughout the project confirmed a continuing need to address four categories of challenges:

- Recruitment and retention, including the need to increase workforce diversity, in an environment at times characterized by heavy caseloads, patients with high acuity of behavioral health and other healthcare needs, time-consuming documentation requirements, low pay, and cultural stigma.
- Skills and training to meet the changing behavioral healthcare environment and to increase integration of behavioral health and physical healthcare. This includes the need to work effectively in inter-professional teams using new models of practice and evidence-based skills, to make effective use of current health information technology systems, and to efficiently meet documentation requirements. These skills are required by new entrants to behavioral health careers, reinforced through “real world” training opportunities, as well as by incumbent workers who need access to ongoing continuing education and training.
- Credentialing, licensing and related policy issues that influence the number, distribution, and scope of practice of the occupations that comprise the behavioral health workforce.
- Paperwork and documentation burdens that take considerable workforce commitment and reduce time spent with patients, contributing to lower morale, and driving behavioral health clinicians out of the field.

RECOMMENDATIONS

1. Adjust reimbursement rates to better support competitive recruitment and retention of a skilled behavioral health workforce.

2. Promote team-based and integrated (behavioral and physical health) care.

- 2-a. Strongly encourage payers (Managed Care Organizations (MCOs)/health plans and Behavioral Health Organizations (BHOs) to contract with and credential licensed community behavioral health agencies, as well as individual licensed clinicians. Work with payers to standardize the credentialing process.
- 2-b. Continue to support the use of/expansion of the Healthier Washington Practice Transformation HUB efforts to promote adoption and training of team-based integrated behavioral health and primary care.

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

3. Increase access to clinical training and supervised practice for those entering behavioral health occupations.

3-a. Improve availability and quality of supervision for behavioral health associate-level providers.

3-b. Review the incentives for Licensed Mental Health Professionals (LMHPs) to become certified as Chemical Dependency Professionals (CDPs).

3-c. Recognize and compensate the function that community-based settings play in training new behavioral health professionals and paraprofessionals in their first year of practice.

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

4. Expand the workforce available to deliver medication-assisted behavioral health treatments.

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

4-b. Graduate more behavioral health professionals licensed as prescribers.

5. Improve workforce supply, distribution and diversity.

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

5-b. Convene education programs with behavioral health care providers to identify mismatches between the skills of graduates/completers and expectations of employers.

5-c. Improve behavioral health literacy as a foundation for healthcare careers.

5-d. 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.

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

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

INTRODUCTION

BACKGROUND

The demand for behavioral healthcare - mental health and substance use disorder treatment - exceeds the availability of services throughout the state. This situation is exacerbated by the growing opioid epidemic and other substance use problems, mandates for greater access to behavioral health services, and limited funding to address these needs. While the state has many highly competent and committed professionals working hard to deliver behavioral health services, difficulties recruiting, educating, training, and retaining a skilled behavioral healthcare workforce may harm the state's ability to deliver on its goal.

Behavioral healthcare delivery is an evolving field. Promotion of the integration of behavioral health and physical healthcare delivery became more commonly referenced in the mid-2000's (Bree Collaborative, 2017), and 2014 saw an upsurge in states moving toward integrated managed care models (Washington State Health Care Authority, "Fully Integrated Managed Care National Review", 2017).

Washington State is also moving towards this model. To promote this systemic shift towards whole-person health, in 2014 Washington's Second Substitute Senate Bill 6312 was signed into law to fully integrate medical and behavioral health services by January 1, 2020 (Washington State Legislature, "SB 6312", 2013). The goal of the legislation is to ensure care is better coordinated and mental health and drug and alcohol disuse conditions are prevented, or caught early and treated (Lee, 2016).

In July 2016, Governor Inslee tasked the Workforce Training and Education Coordinating Board (Workforce Board) to assess workforce needs across behavioral health disciplines and charged them with creating an action plan to address these needs. The Workforce Board assembled a project team that included the University of Washington Center for Health Workforce Studies (UW CHWS) and Agnes Balassa Solutions, LLC to collect and analyze quantitative and qualitative data to describe the supply and distribution of the behavioral health workforce, assess the range of workforce-related barriers to improving access to behavioral health in Washington, and identify recommendations for solutions. Phase I of this 18-month project addressed the initial findings of workforce-related barriers and short-term solutions to accessing behavioral health services in Washington, drawing on stakeholder input to develop recommendations for the 2017 Legislative Session.

On November 3rd, 2017, Governor Inslee issued a [Directive](#) to establish a cabinet-level leadership structure for health with an immediate focus on behavioral health (Inslee, 2017). The health sub-cabinet highlights the need to convene health oversight agencies as well as commerce and corrections, insurance, and others as needed to consider and coordinate key interrelated issues with focus on integration, mental health, and opioid use response. The initial tasks of the sub-cabinet are to develop a strategic plan, advance behavioral and physical health integration, and form an interlocal leadership structure. The issuance of this Directive demonstrates both the understanding of the complexity of integration and the commitment of the state to improve the delivery of behavioral health in Washington.

OVERVIEW OF PROJECT GOALS

In response to the Governor's request to assess workforce needs across behavioral health disciplines, and create an action plan to address them, the Workforce Board project team collected and analyzed quantitative and qualitative data to:

- describe the supply, demand and distribution of Washington's behavioral health workforce,
- assess the range of workforce-related barriers to improving access to behavioral health in Washington, and
- identify recommendations for solutions.

This assessment is one of a number of efforts initiated by the Governor and Legislature to improve access to, and effectiveness of, behavioral healthcare in the state. The Behavioral Health Workforce Assessment team has been in contact with and tracking the activities of the other workgroups in the state focusing on behavioral health to eliminate duplication of effort and align research and analysis where possible.

APPROACH

The tight timeline for Phase I of this project limited the options for obtaining and analyzing data on the behavioral health workforce. The most efficient approach for the initial phase was to conduct the assessment primarily using qualitative (verbal) input through stakeholder meetings and key informant interviews from those with the most experience and interest in the issue across the state. The report of Phase I findings was made available in December, 2016 (Gattman, Reule, Balassa, Skillman, McCarty, Schwartz, 2016). Phase II of the assessment (January–December, 2017) focused on longer-term solutions to the barriers identified in Phase I, and culminated in this final report and recommendations to policymakers on December 15, 2017 for reference during the 2018 Legislative Session and beyond.

Analysis of available quantitative data to better describe workforce supply and demand, such as from state professional licensing records and labor statistics, also help inform the assessment. In Phase II, the team obtained and analyzed quantitative and qualitative data across multiple occupations to add foundational knowledge about the workforce to the assessment. Beyond the typical state-level labor market data describing quantifiable job openings for specific occupations, information about the changing skills and roles of the healthcare workforce, such as those needed by the workforce delivering integrated behavioral and physical healthcare, is key to understanding its dynamics. That type of information is largely found through interviews and conversations (such as through stakeholder meetings and key informant interviews), literature reviews, and through surveys specifically designed for that purpose (such as Washington’s Health Workforce Sentinel Network).

The Workforce Board provided staff for the project management of this initiative, stakeholder convenings, policy analysis, and administrative support. Research, including quantitative data analysis and key informant interviews, was provided by the UW CHWS. Stakeholder meeting planning and facilitation was provided by Agnes Balassa Solutions, and the full project team participated in all stakeholder meetings. From the beginning, this project was informed and supported by the [Washington Health Workforce Council](#). The Council assisted with planning and input, reviewed recommendations at various phases, and provided a final sounding board for recommendations at a meeting on November 17, 2017.

STAKEHOLDER ENGAGEMENT MEETINGS

A total of 189 stakeholders and informants from a broad cross-section of healthcare-related organizations participated in person or by phone, and provided information and feedback via email. A list of participants in stakeholder meetings and reviews is provided in Attachment A.

Phase I Stakeholder Groups: In Phase I, stakeholders were invited to participate in four meetings between July and October 2016 – one in Olympia, two in Renton, and one in Cheney. While Phase I focused on providing a robust list of potential action items and topics for additional research, Phase II focused on refining recommendations to a set of high-priority actionable recommendations, based on the growing experience of those working in the newly integrating healthcare environment.

Phase II Focus Groups: In Phase II, a stakeholder workgroup met in August 2017 to identify progress regarding behavioral healthcare workforce issues since the completion of Phase I. Based on that discussion, stakeholder focus groups were assembled on October 24, 2017 to provide updated information and specific recommendations related to the three topics deemed most relevant from the Phase I report: integrated care delivery and medication-assisted behavioral health treatment; reimbursement; and clinical training and increasing workforce supply, distribution and diversity. Phase II stakeholder focus group participants were

selected for their expertise in these areas and limited to 12 participants per focus group to allow for a deeper discussion. Focus group participants represented state and county agencies, community behavioral health clinics, organized labor, statewide associations, and educators.

Phase II “C-Level” Group: A group of 10 CEOs, COOs, CFOs, and leaders in behavioral health organizations met on November 6, 2017 to help refine and prioritize recommendations for the Phase II report. The meeting was unique in its focus on “C-level” executives in order to provide the broadest possible understanding of trends and issues. The meeting was facilitated in a manner to encourage discussion among the group members to build on their shared experiences and identify trends that cut across sites and systems. Organizations represented at the meeting included:

- Association of Alcohol and Addiction Programs
- Community Health of Central Washington
- Evergreen Recovery Centers
- Greater Lakes Mental Health
- Harborview Medical Center
- Kitsap Mental Health Services
- Lake Whatcom Residential and Treatment Center
- Navos
- Seattle Counseling Service
- Sound Mental Health
- Unity Care Northwest
- Washington Association of Community and Migrant Health Centers
- Washington Council for Behavioral Health

KEY INFORMANT INTERVIEWS

During Phase I, 41 interviews with “key informants” were completed by phone (34) or using an online instrument (7) by researchers at the UW CHWS. Seventy-eight candidates for interviews were selected out of nearly 300 potential key informants to represent a broad cross-section of occupations, behavioral health settings, and geographic areas across the state. A full list of participant organizations is included in the Phase I report. A semi-structured interview guide addressed themes consistent with those used to guide stakeholder conversations. While feedback from key informants is integrated into this report, the full results and report of the key informant interviews are posted [online](#) (McCarty, Schwartz, & Skillman, 2016).

BACKGROUND RESEARCH AND QUANTITATIVE ANALYSIS

During Phase II of this assessment (January–December, 2017), the UW CHWS project team collected quantitative and qualitative data to develop an overview of Washington’s behavioral health workforce and a set of profiles for nine occupations critical to the delivery of behavioral healthcare (see Attachment B). Data used to describe the supply and distribution of these nine occupations were from state credential records, maintained by the Department of Health. The state Office of Financial Management has access to these records and agreed to analyze these data and provide aggregate findings to the project team for purposes of describing the workforce size, distribution, and demographics of each occupation. In addition, the UW CHWS researched the education and training requirements, credentialing, and other characteristics of each occupation, as well as their roles in the provision of care in integrated behavioral and physical health settings and profession-specific challenges. The occupational profiles (Attachment B) were vetted by over 60 reviewers (professionals themselves, profession educators, regulators, and organization representatives) for accuracy and feedback. Findings from this background work were used to identify additional barriers and provide details to recommendations.

This report does not address all components of the behavioral health workforce or settings in which behavioral health needs are encountered. For example, because of data and resource limitations it largely excludes specific treatment of important specialty practice areas such as forensic, infant/child/adolescent/transition-aged youth, and geriatric behavioral health. The scope did not include additional settings in which behavioral health concerns may be encountered, such as criminal justice settings and courts, community housing agencies, and emergency medical services. Nonetheless, it describes major components of, and issues influencing access to, the state's behavioral health workforce, providing a foundation that can be used for further, more detailed assessments in the future.

DESCRIPTION OF THE BEHAVIORAL HEALTH WORKFORCE IN WASHINGTON

BEHAVIORAL HEALTHCARE OCCUPATIONS

There are a variety of ways to define the behavioral health workforce (Heisler & Bagalman, 2015). Researchers in the field of workforce studies have examined some criteria and roles, and government regulatory bodies may derive definitions from statutes related to credentialing and quality assurance (Skillman, Snyder, Frogner, & Patterson, 2016; Centers for Medicare & Medicaid Services, 2017; Washington State Department of Health, "Mental Health Professionals", 2017). In general, the behavioral health workforce is considered to be (1) those occupations that provide mental health and substance use disorder treatment in facilities solely providing these services; (2) occupations providing some behavioral health services in association with their primarily physical/medical care delivery roles; and (3) primarily behavioral health occupations working as part of an integrated behavioral/physical health services team in a variety of care settings.

Twenty-four categories of occupations credentialed (licensed or certified) by the Washington Department of Health are authorized for payment by the state for providing behavioral health services in Washington (Table 1). This set of behavioral health occupations includes independent practitioners as well as affiliates, associates, and trainees who practice under supervision, consultation, or employee status prior to becoming credentialed as independent practitioners. In addition, advanced registered nurse practitioners, physicians, physician assistants, and registered nurses are able to bill for mental health service delivery under specific billing and contract rules, along with hypnotherapists and sex offender treatment providers and affiliates.

Who are "Prescribers", and why do they matter?

A distinction is made between behavioral healthcare providers who can independently prescribe psychiatric treatment medications (e.g., physicians, advanced registered nurse practitioners, physician assistants), and those who cannot independently prescribe (e.g., psychologists, master's level counselors/therapists). Prescribing rights for Medication-Assisted Treatment (MAT), including buprenorphine, for substance use disorders is further regulated, requiring additional training and credentialing. (SAMHSA, "Medication-Assisted Treatment", 2016) Stakeholders report insufficient active MAT providers to meet demand, ongoing difficulty recruiting and retaining "prescribers" to provide behavioral healthcare, and primary care providers who lack confidence in their ability to manage psychiatric medications for seriously mentally ill patients (McCarty, Schwartz, & Skillman, 2016; Andrilla, Coulthard, & Larson, 2017).

Occupational therapists (OTs), and speech-language pathologists (SLPs) are also reported to have roles in providing behavioral healthcare. OTs are considered behavioral health providers in Oregon, Pennsylvania, Minnesota, Tennessee, Massachusetts, Maine, and Illinois. Expanding Washington's definition of mental health professionals to include OTs and SLPs may require a Sunrise Review by the Department of Health (Gattman, et al., 2016).

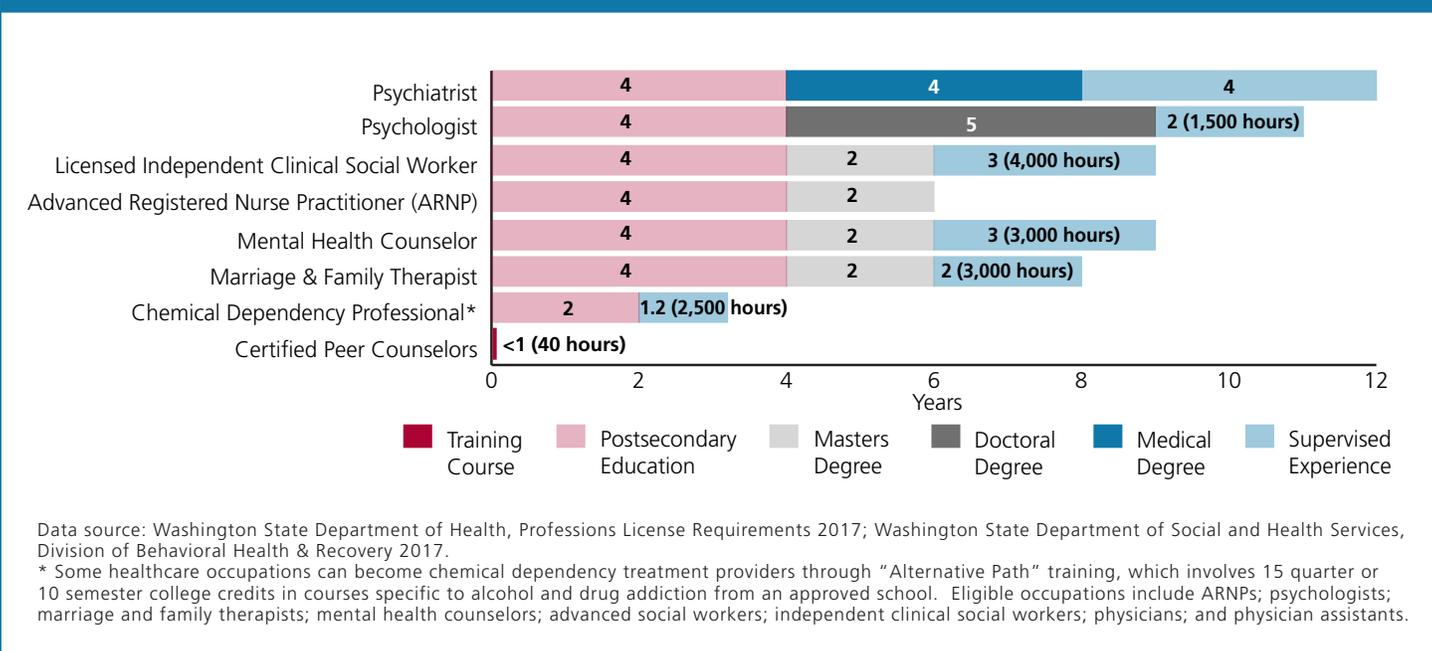
TABLE 1. Credentialed Behavioral Health Professionals in Washington State, 2017

Behavioral Health Providers	Licensed or Certified by the Washington Department of Health	Independent versus Supervised Clinical Practice		Further Described in Attachment
		Independent Practitioner Independent	Under Supervision, Consultation or Employee Status	
Advanced registered nurse practitioner (ARNP), including psychiatric ARNP	X	X		X
Agency affiliated counselor *	X		X	
Certified adviser	X		X	
Certified counselor	X		X	
Chemical dependency professional	X		X	X
Chemical dependency professional - trainee (CDPT)	X		X	X
Hypnotherapist	X		X	
Licensed marriage and family therapist (LMFT)	X	X		X
Licensed marriage and family therapist – associate (LMFTA)	X		X	X
Licensed mental health counselor (LMHC)	X	X		X
Licensed mental health counselor – associate (LMHCA)	X		X	X
Licensed practical nurse (LPN)	X		X	
Physician (MD/DO)	X	X		
Physician assistant (PA)	X		X	
Registered nurse (RN)	X		X	
Psychiatrist (MD)	X	X		X
Psychologist (PhD/PsyD)	X	X		X
Licensed social worker associate, advanced (LSWAA)	X		X	X
Licensed social worker associate, independent clinical (LSWAIC)	X		X	X
Licensed social worker, advanced (LASW)	X		X	X
Licensed, independent clinical social worker (LICSW)	X	X		X
Sex offender treatment provider	X	X		
Affiliate sex offender treatment provider	X		X	
DBHR-certified peer counselor *	X		X	X

* May only practice in a Department of Social and Health Services – Division of Behavioral Health and Recovery (DSHS-DBHR) licensed behavioral health agency.

Attachment B to this report provides details on nine of these behavioral health occupations, including the total number with Washington credentials (licenses or certifications), distribution across the state, wage information, education and certification requirements, and other characteristics. The behavioral health workforce is a highly heterogeneous mix of professions and roles. While most require postsecondary education (certified peer counselors being an exception), the length of that formal education varies. Some occupations require graduate degrees, and some require post-education clinical training such as internship or residency. Formal and often lengthy supervision of practice hours must be completed before some professionals can be licensed to practice independently. Figure 1 illustrates the variety of these requirements by showing the typical length of postsecondary education, graduate education, and clinical training (and/or formal supervised practice) for a selection of behavioral health occupations.

Figure 1. Minimum Years of Typical Education and Supervised Experience Required for Select Behavioral Health Occupations in Washington State



HEALTHCARE OCCUPATIONS INVOLVED IN INTEGRATED BEHAVIORAL HEALTH/PHYSICAL HEALTH

Credentialed healthcare professionals in medical settings are often not readily identifiable as providers of behavioral health services. Physicians, nurses, medical assistants, case managers, peer counselors, and others potentially provide behavioral health services without being defined specifically as behavioral healthcare workers. Psychiatrists and psychiatric advanced registered nurse practitioners (ARNPs) are exceptions, and their roles in the behavioral health workforce are further discussed in Attachment B.

Washington State physician license records do not differentiate between medical specialties, so data on the supply and distribution of physicians with psychiatric specialties are not available from license records. For this report, descriptions of psychiatrists were derived from separate analyses of the American Medical Association Physician Masterfile. Comparable data on physicians with addiction medicine specialties were not available, and so are not described in detail in this report.

General practice ARNPs, registered nurses (RNs), and licensed practical nurses (LPNs) may all practice in settings that specialize in behavioral health treatment (e.g., state mental health hospital), provide behavioral health services in medical settings (e.g., screening for depression or substance use disorder, case management or care coordination), or work in human services or public health settings that touch on behavioral health condition management or outreach.

State licensure data does not distinguish between nurses who provide behavioral health services and those who do not, with the exception of psychiatric ARNPs.

Pharmacists may become Board Certified Psychiatric Pharmacists (BCPPs) and enter a collaborative practice agreement with a physician to assist with medication management. They are usually not allowed to make an initial diagnosis, change a diagnosis, or admit or discharge patients from acute settings. However, they may order referrals and laboratory tests or perform consultations if the collaborative practice allows for these types of services (Ross, 2015; Independent Pharmacy Cooperative, 2015). Pharmacists in Washington are assuming an increasingly active role in promoting better self-

management for persons with chronic diseases such as diabetes or hypertension, and in conducting screenings and immunizations – basic health services that can be difficult to initiate and maintain in persons with serious behavioral health conditions (Druss & Rust, 2012; Ross, 2015; Independent Pharmacy Cooperative, 2015). The College of Psychiatric and Neurologic Pharmacists estimates that there are currently 949 BCPPs in the U.S., and projects that by 2025 there will be more than 2,400 (Board of Pharmacy Specialties, 2017; National Council for Behavioral Health, 2017). In July 2017, there were 32 active BCPPs in Washington State (Board of Pharmacy Specialties, 2017).

Allied Health Paraprofessionals in Behavioral Health Settings: There are no behavioral health technician occupations credentialed by the Department of Health, but “technician” job titles appearing on job posting websites in Washington include terms such as Psychiatric/Mental Health/Behavioral Health Technician/Specialist. Washington hospitals, including the Washington state-owned inpatient psychiatric hospitals, employ nursing assistants under the position title of Mental Health or Behavioral Health Technicians. Residential treatment centers, nursing and rehabilitation homes, county jails, and other facilities may also employ nursing assistants

The Orchestra of Successful Behavioral Health Integration: Case Managers, Community Health Workers, Primary Care Providers, Emergency Department Physicians, and a Client.

“A [MCO] case manager was assigned to work with a client who had been admitted to the hospital or treated in the emergency department on 24 out of 31 days that month. The client also had been dismissed from two primary care clinics that month.

The case manager organized a multi-disciplinary care team that included mental health provider staff, Community Connectors (community health workers), a Health Homes care coordinator, and hospital psychiatric liaisons. She also worked with the client to find a new primary care provider and establish care. The client’s care team identified strengths and barriers and created an action plan, including a process for follow up communication with the team. The following month, the client’s use of hospital care and emergency department visits dropped to eight—a third of the client’s use in previous months. In the next three months the client’s emergency department visits dropped to three and the client has had no inpatient stays. [MCO’s] Community Connector has helped the client form productive relationships with new providers. [MCO’s] case management team currently talks to the client two to three times a day. Between the Community Connector and the case manager, the [MCO] health plan has remained an integral piece of ensuring the client’s many service providers are connected, integrated and working as one team.”

Source: Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care. HCA Publication 82-325, August 2016.

as psychiatric technicians. Three avenues for training to fill behavioral health technician roles are the military (e.g., the Army has a Military Occupational Specialty code for Mental Health Specialist), state-approved nursing assistant training programs, or by meeting minimum requirements in a licensed practical nursing or registered nursing program.

Profiles on community health workers (CHWs) and certified peer counselors (CPCs) are provided in Attachment B. CHWs and CPCs can serve as patient navigators, care coordinators, health educators, advocates, and provide screening assessments. Not all CHWs and CPCs work in behavioral health or integrated health facilities, but roles are emerging in both settings. CPCs certified by the Division of Behavioral Health and Recovery (DBHR) are able to provide Medicaid-reimbursable services in Washington, and the CHWs are reportedly being identified as needed workers in projects selected by the Accountable Communities of Health (ACHs). For example, working with and receiving input from regional partners, the Better Health Together Accountable Community of Health (BHT ACH) chose a community-based care coordination model called “Pathways Community HUB Model” to deliver standardized and measured means of connecting at-risk individuals to health and social services using CHWs (Better Health Together, 2017; Rockville Institute, 2017).

SIZE AND DISTRIBUTION OF THE BEHAVIORAL HEALTH WORKFORCE

The occupational profiles found in Attachment B give summaries of supply and distribution, education and training, credentialing, practice characteristics, skills needed for work in behavioral health and physical health integrated settings, wages, and demand. Some highlights are shown in Table 2.

TABLE 2. Distribution, Age, and Sex of Select Behavioral Health and Related Occupations in Washington, 2017

Occupation	Number Credentialed with Addresses in Washington	Rate per 100,000 State Population	Mean Age	Percent Age >55 years	% Female	% Rural
Psychiatrists*	727	10.1	55	55.6%	40.7%	3.3%
Psychologists	2,295	31.9	52	45.8%	62.6%	3.8%
Licensed Advanced Social Worker	77	1.1	49	31.2%	89.6%	0.0%
Licensed Independent Clinical Social Worker	3,619	50.4	52	44.7%	82.0%	3.8%
Psychiatric ARNP	530	7.4	53	51.9%	87.2%	4.0%
Mental Health Counselors	5,923	85.5	52	45.5%	76.2%	4.1%
Marriage and Family Therapists	1,387	19.3	51	44.3%	76.9%	2.7%
Chemical Dependency Professionals	2,629	36.6	51	44.1%	64.9%	5.1%
DBHR-Certified Peer Counselors	2,346	32.7	NA	NA	NA	NA
Community Health Workers†	1,473	20.5	NA	NA	86%	NA

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System

NA – not available

* Data from 2016 AMA Physician Masterfile

† Washington Department of Health Training Program only

MEASURING WORKFORCE DEMAND

Measuring health workforce demand involves gathering information such as the number of jobs, employed hours, specific skills and workforce roles. Typical workforce demand statistics, such as those maintained by state and federal labor/employment agencies, are represented by job vacancies and turnover measures. It is more difficult to find information describing changes in the skills and roles required to meet employers' needs, and reasons for gaps between workforce supply and demand. A recent initiative funded by *Healthier Washington* (through the Health Care Authority), the state's Health Workforce Sentinel Network, was developed to help provide more detailed information about workforce demand in the healthcare industry as it undergoes transformation.

Through the Sentinel Network, the Workforce Board and the UW CHWS are tracking changes in health workforce demand across the state. This frequent, short survey of Washington healthcare employers was launched in July of 2016, and collects data that signal changes in the workforce occupations, as well as the skills and roles needed by healthcare employers. The Sentinel Network prompted a substantial number of responses from behavioral/mental health settings and community health centers, medical clinics, as well as other settings that employ occupations that provide behavioral health services. These descriptive findings, generally consistent with the stakeholder and key informant input, have been considered in developing the recommendations in this report.

Some key findings related to the behavioral health workforce from recent (Fall, 2017) input to the Sentinel Network are summarized below. Examples of reasons for workforce retention problems are shown in the text box in this section.

Washington's Health Workforce Sentinel Network: Comments from Behavioral Health Clinic (BHC) and Community Health Center (CHC) Employers about Reasons for Long Workforce Vacancies, Fall, 2017

Reasons for exceptionally long vacancies:

"Many [chemical dependency] professionals have obtained dual licensure and have opted to be employed under Mental Health due to higher pay in that area" (CHC)

"Low wages and difficult working conditions [for chemical dependency professionals]" (CHC)

"We are a Not For Profit agency and can't always compete with the compensation packages [for mental health counselors] that others are offering in and around our area" (BHC)

"Losing [mental health counselor] staff to much higher paying entities with lower caseloads, e.g. hospitals and insurance plans" (BHC)

"Low pay, on-call intensive work demands, excessive paperwork. Almost non-existent workforce to pull from for dual-licensed [mental health counselors and marriage & family counselors]" (BHC)

"Hardships of working [as a mental health counselor] for a community mental health company" (BHC)

"Affordable housing shortage, limited employment for spouse/partner, lack of quality child care options for working parents [affecting social worker recruitment]" (BHC)

"[Nurse practitioners] moving to higher paying jobs with family health insurance benefits. Also location with lower patient loads" (BHC)

Source: Workforce Training & Education Coordinating Board. (2017). Findings as reported by facility type. Retrieved from Washington State Health Workforce Sentinel Network: <http://www.wtb.wa.gov/HealthSentinel/findings-facility.asp>.

For which occupations did your facility recently experience exceptionally long vacancies for open positions?

- **Substance use disorder/chemical dependency professionals/behavioral disorder counselors (CDPs)** were cited by more than half of the employer sentinels from behavioral-mental health and substance use treatment facilities.
 - **Mental health counselor, nurse practitioner, and peer counselor** positions were also reported to have long vacancies in these facilities by 20-25 percent of employer sentinels.
- About a quarter of sentinels from community health centers (including federally qualified health centers) reported long vacancies for **mental health counselors, CDPs, psychologists, and clinical social workers** were also reported by these sentinels to be difficult to hire.
- **CDPs** were also reported as difficult to hire by the majority of psychiatric/substance abuse hospitals reporting to the Sentinel Network. Many of these facilities also reported long vacancies for registered nurses and nurse practitioners.

For which occupations did your facility recently experience an increase in demand?

- **CDPs** and **mental health counselors** were most frequently reported to be increasing in demand by sentinels from behavioral health settings.
- Increased demand for **mental health counselors** and **social workers** was cited by about a quarter of community health center sentinels.
- Having more clients and greater community need were commonly cited reasons for this increased demand. Some employers mentioned that added funding from Behavioral Health Organizations and the state requiring integration of substance use and mental health treatment contributed to the increased demand.

What were recent training and skills development needs for new and incumbent workers?

- The top training needs reported by employer sentinels from behavioral-mental health and substance use treatment facilities included Core Content Training (basic crisis counseling skills and services, data collection, and stress management techniques) for **CDPs**.
- Across settings more training was needed to introduce staff to integrated care models and to meet regulatory and administrative requirements such as Medicaid documentation for **CDPs** and **mental health counselors**, and for effective use of electronic health records and health information technology across occupations.
- From a psychiatric/substance abuse hospital sentinel, the need for chemical dependency training for generalist **nurse practitioners** (as opposed to psychiatric/mental health nurse practitioners) was cited as a need in that field.

More of the input provided to Washington's Health Workforce Sentinel Network from industry employers can be examined at <http://www.wtb.wa.gov/healthsentinel/>. Additional behavioral health specific workforce demand information from the Sentinel Network as well as from the federal Bureau of Labor Statistics is included in the occupation profiles in Attachment B of this report. Funding for the Sentinel Network, from Washington's Health Care Authority through its *Healthier Washington* initiative, ends in January, 2018. At this time, there is no funding source identified to continue the program, but the project team is actively searching out opportunities.

EDUCATIONAL/TRAINING PROGRAM CAPACITY

As described in the occupational profiles found in Attachment B, there are many institutions and programs across the state providing education and training for behavioral health roles and occupations. These vary in size and scope and, as seen in the profiles, programs come and go over time. The extent to which the state's education and training programs meet state needs is largely assessed by gauging workforce demand. The profiles describe, to the extent possible with existing data, relevant information about workforce demand for each occupation.

Educational program capacity is one component of the continuum of factors influencing who and how many individuals enter the behavioral health workforce. Factors that can limit potential students' interest in enrolling in behavioral health programs (education input) include the stigma associated with mental health and substance use disorders, lack of exposure to behavioral health occupations, and concerns of low wages. Educational output is greatly affected by shortages of clinical training sites across professions. The entire educational pathway, from student recruitment through clinical training and supervised practice, must be considered when enacting policies that seek to develop a more qualified and sufficient behavioral health workforce.

NEW APPROACHES: TELEHEALTH AND THE COLLABORATIVE CARE MODEL

The current and projected shortage of psychiatrists, and the growing recognition that mental healthcare need is often identified in medical settings, has increased interest in telepsychiatry to expand the distribution of mental health services across geographical areas and care settings. Further discussion of the use of telepsychiatry to improve the reach of psychiatrists is presented in the psychiatrists' profile in Attachment B.

A growing body of evidence supports the effectiveness of the Collaborative Care Model, which integrates physical and behavioral healthcare in Medicaid health homes through a collaborative team comprised of the primary care provider, care management staff (nurse, clinical social worker, or psychologist), and a psychiatric consultant who is

Occupations and Roles: Example from Washington State's Mental Health Integration Program

The University of Washington AIMS (Advancing Integrated Mental Health Solutions) Center, Community Health Plan of Washington, and Public Health Seattle-King County have partnered to implement the Mental Health Integration Program (MHIP) statewide in over 130 primary care clinics. MHIP integrates mental health screening and treatment using the Collaborative Care Model in safety-net primary care settings, and all providers on the team are trained in the fundamentals of the model, which uses psychiatric consultation and care managers (University of Washington, "MHIP", 2017).

Professionals in these sites who served in the care manager role were surveyed and asked to provide their credentials. Most were social workers or psychologists, but many occupations were represented.

Credentials of Care Managers in MHIP Sites	Percent	Number
Social Work	47.2%	34
Psychologist (or Resident)	25.0%	18
Licensed Mental Health Counselor (or Associate)	11.1%	8
Unspecified counselor or therapist	5.6%	4
Behavioral Health Administrator, Manager, or Consultant	4.2%	3
Medical Assistant	2.8%	2
Licensed Marriage and Family Therapist (or Associate)	1.4%	1
Nurse	1.4%	1
Psychotherapist	1.4%	1

Data Source: The Impact of Telepsychiatry Services on the Training of Rural Primary Care Teams in Integrated Behavioral Healthcare study, UW Rural PREP, 2017

available in person or by telepsychiatry (Unutzer, Harbin, Schoenbaum, & Druss, 2013; Unutzer, et al., 2008). Other models might use psychiatric ARNPs in the role of consultant, or have psychiatric specialists provide direct patient care via technology rather than serve as a consultant. A telehealth pilot in Washington uses an onsite nurse care manager and offsite physician to deliver medication-assisted treatment and buprenorphine prescriptions (Speaker, Mayfield, Yakup, & Felver, 2017). First-year outcomes were positive, and while challenges remain around billing and contracts, and added support staff and information technology infrastructure, patients were better served by the program.

Providing care from a distance through technology has been found to be efficacious but ideally requires psychiatric consultants with the skills and confidence to communicate effectively through videoconferencing. Financial incentives for telepsychiatry must be sufficient to compete with the option chosen by a significant number of psychiatric specialists to open private, cash-based practices.

In 2016, the Washington State Legislature passed Senate Bill 6519 to create the Collaborative for the Advancement of Telemedicine to enhance the understanding and use of health services provided through telemedicine and other similar models in the state. The Collaborative's recommendations for improving reimbursement and access to services, provider-to-provider consultative models, technologies and models of care not currently reimbursed, and other issues are due to the Health Care Committees of the Legislature on December 1st of 2016 - 2018 (Washington State Legislature, "SB 6519", 2015). The 2016 report recommended updating the telemedicine statutes to allow for access and reimbursement for any site of origin, which was enacted by SB 5436 in 2017; inventoried the telehealth programs currently in place in Washington; and discussed concerns from stakeholders (Washington State Hospital Association, 2016).

For the behavioral health workforce described above to deliver the highest quality services in Washington, attention is needed to minimize barriers that limit their practice and bolster resources that can enhance its effectiveness. The following section describes key workforce issues that can influence the state's ability to reach its goals to improve the behavioral health of Washington's population.

WORKFORCE ISSUES RELATED TO WASHINGTON'S BEHAVIORAL HEALTH GOALS

A variety of factors influence the supply, distribution of, and demand for, behavioral health occupations and occupations that can deliver integrated behavioral health and physical health services across Washington. While the number of new professionals completing education and training programs is one factor related to workforce adequacy, other key issues that affect workforce development, and can impact the speed and effectiveness of the state's healthcare transformation, include:

- The scope and timing of shifts in payment and policy, such as implementation of *Healthier Washington* initiatives, revision of billing codes, and unanticipated legal concerns.
- Training and education that better connects the behavioral health and physical health care workforces, groups that previously have worked in separate spheres and must be responsive to the rapidly changing demands in the workplace.
- Workforce retention efforts, such as reducing high rates of turnover and addressing low and stagnant wages (especially in safety net settings with the highest acuity clients).
- Approaches to addressing workforce equity in healthcare, with the goal of promoting access to, and opportunities for, diverse populations.

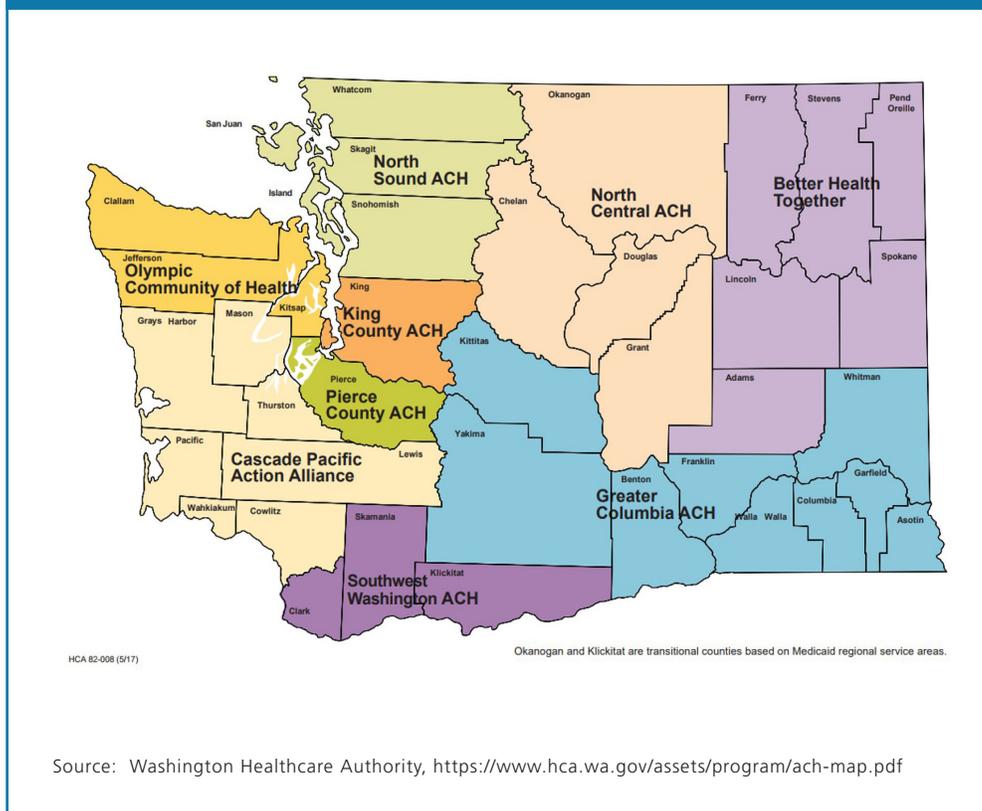
IMPACT OF SHIFTS IN PAYMENT AND POLICY ON WORKFORCE DEMANDS

Driving Force of Healthcare Change in Washington: *Healthier Washington* Initiatives

The health workforce is shaped and organized in response to the payment systems and policy governing the healthcare delivery system. Arguably the most significant healthcare payment and policy change occurring in Washington at present is the state's *Healthier Washington* initiatives. *Healthier Washington* leverages federal and state funding and resources to build healthier communities through a collaborative regional approach, integrate physical and behavioral health needs through increased focus on "whole person" care, and improve how healthcare payment rewards quality over quantity (Washington State Health Care Authority, "Healthier Washington", 2017).

Healthier Washington employs nine regional Accountable Communities of Health (ACHs, roughly aligned with the state's Medicaid regional service areas – see Figure 2) that contract with *Healthier Washington*. Each ACH brings together leaders from multiple health sectors to better align healthcare resources and activities. ACHs can receive millions of dollars to conduct specific projects each year, some required and others chosen from among a list of options. Two of the required projects are behavioral health related and ask each ACH to: (1) integrate behavioral health with physical healthcare, and (2) address the opioid use public health crisis. One of the optional projects for 2018, "Meeting the behavioral health needs of community-based care coordination", includes behavioral health-related goals. In addition, each ACH must address three health system and community capacity-building domains, one of which involves addressing healthcare workforce issues in the region.

Figure 2. Washington State's Accountable Communities of Health



One of *Healthier Washington's* primary strategies to achieving the triple aim of better health, better care, and lower costs is by paying for value ("value-based payment"). Moving from traditional volume-based payment for health services (e.g., fee-for-service) to linking quality and value of care to payment (Washington State Health Care Authority, 2016). may support improved access to behavioral healthcare and better outcomes by enabling healthcare providers/facilities to use their resources for non-face-to-face services that may help improve a person's health and quality of life. Examples include connecting clients to social services

(e.g., food banks or housing programs), providing wellness checks for behavioral health clients, and increasing access to prevention programs (e.g., smoking cessation). The shift to value-based payment may also provide more opportunities for peer counselors and community health workers, whose services may not be directly reimbursable in traditional payment systems, to be deployed in behavioral health settings. Payment rates will require demonstrated quality improvement and attainment against clinics' quality baseline (Healthier Washington, 2017). Effective implementation of *Healthier Washington's* value-based payment strategy will require staffing and workflow adjustments to measure, document, and report outcomes, as well as investment in education and training to foster the new skills required (Soper, Matulis, & Menschner, 2017).

It is too early to assess the effects of ACH implementation on the state's health workforce because implementation of the approved plans has just begun. Nonetheless, as a result of initiatives like *Healthier Washington*, there is great potential for better aligning the workforce with the population's behavioral healthcare needs.

Updates to Billing and Coding of Behavioral Health Services

New Medicare Physician Fee Schedule codes introduced in January 2017 by the Centers for Medicare and Medicaid Services (CMS) address a primary barrier to behavioral health integration by allowing payment to medical professionals who provide behavioral health services (Press, et al., 2017). Three of these "G-codes" specifically paid for integrated behavioral health services described in the Collaborative Care Model, which uses care management support and psychiatric consultation in the primary care setting. In January 2018, the interim "G-codes" will be replaced by standardized medical CPT® (Current Procedural Terminology) codes. At the same time, CMS will implement two new billing "G-codes" for Federally Qualified Health Centers and Rural Health Centers to bill for behavioral health integrated care, chronic care management, and the Collaborative Care Model services (University of Washington, "Financing Strategies for Collaborative Care", 2017).

Passed in the 2017 Legislative Session, SSB 5579 requires the Washington State Health Care Authority to review payment codes related to primary care and behavioral health, and to create and publish a matrix to provide information to providers for successful reimbursement (Washington State Legislature, "SB 5579", 2017). Developed with stakeholder participation, the matrix is intended to help providers in Washington navigate complex billing codes in order to more effectively implement "bidirectional" or integrated healthcare that is also financially sustainable. The matrix will describe the current requirements for selected billing codes as well as eliminate potential barriers to use of these codes. The proposed implementation plan is scheduled to be developed by the end of 2017 (Washington State Health Care Authority, "Behavioral Health", 2017).

Volk Court Ruling

At the same time Washington policymakers are supporting integration of primary and behavioral health care, an unanticipated concern may serve as a barrier to increasing the participation of medical care providers in delivering behavioral health services. The Washington Supreme Court ruling in *Volk v DeMeerleer* expanded the scope of liability for providers specific to the treatment of patients who later harm or kill persons previously not identified as at-risk of harm by the patient (Neiman & Peters, 2016). Specifically, a psychiatrist was deemed as having a "special relationship" with his patient of nine years, and as such was "under a duty of reasonable care...to protect foreseeable victims of his or her patient" (Neiman & Peters, 2016; *Volk v. DeMeerleer*, 2016).

In summary, “The liability rule announced by the Volk decision concerns mental health professionals, but can easily be expanded to other healthcare providers...This decision raises many questions, including whether changes in clinical practice are needed, patients will be deterred from effective treatment, lawsuits will increase, and catastrophic events will lead to mass litigation.” (Neiman & Peters, 2016).

Companion bills Senate Bill 5800/House Bill 1810 were introduced in the 2017 regular legislative session to clarify the obligation to individual healthcare provider or mental health professional, but did not advance past committee (Washington State Legislature, “SB 5800”, 2017).

TECHNICAL SKILLS NEEDED BY THE BEHAVIORAL HEALTH WORKFORCE

Achieving the goals of integrating behavioral and physical healthcare and eliminating barriers to accessing needed mental health and substance use disorder treatment requires significant emphasis on education and training. Technical skills are needed to provide appropriate and evidence-based services. This applies to both new entrants as well as the incumbent members of the workforce.

Lack of adequate training creates discomfort in practice, reduced morale, and likely leads to poorer patient outcomes (Olson, 2016; van der Leeuw, Lombarts, Arah, & Heineman, 2012). Recruitment and retention are enhanced when students and incumbent workers have education and training corresponding to their responsibilities and are trained in up-to-date and evidence-based skills for fast-changing roles in a technologically advancing environment. The training needed includes high-quality practical clinical training sites, the shortage of which creates a bottleneck to increasing the numbers of students in educational programs (e.g., psychiatric ARNPs).

Behavioral health providers who were trained to provide 1-on-1 psychotherapy may be underprepared for the fast-paced environment and brief interventions of an integrated primary care setting. Settings that are processing Medicaid documentation requirements for the first time may require their staff to gain skills in this area. Medical practitioners should understand the importance of addressing patients’ behavioral health needs in the primary care setting to reduce stigma and integrate care. Behavioral health practitioners should be aware of how common medical concerns co-exist with mental health and substance use disorder issues and how to be partners and advocates in whole-person health. Behavioral and physical healthcare

Training as an Ongoing Need: Washington’s SBIRT Primary Care Integration Project

SBIRT (Screening, Brief Intervention, and Referral to Treatment) is an evidence-based means of employing behavioral healthcare in primary care settings through universal screening, prevention and early intervention for problem substance use. It has been shown to be an efficient means of identifying patients who may benefit from integrated behavioral health services (Speaker, Mayfield, Yakup, & Felver, 2017).

Federal grants paid for provider training for SBIRT in the state over a 13-year period. Washington’s Health Care Authority (HCA) also promoted the use of SBIRT by providing Medicaid billing codes for the brief intervention portion of the model. Eligible providers complete at least four hours of documented SBIRT training prior to submitting claims (Washington State Department of Social and Health Services, 2017).

The most recent federally funded project conducted nearly 83,000 screens in 19 healthcare facilities in five counties. Ten of 19 continued to support all core components of SBIRT after funding ended. Facilities reported struggling to provide brief interventions when indicated, and reported the following barriers: confusion and difficulty with billing, inadequate training and education, staff attitudes towards and knowledge about substance use, and lack of “buy in” (Speaker, Mayfield, & Felver, 2017).

providers need coaching in how to collaborate with other healthcare professionals in integrated settings. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) identified core competencies to create an essential foundation for preparing and further developing a workforce to deliver integrated care (see Table 3). They are designed to be used as a benchmark to educate, recruit, train, and evaluate providers of behavioral healthcare services.

But training alone may not be enough. Physicians who wish to prescribe the drug buprenorphine for opioid dependency must complete an 8-hour online training course before applying for and receiving waivers of the special registration requirements defined in the Controlled Substances Act (SAMHSA, “Medication-Assisted Treatment (MAT)”, 2016; SAMHSA, “Qualify for a Physician Waiver”, 2016). Physician assistants and nurse practitioners can apply for and gain a waiver after 24 hours of training. Yet rural waived physicians’ reported concerns about diversion or medication misuse, time constraints, and lack of available mental health or psychosocial support services prevent them from incorporating buprenorphine maintenance treatment into their practice (Andrilla, Coulthard, & Larson, 2017). Those who had received a waiver but did not currently or ever prescribe buprenorphine cited as barriers the lack of specialty backup for complex problems and lack of confidence in their ability to manage opioid use disorders. These both speak to workforce concerns surrounding healthcare system sufficiency and self-perceived competence.

Table 3. Core Competencies for Integrated Behavioral Health and Primary Care

I.	Interpersonal Communication
II.	Collaboration & Teamwork
III.	Screening & Assessment
IV.	Care Planning & Care Coordination
V.	Intervention
VI.	Cultural Competence & Adaptation
VII.	Systems Oriented Practice
VIII.	Practice Based Learning & Quality Improvement
IX.	Informatics

Source: SAMHSA-HRSA Center for Integrated Health Solutions (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014)

RETENTION AND TURNOVER

The ability to recruit and retain healthcare providers with needed technical skills and cultural competency is key to effective functioning of care delivery systems. Some turnover of employees at a workplace is normal, and even necessary to support professional development, accommodate work-life balance, and refresh the mix of workers in the work setting to encourage skills mix, mentoring between experienced and newly trained staff, and adjust team compositions.

High turnover, however, “reduces the availability and continuity of care, and is an obstacle to the creation of stable teams of providers, all of which has a negative impact on quality and cost of service” (Barriball, et al., 2015). High staff turnover is also expensive. Studies have reported costs ranging from \$22,000 to over \$85,000 to replace a single nurse (Drake, Pawlowski, & Riley, 2013; Jones & Gates, 2007). High turnover rates in behavioral health settings reduce productivity, put financial stresses on organizations, disrupt client relationships, and can hinder implementation of evidence-based practices (Clay, 2004; Institute of Medicine (IOM), 2006; Woltmann, et al., 2008).

Lack of formalized supervision opportunities is one reason for turnover, especially in community mental health centers and community substance use disorder treatment facilities. Because these settings offer formal

supervision to new mental health counselors and chemical dependency professionals, they may readily hire new graduates by providing them with required supervision, but lose these professionals to higher-paying practice sites after the supervision period is completed.

Wages can play a significant role in workforce retention. Stakeholders providing input for this report strongly argued that below-market Medicaid reimbursement rates in Washington resulted in low, non-competitive wages in safety net settings, seriously hindering recruitment and retention of

the behavioral health workforce for those service sites. Some safety net settings can only afford part-time workers, presenting another challenge to recruitment. Data comparing wages in public and private settings in Washington are not readily available, but Figure 3 showing 2016 average wages for six behavioral health occupations in Washington illustrates the wide range of wages in behavioral health. Some examples of salaries of other occupations in and outside of healthcare are included for comparison.

Improvements in organizational culture and climate are likely to improve job satisfaction and organizational commitment, and, subsequently, reduce staff turnover. Although agencies and programs cannot always offer competitive salary and/or benefits, having a positive culture and climate can still influence staff to stay.

Preventing turnover benefits behavioral health settings because money invested in training staff will be less likely to be wasted on those who take those marketable new skills to another employer. Relationships are important in the workplace, especially in the human services. High turnover negatively impacts the development of long-term occupational relationships, reducing camaraderie and perceived peer supports. Because turnover increases during times of organizational change, organizations should consider how to bolster staff retention when implementing new technologies or service models—a particularly salient point as behavioral health and physical health are integrated in Washington. Technical assistance, training, and support are vital to the stability of the behavioral health workforce (Aarons & Sawitzky, 2006).

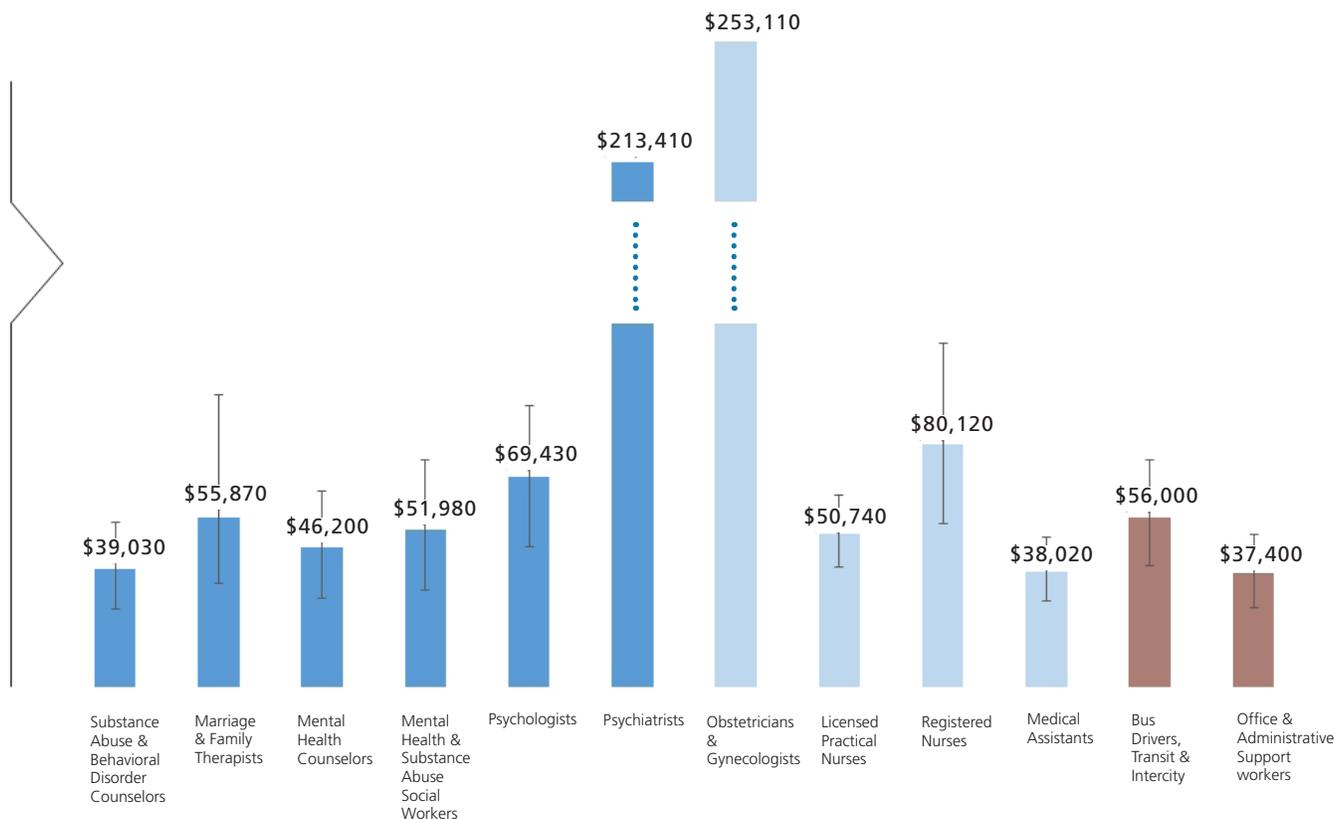
Health professionals respond to incentives, but financial incentives alone are not enough to improve recruitment and retention. Beyond increasing wages, there are measures which healthcare providers and facilities can take to improve staff retention (Barriball, et al., 2015). Many resources exist to improve retention in behavioral health settings, such as toolkits offering tools to collect retention data at agencies, to perform a job analysis to identify qualified candidates, and to build a retention plan (see Box on page 25).

A Tale of Turnover in Southwest Washington Agencies

Community Youth Services (CYS) in Olympia is the largest child welfare agency serving southwest Washington. (Community Youth Services, 2017) In 2015/2016, CYS conducted an open online survey to master's level mental health clinicians operating within the behavioral health field and community services throughout the state. 206 responses, including private practitioners, were collected. 86% of respondents had been employed at a community mental health agency (CMHA) at some time, but 43% were still employed at a CMHA. Conditional associate credentials (Mental Health Counselor Associate and Marriage and Family Therapist Associate) were more commonly reported while employed at a CMHA than independent licensure. Nearly 50% of respondents worked at a CMHA for less than 4 years. The top reasons reported for leaving employment were low pay, being overworked, too much paperwork, and perceived poor management. Top ways to make a position more appealing were reported as: increased pay, reduced caseload/workload, flexible hours, and positive/supportive work environment.

(Source: Alicia Ferris, Clinical Director, Community Youth Services, personal communication, December 4, 2017)

Figure 3. Full Time Salaries of the Behavioral Health Occupations & Comparison Occupations in Washington State in 2016



* Ranges on bars indicate 10th and 90th percentiles of salaries for each occupation
 Data Source: Bureau of Labor Statistics, May 2016 Occupational Employment Statistics 2016 Occupational employment and wage estimates

Examples of Workforce Retention Resources

- Behavioral Health Education Center of Nebraska's Retention Toolkit (<https://www.unmc.edu/bhecn/workforce/retention.html>)
- SAMHSA Recruitment and Retention Toolkit (<http://toolkit.ahpnet.com/Home.aspx>)

LESSONS FROM EARLY ADOPTERS OF BEHAVIORAL HEALTH AND PHYSICAL HEALTH INTEGRATION

Through *Healthier Washington* initiatives, Medicaid service provision is being redesigned to bring together payment and delivery of physical and behavioral health services through managed care. The strategy of integrating the financial systems of behavioral health and physical health as a catalyst to integrate the delivery of those services was launched in the

Southwest Washington Accountable Community of Health (SW ACH) region in April 2016. Clinically, the biggest shift in the early adoption of integrated behavioral health and physical health care was on how payers and providers coordinated and communicated. SW ACH has observed changes in the behavioral health workforce needs through their integration efforts. Recommendations from SW ACH on best practices can be found in the box on page 26.

Lessons from the Early-Adopter Region: Integration in Southwest Washington

A foundational goal of the *Healthier Washington* initiatives is integration of physical and behavioral health care in the state. In April 2016, the Southwest Washington Accountable Community of Health was the first region to integrate the financial systems of behavioral health and physical health to support integration of services. Key workforce-related recommendations reported from their experience are:

1. Focus on bringing stakeholders together to create a more regional approach to clinical service delivery.
2. Break down silos between primary care and behavioral healthcare cultures.
3. Prepare for an increased demand for dual credentialed (mental health and substance use disorder) professionals.
4. Prepare for new training and onboarding in Medicaid documentation for chemical dependency professionals.
5. Prepare for an increased need for experienced, well-trained back office personnel who can navigate claims and explanations of benefits in a multi-payer environment.
6. Build fully integrated managed care systems on well-trained paraprofessionals and care coordination rather than advanced degree holding, difficult-to-recruit specialists.
7. Explore leveraging resources from multiple sources, such as shared practitioner models and consulting with psychiatric nursing programs, to address the shortage of psychiatrists.
8. The optimal employee for the integrated environment would be comfortable in different evidence-based, brief treatments, have a good overview of common elements of primary care as well as behavioral health, have excellent people skills, use advanced motivational interviewing, and think critically about whole-person care (“connect the dots”).

(Source: Daniel Smith, Vice President for Clinical Integration, personal communication, November 20, 2017)

FINDINGS SUMMARY

Ensuring adequate access to behavioral healthcare is complex; while workforce shortages exist in a variety of occupations at all levels of delivery, simply “turning on the spigot” to increase output from education programs will not resolve all of the challenges. A number of underlying systemic, structural, and perceptual problems affect the ability to recruit, educate, train, credential, and retain a sufficiently large and adequately skilled and diverse workforce to provide access to behavioral health services for those who need them most.

KEY FINDINGS FROM OCCUPATIONAL PROFILES

Several interesting issues were revealed while studying the behavioral health occupations included in the profiles (Attachment B).

- For professions who may practice independently (licensed independent clinical social workers, psychiatric ARNPs, psychologists, psychiatrists), literature and stakeholder reporting suggests that self-employment in cash-only practices is a threat to behavioral healthcare access.
- In psychiatric nursing and social work, securing adequate numbers of clinical placements sites for students is the largest barrier to increasing enrollments in these programs.
- Employment of peer counselors and community health workers may help eliminate health disparities, but their successful deployment in healthcare settings relies on strong support in the workplace and clarity around their value and roles.

Highlights for specific occupations include:

- **Psychiatric ARNPs** programs show the largest proportional growth of the behavioral health educational programs studied here, and while the profession currently represents a small part of the behavioral health workforce, their ability to prescribe psychiatric medication is greatly valued by employers. The Washington State Hospital Association specifically called out the need for more psychiatric ARNPs in their 2017 legislative agenda (Whiteaker, 2017).
- To combat the opioid epidemic, in 2016 the Comprehensive Addiction and Recovery Act extended the privilege of prescribing buprenorphine in office-based settings to qualifying **ARNPs** until October 1, 2021. It is too early to measure the impact of this expansion.
- New requirements for **psychologists'** internships expected to be enacted by 2020 may affect the solvency of currently non-accredited internships, thereby further limiting access to this critical training.
- The facility types in which **chemical dependency professionals** may work was expanded in 2017 by SB 5779, but it is too early to measure the impact on the workforce (Washington State Legislature, "SB 5779", 2017).
- ESHB 1713 (passed in 2017) calls for the creation of a new residency position for a child and adolescent **psychiatrist** at Washington State University, which would help to grow this high-demand workforce (Washington State Legislature, "HB 1713", 2017).
- **Social workers** and medical family therapists (a specialty within **marriage and family therapy**), as behavioral health professionals who already work in medical settings, are a resource for further integrating behavioral and physical health care.
- **Peer counselors** and **community health workers** commonly have college-level education and are already employed in agencies when they pursue their training.
- The sustainability of **peer counselor** and **community health worker** training programs is of concern because they are largely grant-funded. The Washington Health Workforce Sentinel Network reports high demand for these professionals, but lack of funding and salary constraints are barriers to their employment.

BARRIERS IDENTIFIED BY STAKEHOLDERS

Barriers identified by stakeholders and key informants fall into four categories:

- Recruitment and retention: Recognizing that the integration of behavioral health with physical health will fundamentally change how and where many patients will access behavioral health services, there will likely be an ongoing need to provide services for some patients in behavioral health settings. The behavioral health work environment, especially in settings serving low-income populations, is characterized by heavy caseloads, patients with high acuity of behavioral health and other healthcare needs, time-consuming documentation requirements, and relatively low pay. Cultural stigma related to behavioral health was identified by stakeholders and informants as an additional challenge to workforce supply for this field. As a result, recruiting and retaining a skilled and diverse workforce across the range of occupations required to deliver appropriate behavioral health services is difficult.
- Skills and training: The changing behavioral healthcare environment, including moving toward the goal of integration of behavioral health and physical healthcare, increases the need for the behavioral health and physical health workforce to work effectively in inter-professional teams, be up-to-date with new models of practice and evidence-based skills, have access to and demonstrate proficiency using current health information technology systems, and efficiently meet documentation requirements. The opportunities and resources to meet these training needs are not adequate to meet demand, both in initial education

programs as well as for incumbent workers. Stakeholders and key informants identified concerns not only with the availability of “real world” training opportunities, such as preceptorships and supervised practice sites in integrated settings, but also with the ability of new and incumbent workers to keep up with the competencies needed to deliver evidence-based and integrated behavioral healthcare.

- Credentialing, licensing and related policy issues: Numerous policies and regulations influence the number, distribution, and scope of practice of the occupations that comprise the behavioral health workforce. These include what were described by stakeholders as overly burdensome requirements for credentialing some occupations, limited opportunities for dual credentialing or the addition of endorsements to those with credentials, lack of supervisors for mental health associates, and long timelines to receive some types of credentials.
- Paperwork and documentation burdens: The healthcare system, including behavioral health, must respond to requirements of multiple payers/insurers and oversight organizations. Responding to these reporting requirements takes considerable workforce commitment to keep up with the paperwork and to respond to documentation and audit requirements. These processes can be duplicative and inconsistent. In addition, compliance with these requirements demands considerable resources to train clinicians and staff to use the different systems for reimbursement and compliance. Stakeholders identified these administrative burdens as contributing to low morale and high turnover in the field.

POLICY RECOMMENDATIONS

WHAT'S NEW IN THIS REPORT?

Many of the issues and recommendations for actions from the [Washington's Behavioral Health Workforce Assessment: Project Phase I](#) report have been updated and refined in this Phase II report. The delivery of healthcare in Washington is beginning to change as providers move from planning to implementation of integrated behavioral and physical health services. In Phase II, providers were able to offer more detailed and nuanced descriptions of the challenges facing them and the potential solutions.

Additionally, since the Phase I report was completed in November 2016, a number of policy actions have been taken by the Governor and Legislature to address behavioral health needs. For example, ESHB 1713, which was passed into law, includes a provision requiring behavioral health organizations to reimburse providers for the use of telemedicine to deliver medically necessary services to Medicaid clients. SB 5436 expands the definition of “origination site” for telehealth to any site of the patient’s choosing, removing an additional barrier to the use of telehealth for patients in underserved areas. Implementing recommendations from the Children’s Mental Health Workgroup, ESHB 1713 requires Washington State University to establish one additional 24-month residency position specializing in child and adolescent psychiatry, and requires the Office of the Superintendent of Public Instruction (OSPI) to fund pilot programs in two Educational Service Districts to employ a lead staff person for mental health, which could expand mental health education programs over time. HB 1819 requires the Department of Social and Health Services (DSHS) to review documentation policies by April 1, 2018 in order to reduce paperwork, also addressing issues identified in the Phase I report. The legislatively-adopted 2017 budget increased behavioral health Medicaid rates effective October 2017, although a number of factors have limited the impact of that effort. In March 2017, the Bree Collaborative adopted its [report](#) and recommendations for promoting Behavioral Health Integration in the state (Bree Collaborative, 2017).

Most recently, on November 3, 2017, Governor Inslee issued a [Directive](#) to establish a cabinet-level leadership structure to develop a strategic plan, advance behavioral health integration, respond to opioid use and form an interlocal leadership structure (Inslee, 2017). This sub-cabinet convenes health oversight agencies as well as the Department of Commerce, Corrections, Insurance, and others as needed to consider and coordinate key interrelated issues. The issuance of this Directive demonstrates both the commitment of the state to improve the delivery of behavioral health in Washington, and an understanding of the complexity to do so.

In light of the ongoing evolution of Washington efforts to support greater healthcare integration, this final report focuses more narrowly on actionable recommendations, and includes fewer suggestions for future research, than the [Phase I](#) report.

RECOMMENDATIONS

1. ADJUST REIMBURSEMENT RATES TO BETTER SUPPORT COMPETITIVE RECRUITMENT AND RETENTION OF A SKILLED BEHAVIORAL HEALTH WORKFORCE. (UPDATED FROM PHASE I)

Workforce-related barrier: In Phase I of this project, low reimbursement rates for behavioral health services were identified as a major barrier to healthcare integration. Stakeholders consistently identified low reimbursement rates for behavioral health services as the root cause for challenges to paying competitive salaries, and for recruiting, educating, training, and retaining a skilled behavioral healthcare workforce, especially in settings with large numbers of Medicaid-insured patients, such as Community Behavioral Health Centers. The primary recommendation in the Phase I report was to “adjust reimbursement rates to better support competitive salaries, and recruitment and retention of a skilled behavioral health workforce.”

Stakeholder input for this Phase II report once again identified the continued need to address the issue of low Medicaid reimbursement rates for behavioral health providers. Medicaid expansion, increased emphasis on physical care and behavioral health integration, and growing awareness of behavioral health needs among the public and the medical profession increase the need for skilled behavioral health workers throughout the healthcare system. The national opioid epidemic has hit Washington hard, ramping up pressure on the behavioral healthcare system. Low reimbursement rates exacerbate these issues.

Because Medicaid is the primary funder of community mental health¹ services, Medicaid capitation rates are a primary determinant of community-based Medicaid providers’ ability to recruit and retain a qualified workforce. Stakeholders and key informants emphasized that low reimbursement rates mean that community-based agencies cannot compete effectively with hospitals, including the state hospitals, larger health systems, managed care organizations (MCO), or government salaries.

Actuarial studies used to set Medicaid rates reflect current system capacity based on historical use, not accounting for increased need or interest in prevention and early intervention work. Low rates perpetuate the problem. If rates remain low, capacity continues to fall, producing fewer encounters and even lower rates (and therefore capacity) in successive actuarial cycles.

Additionally, state-determined low Medicaid reimbursement rates – which are passed on to providers – results

¹Note that while Washington is working toward an integrated behavioral and physical health system, in this section we are specifically talking about the impact of reimbursement rates for behavioral health services. To that end, we have been specific in referring to mental health in this section.

in fewer providers willing to accept Medicaid patients. Many psychiatric care and counseling providers who are allowed to practice independently are now working in cash-only private practice. This in turn burdens the public behavioral health system, which is already stretched to meet high demand from acute patients with co-occurring disorders and health challenges. Low reimbursement rates translate directly into reduced capacity for outpatient treatment, which overloads the crisis, inpatient, and criminal justice components of the healthcare system.

In 2016, the legislature's Children's Mental Health Work Group mirrored these findings, reporting: "Medicaid rates reflect current system capacity (i.e., historical use), not service need or demand, or the desire to actively engage people in treatment further upstream. This is even more apparent in rural areas. Qualified providers choose to opt out of serving Medicaid clients, and many are taking private pay only. Medicaid rates are only about two-thirds of Medicare rates for the same units of service, highlighting care inequities between children and adults within our system." (Washington State Legislature, "Children's Mental Health Group", 2016).

While the long-term effort to reform healthcare in Washington may address some of these challenges by creating new care models and funding arrangements, in the short term, reduced system capacity negatively impacts patient care. Additionally, the move to integrate behavioral health services in physical health settings will not eliminate the need for community-based behavioral health care providers. Patients with severe mental health and/or substance use disorder (SUD) issues can display disruptive behavior, posing management problems in physical health settings. In addition, primary care providers are not always confident in the management of patients with severe mental illness, and tend to refer these patients to specialists.

The opioid epidemic means a growing number of patients need mental health and SUD treatment; many delay seeking treatment for these issues, as well as physical health issues, until they are very sick. Community-based behavioral health providers incorporate proactive outreach and intervention functions to identify these patients earlier, potentially reducing the need for more expensive treatments later. These outreach services, however, are not reimbursable under the current state Medicaid plan. In addition to raising rates, stakeholders recommended amending the state plan with the goal of incorporating additional medically necessary services, including outreach and patient navigation. Adding services to the state plan would accomplish two goals: (1) expanding the number of services that could be documented and billed or reported as encounters (and thus captured in the utilization data for the actuarial study); and (2) capturing federal match, bringing new resources into our state system.

Any effort to increase reimbursement rates needs to be sufficiently high to achieve the desired effect of increasing pay and capacity. For example, during the 2017 session, the Legislature provided a 2.5 percent rate increase to Behavioral Health Organizations (BHOs) and the fully integrated managed care region, which became effective on October 1, 2017. The budget proviso required DSHS to work with the actuaries responsible for certifying behavioral health capitation rates to adjust average salary assumptions in order to implement the increase. However, the rate increase was not large enough to balance out the millions of dollars in cuts that the community behavioral health system has sustained over a number of years or to raise salaries to a currently competitive level.

Lack of action to remedy low behavioral health reimbursement rates puts transformation to behavioral and physical health integration at risk. In order for integration to work, the portion of the healthcare system that

provides behavioral health services in community-based settings needs to be strong and robust.

Action required: In order to better support the competitive recruitment and retention of a skilled behavioral health workforce at the community-based level that is necessary for both healthcare integration and the treatment of a growing mental health and substance use disorder crisis, policymakers, Department of Social and Health Services, and/or the Health Care Authority should act on the following recommendations:

- Prioritize funding levels that keep Medicaid capitation rates high enough to positively influence wages.
- 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. This would allow providers to hire more staff to meet the growing demand for community-based behavioral health treatment. 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. Community behavioral health agencies providing CMS-eligible services are not reimbursed for them because they are not currently included in Washington’s state plan amendment. Community behavioral health agencies specifically called out the need to reimburse outreach, patient navigation/management, travel, and similar care coordination activities, and should be consulted in this process.
- 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. This can be accomplished using the existing Healthier Washington Practice Transformation Hub (HUB) or other mechanisms. Smaller community-based facilities stated that they are already disadvantaged based on their inability to provide competitive salaries. As they transition to new Value-Based Payment systems, they need to know if their pay rates are competitive within their regions. Greater transparency regarding the costs of doing business would help these organizations make reasonable assumptions about costs.

2. PROMOTE TEAM-BASED AND INTEGRATED (BEHAVIORAL AND PHYSICAL HEALTH) CARE.

Workforce-related barrier: The Phase I report identified the following barrier to integration: “too little education and training in team-based and integrated (behavioral and physical health) care is available for the incumbent workforce and for students entering clinical occupations.” Providing more team-based integrated training could be one of the most effective solutions for ensuring healthcare integration has the desired impact. Stakeholders identified the need for more cross-training, development of common language/approaches, and training to communicate with and work in cross-disciplinary teams. A report resulting from a taskforce convened under ESHB 1713 (2017) supported these observations, recommending the delivery of substance use disorder and mental health services in a less fragmented way, and noting the complexity of integrating primary and behavioral healthcare beyond funding challenges.

Stakeholders also identified structural challenges to integrating teams and called out two opportunities to address them: (1) adjusting the way that payers credential professionals and sites to reduce administrative burdens and create an opportunity to expand integrated team-based care, and (2) expanding the occupations that can bill as mental health providers.

2-a. Strongly encourage payers (Managed Care Organizations (MCOs)/health plans and BHOs) to contract with and credential licensed community behavioral health agencies, as well as individual licensed clinicians. Work with payers to standardize the credentialing process. (Revised and expanded from Phase I) Many of the recommendations in this report refer to the credentialing of individual practitioners via licensing or certification by the DOH. However, the term credentialing, as used in this recommendation, refers to the process whereby a health plan or carrier (MCO) approves a practitioner, facility, or organization for inclusion in the health plan's provider network. Most payers' credentialing processes and payments are directed to a specific licensed clinician. While there will likely be an ongoing need to contract with individual licensed clinicians, credentialing licensed behavioral health agencies at the organizational level is allowable and more in line with healthcare transformation. Strongly encouraging payers to contract with, and credential, licensed community behavioral health agencies could encourage a systemic shift toward value-based, integrated delivery of care models by providing the financial flexibility for community behavioral health agencies, as well as private practices, hospitals, etc., to employ and adequately compensate "care-teams" as opposed to individual provider "fee for service" visits. By supporting the use of licensed positions working 'at the top of their credential' to oversee the work of non-licensed individuals, this recommendation expands the overall behavioral health workforce pool and provides opportunities to expand workforce diversity by employing non-licensed individuals who work within an organizational and supervisory structure that ensures appropriate standards and protections. However, it should be noted that broad supervision/oversight of unregulated/unlicensed practitioners may add to the concerns related to scope of practice and ethics associated with such individuals as expressed by licensees in counseling professions, and could shift quality assurance responsibilities to agencies and organizations.

Additionally, each MCO uses its own standards, forms and approaches for credentialing. Stakeholders report that the process is time-consuming, repetitive and needlessly complex for provider agencies that are already licensed by the state and may employ hundreds of clinicians. 2SHB 2335 was passed in the 2016 session to streamline credentialing by requiring providers and carriers to use the credentialing database created by OneHealthPort for this purpose, eliminating redundancy. 2SHB 2335 applied the requirement to private insurers, but the requirement could apply to MCOs in their capacities as licensed carriers. The final 2017-19 Operating Budget, SSB 5883 included a directive (Sec.204(1)(x) (2017)) to implement a standardized provider credentialing system via a single credentialing platform.

It should be noted that this approach does not necessarily address the potential that requests for credentialing could be denied due to network adequacy. Once payers determine that they have an adequate network, they have no incentive to consider additional applications.

Action Required: The Department of Social and Health Services and the Health Care Authority should move quickly to identify and implement a single-platform provider credentialing system as directed by SSB 5883, and encourage credentialing licensed behavioral health agencies at the organizational level.

2-b. Continue to support the use of/expansion of the Healthier Washington Practice Transformation HUB efforts to promote adoption and training of team-based integrated behavioral health and primary care. (Updated from Phase I) The Healthier Washington Practice Transformation Hub (Hub) is actively providing resources to support healthcare practice transformation and achieve the reform goals of better healthcare quality, greater patient satisfaction, more efficiency, and more satisfied practitioners. Practice coaches are now in place,

or just getting into place throughout the state. The Hub's web-based Resource Portal provides an extensive suite of curated resources 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. A workgroup of about 30 providers, administrators, and others from every Accountable Community of Health (ACH) in the state meet monthly to provide feedback on Hub activities.

Stakeholders report that they are starting to use the Hub as an important resource to support their transformation efforts, as they move from planning to implementation, and gain new knowledge of both the opportunities and challenges that come with transformation. During Phase II, stakeholders specifically called out the need for increased technical assistance. Their need for health care transformation support to transition to value-based payment and clinical integration is anticipated to continue several years past 2020, but financial support for the Hub will end in December 2019.

Action Required: A sustainability plan should be developed to support the Practice Transformation Hub after the conclusion of the Healthier Washington initiative and funding period in 2019.

2-c. Expand the list of professions eligible to bill as mental health providers. (Updated from Phase I) In Phase I, stakeholders identified expanding the list of professions able to perform and bill for behavioral health functions as a way to support greater team-based and integrated care. In Phase I, based on an approach used by Oregon, Pennsylvania, Minnesota, Tennessee, Massachusetts, Maine, and Illinois, the majority of stakeholders and key informants (see stakeholder concerns below) recommended adding Occupational Therapists (OTs) to the list of professions allowed to provide and bill for behavioral health services. Currently, OTs may be able to perform limited behavioral health services, such as Applied Behavior Analysis for autism, but they are not defined as mental health professionals. During Phase II, stakeholders also suggested expanding the list beyond OTs to include other professions, including speech-language pathologists. The definition of mental health professional found in the mental health-related Revised Code of Washington (RCW) and Washington Administrative Code (WAC) would need to be addressed in order to expand the list of healthcare professions who may provide and bill for mental health services in Washington. Research and stakeholder input would help determine which professions should be added to yield the greatest expansion to needed services at the lowest risk to patient safety.

Stakeholder Concerns: In Phase I, the Washington State Society for Clinical Social Work objected to including OTs in the definition of mental health professionals. The Society noted that OTs cannot bill as mental health providers under Medicare and are not "trained specifically to create differential diagnoses in mental health or the counseling and psychotherapy to alleviate these conditions." Some stakeholders suggested that additional research should be conducted to determine whether there is sufficient capacity within the OT workforce to add behavioral health work, as some parts of the state, especially rural areas, report difficulty recruiting OTs, and questioned whether OT mental health billing would significantly increase access for clients.

Action Required: Policymakers should request that the Department of Health conduct a Sunrise Review of the professions recommended for an expanded scope of practice to include a greater range of behavioral health services, and the Health Care Authority/DSHS to review billing limitations for approved services.

Items for further study to promote team-based and integrated (behavioral and physical health) care.

- *Provide the incumbent medical and behavioral health workforce with additional training in effective practices in integration.* Skills training for team-based care provision exists for providing behavioral healthcare in the community (Wraparound with Intensive Services (WISe) and Program of Assertive Community Treatment (PACT)), in primary care settings and behavioral health settings (SAMSHA-HRSA Center for Integrated Health Solutions (CIHS), see example [models](#)), and by occupation (see Attachment B for occupational profiles). Further research could review options to incentivize additional training on best practices in integration, and encourage staff who participate in care coordination, screening, etc. to take training to identify potential behavioral health issues earlier. Due to the national interest in integrating healthcare, trainings and models exist, but adoption must be incentivized and championed. Disseminating best practices in use at CIHS Level 5 and 6 fully integrated clinics in Washington could be beneficial. State programs are also in development and dissemination, such as the University of Washington AIMS Center resource library, University of Washington Psychiatry and Addictions Case and Conference (PACC) telepsychiatry case review podcasts, and the Washington Association of Community Migrant Health Center topical online and in-person trainings. The work of ACHs may introduce some new opportunities.
- *Review workforce and staffing-related recommendations promoted by the Bree Collaborative in March 2017's "Behavioral Health Integration Report and Recommendations."*
- *Support psychology internship/fellowships and psychiatric fellowships for team-based, fully integrated programs.* The state could consider incentives to community health centers to support an increase in integrated programs.
- *Reduce the cost of maintaining dual credentials.* Maintaining dual credentials is expensive to the individual, and without incentives to continue one or both credentials, some providers let their credentials lapse. Providing a "bundled rate," dual credential discounts, or reimbursement might address this issue, although the Department of Health has noted that current fees are set at the minimum level required to regulate the profession. Implementation would require subsidies to address the cost of credentialing.

3. INCREASE ACCESS TO CLINICAL TRAINING AND SUPERVISED PRACTICE FOR THOSE ENTERING BEHAVIORAL HEALTH OCCUPATIONS.

Workforce-related barrier: Current capacity to provide students and new graduates with real world, hands-on, clinical training and supervised practice for behavioral health occupations is inadequate, which negatively impacts both trainees and behavioral health institutions. Stakeholders in Phase I identified too few internships, residencies, clinical training placements/practicums, supervised practice sites, and other "real-world" learning opportunities for behavioral health workforce development as a significant challenge to expanding the behavioral health workforce. In addition, they identified too few incentives to overcome the added burden on preceptors and administrative staff responsible for clinical training as a challenge. In Phase II, stakeholders confirmed these challenges remain, but focused in on issues related to supervision and dual credentialing as additional issues.

3-a. Improve availability and quality of supervision for behavioral health associate-level providers. (New Recommendation) To obtain their independent credential, mental health professionals (mental health counselor, marriage and family therapist, and social workers) and chemical dependency professionals must find approved

supervisors to complete their required supervised hours. While there are many overlaps in the competencies needed for various occupations, the statutory requirements regarding the number of supervised trainee hours necessary for certification/licensure, and which occupations may supervise which percentage of those hours, create challenges for training sites as well those entering the field. DOH staff report receiving frequent requests from mental health associates searching for supervisors with the appropriate licenses to supervise practice hours. Community-based agencies more frequently offer supervised practice opportunities than other settings, and so many new graduates work in community-based settings for this purpose, leaving those with the least experience working with the highest-acuity clients in the most under-resourced environments. Others pay private supervisors out-of-pocket. Stakeholders reported practitioners leaving the field before completing licenses, due to challenges finding supervisors and completing hours. A lack of supervisor training was also identified as a barrier, as many supervisors are practitioners who have risen through the ranks. Without training and support, supervisors may lack effective teaching and management skills, leading to frustration on all sides.

Action Required: DOH should, with additional resources allocated for this purpose, convene a workgroup to develop policy and practice recommendations to standardize behavioral health supervision, to the extent possible, and streamline supervisory requirements. The workgroup should:

- Review best practices in other states, and identify potential new models or support expansion of existing best practice models for supervision that will promote healthcare transformation to improve and integrate behavioral health.
- 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 centers in their training role).
- Expand the access to supervisor training opportunities.

3-b. Review the incentives for Licensed Mental Health Professionals (LMHPs) to become certified as Chemical Dependency Professionals (CDPs). (New recommendation) While behavioral health education programs are adjusting to provide more students with dual credentials, facilities working to better serve patients with co-occurring mental health and substance use disorders reported a number of challenges to dually credential incumbent mental health practitioners as chemical dependency professionals (CDPs). In response to feedback from these agencies, the Department of Health adopted new rules in July 2016 to facilitate the expansion of dual credentialed professionals. The new WACs, which reduced requirements for supervised practice hours, were the culmination of a rulemaking process to create an alternative CDP track.² However, in Phase II, behavioral health providers reported challenges with this new alternative track: coursework that duplicates what licensed mental health professionals already receive and the requirement for the first 50 hours of supervised practice to be face to face. As noted in Recommendation 3.a., it can also be challenging to recruit CDP supervisors.

Additionally, there are few incentives for mental health practitioners to earn the dual credentials. For example, psychologists eligible for the alternative track to obtain a CDP credential can provide and bill Medicaid for

²Practitioners with one or more of the following Washington State active and “in good standing” credentials – licensed advanced registered nurse practitioners, licensed marriage and family therapists, licensed mental health counselors, licensed advanced social workers, licensed independent clinical social workers, psychologists, osteopathic physicians, osteopathic physician assistants, physicians, and physician assistants – may be certified as CDPs by completing 15 quarter or 10 semester hours of education in specific topics from an approved school, as well as 1000 hours of experience while under the supervision of a CDP. Practitioners with specified national certifications (e.g., American Society of Addiction Medicine or American Board of Addiction Medicine) can meet the CDP educational or experience requirements. (Washington State Department of Health, 2017)

treatment delivered to clients with addiction without being certified as a CDP. Physical health settings are not required to become substance abuse disorder (SUD) agencies in order to offer and bill for SUD treatment. These sites may draw away mental health practitioners, who do not want to become dually credentialed, from settings requiring dual credentials, exacerbating recruitment and retention challenges at community-based sites. One community-based site reported losing the majority of its master's level therapists as a direct result of requiring dual credentialing for these practitioners, despite a commitment to pay for training and raise pay for completers.

Stakeholders reported that discussions about dual credentialing tend to break down with LMHPs on one side and CDPs on the other, limiting progress on this issue, and suggested engaging someone from outside the state to take a fresh look at this issue.

Action Required: Department of Health should consider the following actions to address these issues:

- Continue with its plan to monitor the use of the new CDP 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.
- 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.

3-c. Recognize and compensate the function that community-based settings play in training new behavioral health professionals and paraprofessionals in their first year of practice. (Carried forward from Phase I)

Community mental health agencies, SUD treatment agencies, and federally qualified health centers (FQHCs) often serve the most complex and chronically ill behavioral health clients, which can be a challenging population for new entrants to the workforce. At times, due to the reimbursement issue covered in recommendation 1, providers leave for better-paid opportunities after only one year of employment at community-based sites, and often after completing their facility-sponsored supervision requirements. As a result, these sites serve as de facto training sites, a role which is not compensated and has a disproportionate impact on the ability of these sites to meet their primary mission: to provide behavioral healthcare services. Recognizing and compensating these sites for this function may help community-based settings better retain workers. Additionally, providing such compensation would, at least partially, address reductions in standard clinical productivity as a result of time spent supervising new workers, enabling better absorption of the costs of high turnover, and/or allowing for these settings to staff appropriately to support a training function.

Action Required: The Washington Association of Community and Migrant Health Centers (WACMHC) and the Washington Council of Behavioral Health (WCBH), in coordination with the Washington Association of Alcoholism and Addition Programs (AAP) should:

- Charter/convene a work group of community mental health agencies, federally qualified health centers, and similar organizations that are Medicaid funded for mental health services to determine which incentives would be useful, and identify the level of funding needed if financial incentives were recommended.
- Work with policymakers to establish and obtain funding for incentives for community mental health agencies, substance use disorder programs and federally qualified health centers with existing training programs.

3-d. Increase the ability of behavioral health agencies to accept students/trainees by incentivizing and supporting clinical training sites. (Updated from Phase I) Stakeholders emphasized that trainees gravitate to where they had positive clinical training experiences and role models, and that competence gained in challenging settings/populations increases job satisfaction. Appropriate clinical training prior to credentialing is necessary not only to effectively teach real-world practice, but also to ensure that skills that were introduced in school programs are mastered. Staff at behavioral health sites take on additional responsibilities when serving as preceptors. Backfill arrangements must be made to adequately manage caseloads for those also serving as preceptors. Informants have expressed concern that too few clinical training sites with appropriately trained preceptors are available to adequately support existing behavioral health education programs and future expansion, and that the costs of precepting need to be covered. They have requested incentives for training sites and preceptors.

Action Required: WACMHC, universities and colleges with behavioral health programs, and clinical training sites (such as FQHCs) will need to work together on the following tasks:

- Develop and implement a readiness assessment to support clinics to evaluate their capacity and ability to implement long-term residency and training programs.
- Promote increased collaboration between universities/colleges and clinics for clinical training of behavioral health professions. Examine the approach used by Clinical Placements Northwest³ as a potential model for expanding coordination across the state.
- Consider legislative and funding support that provides financial incentives for current and potential clinical training sites to make up for the time and money lost while training new healthcare workers.
- Review opportunities to provide additional incentives, possibly to include loan repayment or stipends, for clinical training sites to send preceptors to become trained as supervisors and provide clinical training.

Items for further study to increase access to clinical training and supervised practice for those entering behavioral health occupations.

- *Work toward a standardized core curriculum for entry-level workers across behavioral health professions.* Development and implementation of a common curriculum could encourage and expedite behavioral health training across a range of entry-level occupations. Consider convening a work group composed of education/training program and employer stakeholders to review existing efforts to standardize or develop a curriculum for this purpose. Once developed, the core curriculum could be used by community-based health clinics to provide as the basis for a more robust on-boarding of new employees.
- *Increase the number of psychiatric residencies, especially in rural and other underserved communities.* There are not enough psychiatric residencies to support the workforce needs of the state. Research shows, and key informants have observed, that physicians and other doctoral-level providers are more likely to stay with an organization or in sites similar to where they complete residency training (such as rural locations) when they enter practice. In 2016, 41.4 percent of psychiatrists practicing in Washington had completed a residency in the state (Skillman & Dahal, 2017). To encourage more psychiatrists to practice in Washington, the state should support expansion of the number of psychiatric residencies. ESHB 1713 requires Washington State University to establish one additional 24-month residency position

³Clinical Placements Northwest (CPNW) is the umbrella of three clinical placements consortia (East, North & South) representing 34 healthcare organizations and 35 nursing education programs working to consolidate into a single organization. CPNW negotiates nursing student clinical placements between healthcare partners and education programs and identifies additional placements when there is shortfall. CPNW is working to provide “one-stop shopping” and an automated placement grid to allow a clinical placement coordinator to work on placements for all healthcare students.

specializing in child and adolescent psychiatry, per the recommendation of the Children’s Mental Health Workgroup, but additional residencies are needed.

4. EXPAND THE WORKFORCE AVAILABLE TO DELIVER MEDICATION-ASSISTED BEHAVIORAL HEALTH TREATMENTS.

Workforce-related barrier: Too few providers have the prescribing authority needed to deliver medication-assisted treatment for substance use disorder and manage psychotropic medications. Currently, physicians (including physical care physicians and psychiatrists), advanced registered nurse practitioners (ARNPs), including psychiatric-mental health nurse practitioners (PMHNPs), physician assistants (PAs), and pharmacists working under a physician’s prescriptive authority may prescribe medications for behavioral health conditions. Only licensed physicians, PAs, and ARNPs who have received a waiver from the Drug Enforcement Agency can currently prescribe drugs such as buprenorphine to treat opioid addiction. There are too few of these professionals available to efficiently serve the needs of all behavioral health service sites in the state. This is a both supply shortage issue and a recruitment/retention issue. Low Medicaid rates, discussed in recommendation 1, further reduce the number of buprenorphine prescribers in behavioral health settings.

4-a. Increase primary care providers’ (physicians, ARNPs, PAs, pharmacists) confidence to use their full prescriptive authority for psychiatric medications. (Updated from Phase I) In Phase I, stakeholders and key informants cited a lack of comfort or confidence managing serious behavioral health conditions as a challenge to current prescribers’ willingness to practice to the full scope of their licenses, including prescribing psychiatric medications and those used to treat opioid addiction. Providing training and support within integrative collaborative systems is ideal, but challenging, due to the shortage of psychiatrically trained providers. The University of Washington’s (UW) AIMS Center is working to expand the reach and availability for consultation of Washington’s psychiatric prescribing workforce by offering educational modules, coaching, and evaluation for sites implementing the collaborative care model. The UW Integrated Care Training Program provides an integrated care fellowship program to provide up to five psychiatric providers annually an opportunity to learn how to provide integrated care through consultation to non-mental health settings (such as primary care) and telepsychiatry, as well as enhancing leadership to improve systems of care. Additionally, Columbia Health is testing a model of partnering with a managed care organization to fund a nurse care manager to allow for the monitoring that is critical to prescribing.

A 2016 report by the Children’s Mental Health Work Group recommended providing psychiatric care consultations via telemedicine.(Washington State Legislature, “Children’s Mental Health Group”, 2016) Stakeholders in Phase II suggested gathering information on the effectiveness of the Children’s Hospital Partnership Access Line (PAL) telephone consultative service as a potential best practice. PAL provides reimbursable, interactive consultations with psychiatrists within or outside of Washington via telehealth. The lack of reimbursement for consultative services was identified as a challenge to expanding its use; providers are not paid for the time they spend using the line. There are no billing codes for staff members who manage care, outreach, etc. to be able to bill as part of telehealth-delivery team.

Action Required: In order to increase capacity to support the comfort of primary providers prescribing psychiatric medications, several actions should be considered:

- Adjust the Medicare, Medicaid, PEBB, commercial insurance, and other relevant payment models to provide greater support for and sustainability of telepsychiatry to support primary care providers via tele-consulting services with a psychiatrist. Two bills passed in the 2017 legislative session have begun

to address this challenge: SB 5436 expands the definition of origination site to any site of the patient's choosing and ESHB 1713 includes a provision requiring Behavioral Health Organizations to reimburse providers for the use of telemedicine to deliver medically necessary services to Medicaid clients.

- Provide resources and billing codes for those who manage care, outreach, etc. to be able to bill as part of a telehealth delivery team.
- Expand MCOs/BHOs providing telepsychiatry networks for contracted provider networks.
- Continue support for psychiatrist training through the 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.
- Review and consider implementation of the recommendations made by the Collaborative for the Advancement of Telemedicine, a workgroup created by SSB 6519 (2016).

4.b. Graduate more behavioral health professionals licensed as prescribers. (Updated from Phase I) 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 in Phase I. Since 2016, ARNPs have been able to prescribe both psychiatric and physical health medications, but stakeholders report that many ARNPs are not comfortable providing psychiatric medication management for patients with an acute mental health diagnosis. Prescribing medication-assisted treatment (MAT) for opioid misuse treatment requires a special training and waiver process beyond the necessary ARNP education and credentialing. It is too soon to measure the impact of extending ARNPs' prescriptive rights.

In Phase II, CEOs reported a need for both types of practitioners and stated that it had become increasingly challenging to recruit for ARNPs in general and PMHNPs in particular. One CEO reported relying on consultation with a professional located in Kentucky, another worked with a provider from Texas. At least one stakeholder cautioned that as ARNP programs are moving from the master's level toward doctoral level training, fewer ARNPs may enter the workforce over the next several years. However, schools report an anticipated increase in PMHNP outputs in the next few years.

In Phase I, the Washington State Hospital Association (WSHA) identified that universities offering PMHNP programs could accept more qualified candidates if they had more funding to recruit faculty to teach the courses and to increase the number of clinical preceptorship placements. A preceptor's productivity is reduced while educating students, meaning the clinician's billable hours decline without compensation. Stakeholders also suggested finding ways to support both costs and time for registered nurses to become trained as ARNPs and PMHNPs. However, increasing the numbers of PMHNPs produced by schools will not provide employers with a greater applicant pool if these practitioners choose to work in private practice, where they may earn better salaries with less paperwork burdens. An occupational profile for PMHNPs is included in Attachment B of this report.

Action Required: The Phase I recommendation that policymakers create a grant program to increase capacity in PMHNP training programs is carried forward here. If the grant program was created, universities could apply for single or multiple \$400,000 grants for a 2-3 year cycle to educate and train additional PMHNPs and support preceptorships, resulting in approximately 80 additional PMHNPs over the next 2-3 years. Efforts to help RNs move along career ladders to become ARNPs and PMHNPs should also be explored.

Items for further study to expand the workforce available to prescribe behavioral health treatment medications:

- *Provide prescriptive training/examination/credentialing to a broader range of behavioral practitioners.* While some states address this issue by allowing clinical psychologists with additional training to become prescribers for psychiatric medication, some stakeholders cautioned against providing prescriptive training/examination/credentialing to a broader range of behavioral healthcare practitioners without careful consideration. As one stakeholder stated: "...because medical complications can arise from the administration of medications, and medical training currently consists of four years, please keep in mind any adverse outcomes that might arise if the approaches are not thoughtful." In order to implement such an approach, a Sunrise Review and legislative action would be required, and research into what other states are doing is strongly recommended.
- *Increase the number of psychiatric prescribers by:* (1) Increasing the number of residencies and encouraging medical school graduates in Washington to enter psychiatric residencies in Washington; and (2) Consider developing a PMHNP residency program and expanding the behavioral health training slots in the current ARNP training programs. Washington is facing a major shortage of psychiatrists, as those currently in the field are aging out and demand for these services is increasing. Encouraging psychiatrists to complete their residencies in Washington could help to address this shortage while increasing the pool of prescribers, but is an expensive proposition. Another, less costly option, might be to develop a PMHNP residency and increase the behavioral health training slots in current ARNP and PA programs.
- *Identify and resolve barriers to community-based facilities to host psychiatry residents for rotations.* For example, a stakeholder noted that community-based sites must cover the costs associated with hosting a psychiatry resident, creating a disincentive to training psychiatrists in underserved settings.
- *Consider facilitating expansion of PA internships in psychiatry.*

5. IMPROVE WORKFORCE SUPPLY, DISTRIBUTION AND DIVERSITY.

Workforce-related barrier: While stakeholders report shortages in various behavioral health occupations, simply expanding the workforce pipeline will not sufficiently resolve the issues in the field. The behavioral health workforce, in general, inadequately reflects the diversity of the population wanting to access services. Additionally, the workforce is not distributed based on the needs of specific communities, particularly in rural areas. As a result, it is difficult to provide culturally appropriate care early and in a proactive way that reduces the need for addressing behavioral and physical healthcare issues when they become more acute. Access to services is uneven.⁴ For the purposes of this report, the term diversity is used to focus on the broad category of underserved populations, including but not limited to providers representing various genders, class, sexual orientation, countries of origin, disabilities, race/ethnicities, and history of substance use disorders. For example, one key informant was concerned with the ability to replace a provider for deaf clients, were that provider to leave the facility.

5-a. Provide financial support and other incentives to those pursuing careers in behavioral health. (New recommendation, combining and updating several recommendations in Phase I) Stakeholders identified a variety of financial supports and other incentives that could help increase the quantity, diversity and distribution

⁴Behavioral health occupations' rate per 100,000 population by Accountable Communities of Health are available in the occupational profiles, see Attachment B.

of the behavioral health workforce, including loan repayment, work study, apprenticeship (especially for non-credentialed or entry-level occupations), as well as direct incentives.

Loan repayment programs. In Phase I, stakeholders encouraged expanding both the funds appropriated and occupations approved for existing state loan repayment programs, recognizing that these programs are limited to those who financed their education and training using loans. Four licensed behavioral health occupations – Clinical Psychologist, Licensed Independent Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor – have recently been added to the state Health Professional Loan Repayment Program, allowing providers in these occupations with a minimum of a Master or Doctoral Degree level education working in an integrated setting/system of care to apply for loan repayment.

In Phase II, stakeholders again voiced a desire to increase the program appropriation and the settings and professions eligible for loan repayment programs. Because the number of loan repayment awards directly results from the size of the state appropriation, making more sites and occupations eligible does not equate to more loan repayment awards, unless the appropriation also grows.

In both Phases of this project, stakeholders expressed confusion regarding various program aspects, such as eligibility, and the difference between the state programs and federal National Health Service Corps. They encouraged more outreach to facilities and practitioners. Stakeholders noted challenges with the state application process and the financial penalties, set in the RCW 28B.115.110, for those who do not fulfill their service commitment, as possible disincentives for those who might otherwise benefit from the program. In an effort to streamline the process, the Washington Student Achievement Council (WSAC) reports that beginning in 2017 sites only need to fill out one application per physical location, whereas in prior years sites had to fill out an application for each discipline and location. This improvement cuts the workload down significantly, as a majority of sites may now complete just one application instead of three. There remain other issues with the application process that WSAC continues to work to improve.

Direct Incentive. Stakeholders suggested that the DOH consider convening a workgroup or task force to explore a new direct incentive program, since the current loan repayment program doesn't help those providers without educational debt who might be incented to practice in underserved behavioral health settings. A direct incentive could be less restrictive and require a less complicated application process. For example, a direct incentive could be created for practitioners who work at a community based behavioral health facility for a set period of time, perhaps 3-5 years. This would reduce turnover at these sites and support greater continuity of care.

The Alaska SHARP program was identified as a potential [model](#) (Alaska Department of Health and Social Services, 2017). The program provides support for service to practitioners in the form of either repayment of qualifying education loans and/or payment of direct incentive for practicing in underserved sites.

Work Study. The state work study program is the only state funded student financial aid program that includes support for graduate and professional students as well as undergraduates. Work Study is an approach to make higher education more affordable for students, while also providing them with work experience. Student participants are placed with employers that meet their career interests. There are work study sites at behavioral health service providers across the state, largely in community health centers, which increase exposure to behavioral health career paths serving a diverse clientele. At one time, Washington had the largest state Work Study program in the country; however, the program has been cut by two-thirds since the Great Recession. WSAC has requested an additional \$10 million for the program in the 2018 legislative session to serve an additional 3,000 students.

Apprenticeship. As an “earn and learn” model, apprenticeship provides a vehicle for trainees to earn an income while they become proficient in their occupation. Apprenticeship could be especially useful to train non-credentialed or entry-level behavioral health occupations by providing the supervised, hands-on, real world experiences these trainees need, without requiring them to reduce their incomes to attend traditional education programs and/or accumulate educational debt. The Washington Association of Community and Migrant Health Centers (WACMHC) is conducting a needs assessment within the FQHCs and rural and tribal clinics to develop a behavioral health apprenticeship program for integrated care implementation. The behavioral health apprenticeship program would train incoming and current support staff using didactic and clinical training at participating FQHCs and rural clinics to triage, do brief interventions, screening, motivational interviewing, and support care coordinators, allowing more time for providers in higher demand (e.g., psychiatrists, child psychologists, physician assistants, and psychiatric advanced registered nurse practitioners) to carry out work at the top of their scope of practice and training. A similar model of apprenticeship could be developed and implemented for Community Behavioral Health Centers.

Action Required: Actions to provide financial support and other incentives to those pursuing careers in behavioral health include:

- DOH, WSAC and the Washington State Behavioral Health Council should convene a workgroup to develop a list of options to incent and retain the behavioral health workforce, including loan repayment, simple direct incentives, expanding the state Work Study program, and exploring apprenticeships in behavioral health settings in order to create a flexible package of financial supports to increase the distribution and diversity of the behavioral health workforce.
- The state should fund additional resources for the Department of Labor & Industries Apprenticeship Division to support development of apprenticeship programs, in consultation with behavioral health leaders and healthcare union leaders, for entry-level roles in the behavioral health field.

5-b. Convene education programs with behavioral health care providers to identify mismatches between the skills of graduates/completers and expectations of employers. (Updated from Phase I)

Stakeholders identified mismatches between the skills of trainees completing programs and the skills necessary for success in behavioral health settings as being among their challenges to providing high quality care. Encouraging frequent connections between employers from a specific industry sector and the educational system is a best practice to align training programs with the needs of employers. Convening regional or statewide conversations among behavioral health employers, professional associations, postsecondary education institutions, and other training providers would allow for better understanding of employer needs for these occupations, and encourage partnerships between industry and education to meet future workforce demands. A team would need to identify the specific outcomes to be achieved, identify a lead organization(s), and otherwise organize the meetings.

Action Required: The State 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 health care employers to identify mismatches between the skills of graduates/completers and expectations of employers.

5-c. Improve behavioral health literacy as a foundation for healthcare careers. (Carried forward from Phase I with minimal changes)

Stakeholders identified the stigma associated with behavioral health as a barrier that reduces the number of individuals considering behavioral health careers, and the diversity of that

workforce. Earlier exposure to behavioral health concepts, literacy, and career paths, particularly those leading to targeted postsecondary education and credentialing, may reduce this stigma. In Phase II, behavioral health CEOs advocated for getting young people interested in healthcare, and especially behavioral health occupations, at the earliest age possible. Existing approaches in Washington and elsewhere could be implemented locally or expanded for this purpose:

- Washington State University has a program in partnership with tribal groups focused on nursing, which could be adapted to include behavioral health as well.
- 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 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.

Action Required: Actions that could expand behavioral health literacy in Washington include:

- Policymakers could enhance funding for behavioral health literacy education; using models such as the programs listed above, and emphasize support for programs which include training and resources for educators.
- 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.
- Policymakers could consider funding a program manager for behavioral health literacy efforts at OSPI.
- 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
- 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.

5-d. 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 from Phase I) By their very nature, peer counselors and other community health workers in the behavioral health workforce 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 community behavioral health organizations are increasing their demand for peer counselors and other community health workers. In the Phase I report, stakeholders identified limited availability of training spots and oral examinations required for a certificate of completion for peer counselors as a major hurdle in Washington. Washington's Office of Consumer Partnerships (within the Department of Social and Health Services) plans to increase the number of certifications by 15-20 percent in 2018 (from approximately 350 to 410 individuals trained annually) by increasing the number of trainings and the capacity per training. However, with over 12 different titles for community health workers, stakeholders reported a desire for clear standards and some level of consistency across this category of workers. In 2018, the DSHS Division of Behavioral Health and Recovery will be adding SUD peer counselor training for targeted SUD recovery support as part of the State Targeted Response to the Opioid Crisis Grant ("Opioid STR") efforts, though their services will not be eligible for Medicaid reimbursement.

Action Required: The Community Health Worker (CHW) Task Force was created to develop policy and system change recommendations to align the CHW with the Healthier Washington initiative and recommend measures to support CHW integration into our healthcare system. The Task Force provided [recommendations](#) in 2015 concerning increasing the scope of training and education for CHWs, investigating sustainable financing options, and means of integrating CHWs into transformation initiatives. (Community Health Worker Task Force, 2016) Policymakers and stakeholders should review and consider implementation of these recommendations.

5-e. Expand access to the I-BEST teaching model, and encourage additional programs that include behavioral health occupations. (Carried forward from Phase I) 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. Some I-BEST programs focus on healthcare occupations, and there are a few programs in the state that include a focus on behavioral health. For example, Grays Harbor Community College has an I-BEST for their Human Services program that admits 40 students per year, and generally has a waiting list of students. The program has a generalist track, and a track that leads to the CDP certificate. Expanding I-BEST healthcare programs to include more information on behavioral health occupations could provide the state an untapped resource of diverse entry-level and paraprofessional providers, such as CDPs (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.

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

5-f. Reduce paraprofessional care worker turnover and improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles.. (Carried forward from Phase I) Underrepresented minorities, immigrants and refugees, and others from diverse population groups often work at the entry and middle-skilled positions across the healthcare sector. Viable pathways to better-paying healthcare positions are limited, especially for those with barriers to traditional education and training programs. The development of career lattices, with wage and job progression across the full spectrum of the healthcare workforce, can support the retention and advancement of these workers, resulting in a more diverse healthcare workforce, and potentially improving patient outcomes as the workforce develops from within communities being served.

National and international efforts to stem the loss of care workers by using career pathway development and increased autonomy over the work have shown success. These efforts have generally been focused on one or a few aspects of caregiving, like long-term care, with limited position or wage growth. Even so, Pennsylvania, Massachusetts, New York, Oregon, North Carolina, Georgia, Florida, and Vermont all had successful long-term care career pathway efforts, and have been able to show significant turnover reductions. Massachusetts, the only state that looked at the effect of workforce development interventions on federal patient care quality indicators, showed a significant increase in certain quality indicators, and positive changes in revenues that were transferred to direct patient care and care worker wage increases. The five states that participated in Robert Wood Johnson Foundation's "Better Jobs for Better [long-term] Care Initiative" were able to show reductions in worker turnover. The United Kingdom, anticipating an almost double-digit increase in the need for care workers, has begun an effort to look across the caregiving subsectors to improve front-line worker recruitment and retention. The project looks at career pathways, portable and stackable credentials, and customer-endorsed badges.

The Health Workforce Council (HWC), with adequate funding support, could be the logical body to convene a Care Worker Task Force. The Workforce Board, which staffs the HWC, could work with the Council to support a stakeholder process to create a statewide care worker career lattice framework over an 18 to 24-month period.

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

Items that require further study to improve workforce supply, distribution and diversity in the behavioral health workforce.

- *Expand the Welcome Back Center program to additional sites.* Several colleges in Washington provide this program to help foreign-trained professionals enter careers in the U.S. Further study could examine the applicability of this program to address behavioral health workforce needs.
- *Consider the recommendation of the Children's Mental Health Work Group to increase payment for providers offering interventions in community locations.* The interventions may include primary care, education, child welfare, and juvenile justice. The Work Group also called for ensuring that payment can be made when providing services in non-traditional settings by a variety of professionals. (Washington State Legislature, "Children's Mental Health Group", 2016).
- *Consider addressing challenges related to obtaining and maintaining a CDP certificate.* CDPs were among the occupations in the highest demand according to stakeholders. Stakeholders noted that the cost of obtaining and maintaining a CDP certificate may be a barrier. DOH is required to monitor the recovery of impaired practitioners including CDPs through measures such as drug screening and required attendance at for-cost peer support groups, the cost of which is paid by the practitioner and cuts into earnings. For dual credentialed professionals, the cost of maintaining an additional license may be a barrier. Stakeholders suggested creating a pool, maintained by fees in low-cost years to offset certificate costs in high-cost years. Stakeholders also noted that some CDPs are lost to the system because they do not complete training and supervised practice in the five-year window, causing them to take other jobs, wasting the investment in their training. Expanding the window for completion might address this.

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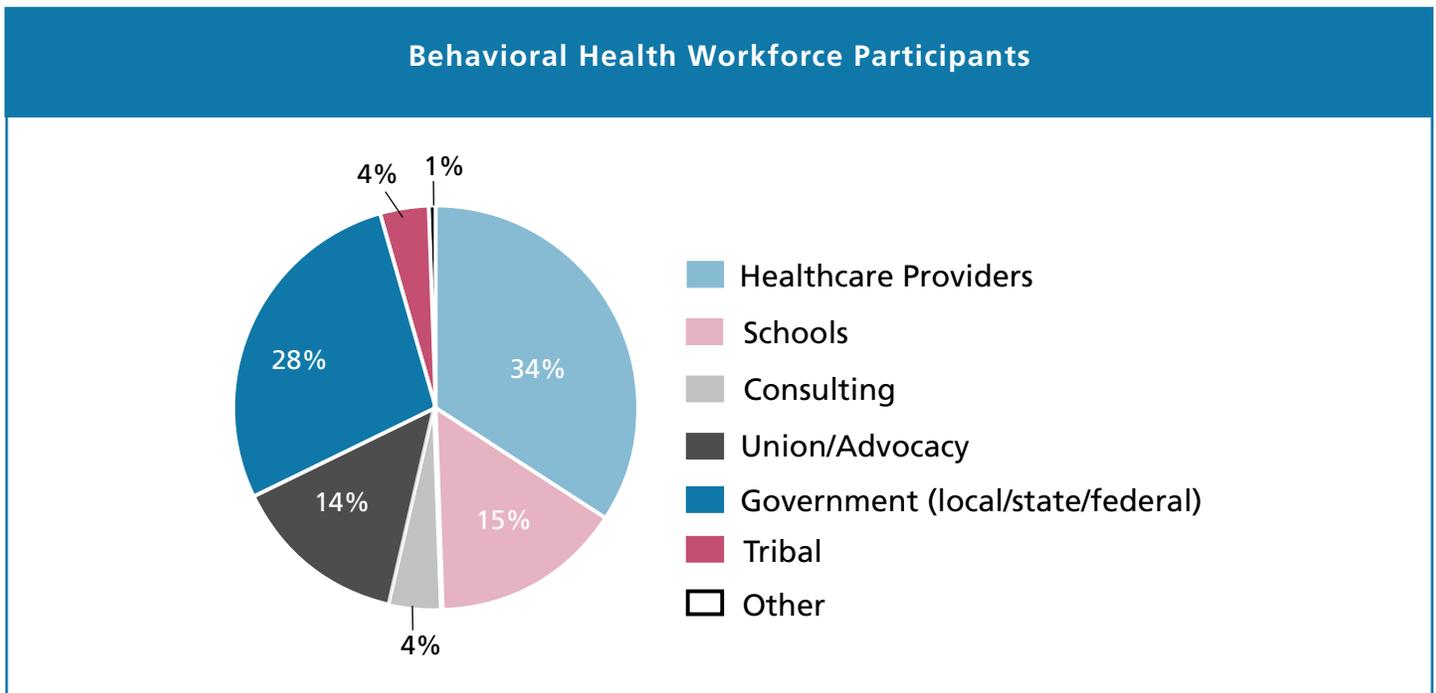
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ATTACHMENT B

OCCUPATIONAL PROFILES

PSYCHIATRISTS

PSYCHOLOGISTS

SOCIAL WORKERS

ADVANCED REGISTERED NURSE PRACTITIONERS (ARNPs)

MENTAL HEALTH COUNSELORS

MARRIAGE AND FAMILY THERAPISTS

CHEMICAL DEPENDENCY COUNSELORS

PEER COUNSELORS

COMMUNITY HEALTH WORKERS

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OCCUPATIONAL PROFILE: PSYCHIATRISTS

Psychiatrists are physicians who can independently provide psychiatric services to patients, or provide consultation support to a primary care team regarding behavioral health treatment. As a physician, psychiatrists can prescribe medication (including psychotropic medications) for patients.

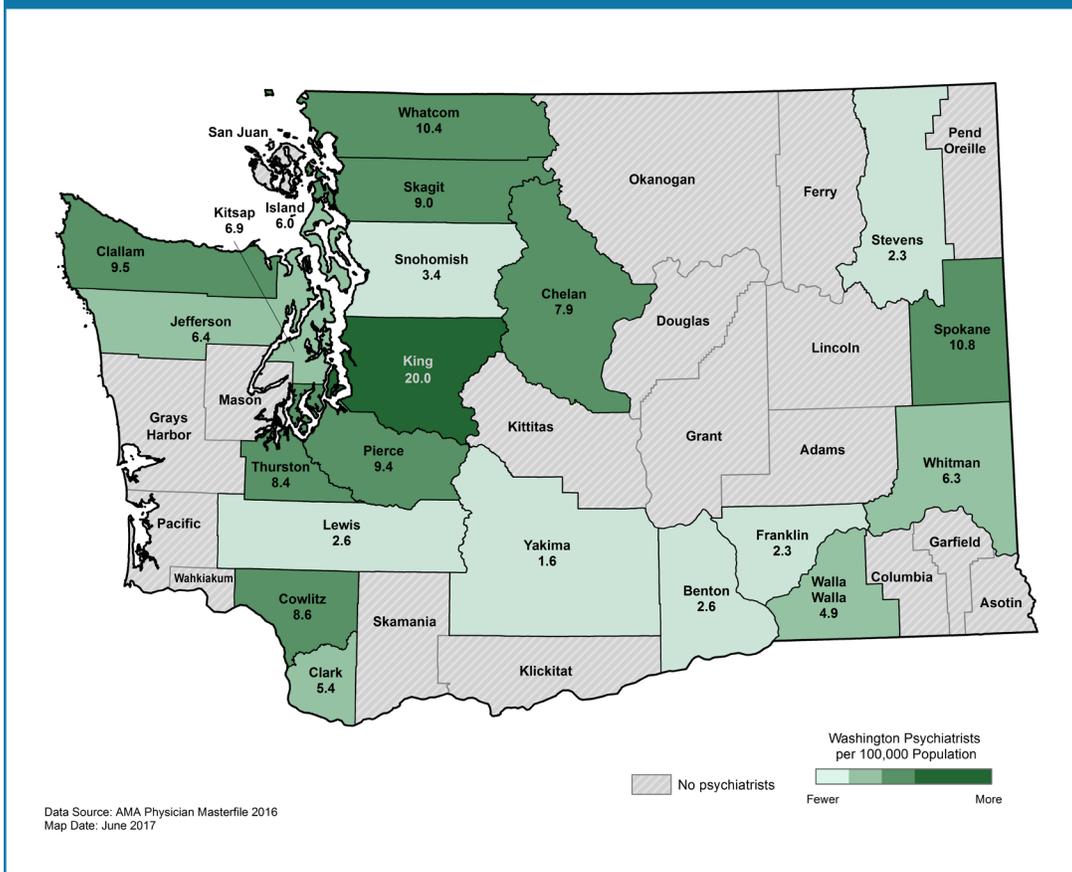
Size, Distribution, and Demographics of Supply

In 2016, there were 727 psychiatrists providing direct patient care in Washington state, a 7.7% increase from 2014. (Skillman & Dahal, 2017) Over half (55.6%) were over the age of 55, and 40.7% were female.

While there were 10.1 psychiatrists per 100,000 persons in the state, there were 11.6 per 100,000 in western Washington counties, and 4.9 per 100,000 in eastern Washington counties, and the number in eastern counties decreased 2.5% between 2014 and 2016. (Skillman & Dahal, 2017) Of the 727 psychiatrists in Washington, only 3.3% practiced in rural areas. This is similar to national data, where there were 15.6 psychiatrists per 100,000 persons overall, but only 3.4 per 100,000 persons in non-core, non-metropolitan areas. (Larson, Patterson, Garberson, & Andrilla, 2016)

Nationally, data from Area Health Resource Files from 2003 and 2013 showed a 10.2% reduction in the median number of psychiatrists per 100,000 residents in hospital referral regions, whereas other physician specialties increased in numbers. (Bishop, Seirup, Pincus, & Ross, 2016)

Figure 1: Washington Psychiatrists per 100,000 Population by County, 2016



Education and Training

As medical doctors, psychiatrists are required to complete the greatest amount of education and training in the behavioral health workforce. Upon completion of a four-year bachelor's degree, they must complete four years at a medical/osteopathic school and pass a standardized national medical licensing exam. They further complete four years of residency in general psychiatry, and are then eligible to sit for board certification in psychiatry. Psychiatrists may also pursue additional training fellowships resulting in certifications in child, geriatric, addiction, and other psychiatric subspecialties.

List: Psychiatric Subspecialties (American Board of Medical Specialties, 2017)

- Addiction psychiatry
- Child and adolescent psychiatry
- Clinical neurophysiology
- Forensic psychiatry
- Geriatric psychiatry
- Hospice and palliative medicine
- Pain medicine
- Psychosomatic medicine
- Sleep medicine

Psychiatrists commonly enter the workforce in the geographical area where they complete their residency, exacerbating the challenge to meet behavioral health workforce demands in less urban areas, far from residency programs.(Cowley, et al., 2016) In Washington in 2016, 41.4% of psychiatrists completed their residency in-state, compared to 15.3% who graduated from medical school in-state. (Skillman & Dahal, 2017)

In 2017, there were two accredited psychiatry residency programs in Washington: the University of Washington program located in Seattle, and the Providence program in Spokane. According to the National Resident Match Program® data, there were 19 first-year psychiatry residencies available and filled in Washington in 2016.(National Resident Matching Program, 2016) As reported in 2015, the University of Washington (UW) Psychiatry Residency program trained 70 residents at a time and graduated 18 per year, 5 of whom were child and adolescent psychiatric fellows.(Goodhew, 2015) In 2017, the state legislature passed ESHB 1713 which calls for the creation of a new residency position for a child and adolescent psychiatrist at Washington State University.

The program in Spokane was originally administered as a “track” of the UW residency program, but in 2016 became an independent community-sponsored program affiliated with UW. Between 1994 and 2014, 41.5% of the graduating psychiatry residents in this track took jobs in the Spokane region; the percentage increases to 50.0% if looking at the last five years of the program only.(Cowley, et al., 2016) The new program had 6 enrollees in 2017 and could total 12 at any one time, with the first 3 psychiatrists set to graduate in 2019.(Goodhew, 2015) Like the former Spokane track, the UW program also had a track located in Boise, Idaho, which graduated 3 residents each in 2017 and 2018, then 4 residents per year thereafter. Between 2010 and 2015, 58.3% of the Idaho residents remained in Idaho on completion of their program.

Beginning new psychiatric residencies in Washington is reportedly challenging as the residency site must pay the salary for the trainee, which limits access to community health centers, forensic, and rural sites.

Practice Characteristics

Psychiatrists work in private practice, clinics, general and psychiatric hospitals, community agencies, courts and prisons, many other settings and commonly in multiple settings.(American Psychiatric Association, 2017) About half of psychiatrists in the U.S. work in private practices, and 60.0% of those are practicing in non-federally funded, non-hospital-based offices.(American Psychiatric Association, 2017; Bishop, Press, Keyhani, & Pincus, 2014)

Data published in 2014 showed that between 2005 and 2010, office-based psychiatrists reduced their acceptance of insurance (private non-capitated insurance and Medicare) by 17.0 – 19.5%. Medicaid acceptance rates did not decline significantly over those years, but psychiatrists were uniformly less likely to accept insurance than other physician types. In 2009 – 2010 in the Western practice region (including Washington), 57.8% of psychiatrists accepted new private non-capitated insurance patients, 40.9% accepted new Medicare patients, and 31.5% accepted new Medicaid patients.(Bishop, Press, Keyhani, & Pincus, 2014) This seriously limited access to psychiatric care for those unable to pay on a cash-only basis.(National Council for Behavioral Health, 2017) While low reimbursement rates are cited as an incentive to have a cash-only practice, the rates are actually similar to other office-based services; however, psychiatric visits, particularly those including psychotherapy, likely take more time to complete than other medical services.(Bishop, Press, Keyhani, & Pincus, 2014)

The 2016 mean annual wage¹ for psychiatrists in Washington was \$213,410.(Bureau of Labor Statistics, “Employment Statistics”, 2017) The 10th percentile mean annual wage was \$107,160 and the 90th percentile mean annual wage datum was not available.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

As medical providers with special training in mental health, psychiatrists can perhaps most readily bridge the gap between physical health care and behavioral health care. Some primary care tasks for which psychiatrists would be well-suited include: minimizing metabolic effects of psychotropic medicines, screening for cardiometabolic risk factors and other conditions (cancer, HIV, vaccination status, substance abuse, nicotine dependence), counseling for lifestyle issues, leading teams in behavioral health homes, and treating common medical conditions in their practice setting.(Druss, 2012)

The shortage of psychiatrists and the unmet mental health needs in primary care is creating tremendous interest in using psychiatrists as consultants to other mental health professionals and primary care providers. In this role, they may provide written, oral, or face-to-face consultation to enhance understanding and management of psychoactive medication, and advise on diagnoses and treatment plans. There are training curricula, resources, and programs for psychiatrists to maximize their effectiveness as consultants, such as the Integrated Behavioral Health Partners (www.ighpartners.org), the University of Washington’s AIMS Center (aims.uw.edu), and the SAMHSA-HRSA Center for Integrated Health Solutions (www.integration.samhsa.gov). However, the high (and increasing) percentage of psychiatrists working in solo, cash-only practices may limit the numbers available to supervise or collaborate with other providers. (National Council for Behavioral Health, 2017)

Telepsychiatry or telemental health is one way that psychiatrists can expand their role geographically as either a consultant or direct service provider. The process of providing behavioral health care from a distance through technology has been found to be effective in a variety of conditions, populations, and settings.(Hilty, et al., 2013) It also appears to increase access to care with high levels of satisfaction and few caveats.(Hilty, et al., 2013) There is a great deal of enthusiasm for the potential of telepsychiatry to address the barrier of too few psychiatrists practicing in rural areas.(Crawford, Sunderji, Lopez, & Soklaridis, 2016; McCarty, Schwartz, & Skillman, 2016) However, psychiatrists (and other highly trained psychiatric providers) must be trained to provide this type of care. Videoconferencing alters the communication style and interactions, and the ability of the psychiatrist to engage emergency protocols. (Shore, 2013) Without formal training and understanding of the expectations and challenges surrounding telepsychiatry, psychiatrists may be hesitant to adopt this therapeutic technique.(Crawford, Sunderji, Lopez, & Soklaridis, 2016) Psychiatrists who want to expand their reach can gain confidence providing telepsychiatry services using materials from sources like the American Psychiatric Association (<https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/telepsychiatry-toolkit-home>).

Demand

Psychiatrist shortages are occurring across the nation.(Japsen, 2017; National Council for Behavioral Health, 2017; Levin, 2017; Lowes, 2015) The problem will likely get worse in Washington, as well as nationally, because over half of the current workforce is approaching retirement (age 55 or over). And, the demand for services is increasing. Stakeholders contacted for this assessment consistently reported difficulty accessing psychiatrists as a problem across a wide range of settings.

State data from the Washington State Employment Security Department indicates that the average annual growth rate for psychiatrists between 2015 – 2020 will be 2.0% and for 2020 – 2025 will be 1.5%.(Washington State Employment Security Department, 2017) This equates to 7 and 6 annual openings due to growth, respectively. ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations.

To address the current shortage and increased projected demand, the National Council for Behavioral Health’s Medical Director Institute convened a panel of diverse psychiatric service experts to highlight key problem areas and root causes, and find specific innovative solutions being implemented in the country. (National Council for Behavioral Health, 2017) They produced “The Psychiatric Shortage: Causes and Solutions”, a report that details solutions for expanding the psychiatric workforce and increasing the efficient delivery of psychiatric services. These solutions are presented to specific stakeholder groups (e.g., payers, psychiatric training programs, health

¹Estimates do not include self-employed workers.

care treatment organizations, etc.), and by more broadly identified change areas (e.g., expanding the psychiatric workforce, increasing efficiency of service delivery, implement and train for innovative models, etc.)

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TECHNICAL NOTES

- Supply Map - Analyses included physicians with a psychiatric specialty, having an in-state practice address (or mail address, when practice was not available), who were age 74 or younger, provided direct patient care, and were not a federal employee.
- Washington State Employment Security Department, SOC code 29-1066 (Psychiatrists).

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McCarty RL, Skillman SM. Washington State's Behavioral Health Workforce - Occupational Profile: Psychiatrists. Center for Health Workforce Studies, University of Washington, Dec 2017.

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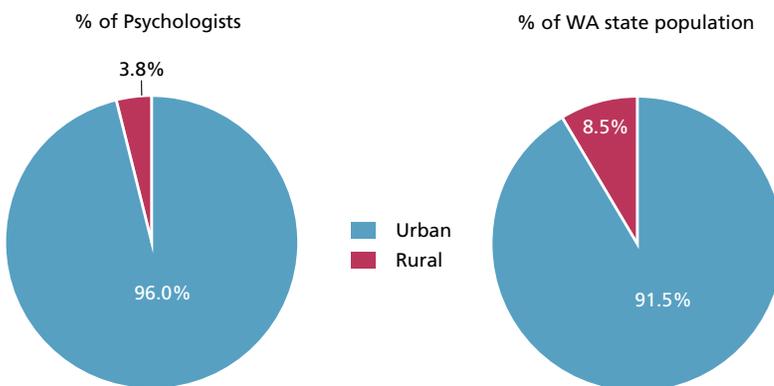
OCCUPATIONAL PROFILE: CLINICAL/COUNSELING PSYCHOLOGISTS

Psychologists are licensed independent mental health clinicians who administer assessments to derive mental health diagnoses, and treat mental disorders, cognitive behavioral and emotional problems, and learning disabilities, using psychotherapy or talk therapy, behavior modification programs, and other therapeutic interventions. They cannot prescribe medications in Washington state.

School psychologists' numbers are often included among psychologists in counts of the workforce, but their training and credentialing requirements in Washington state differs from that of clinical or counseling psychologists. School psychologists may be master's

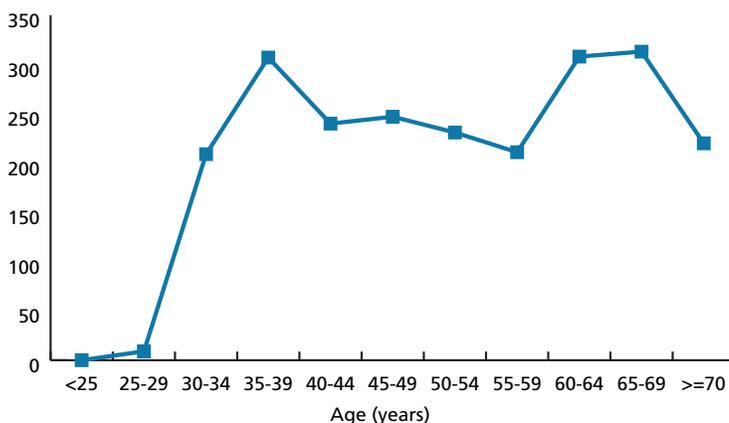
or doctor's level-trained professionals and often receive their degrees through Colleges of Education rather than Departments of Psychology. In addition, school psychologists are credentialed through the Office of Superintendent of Public Instruction rather than the Department of Health. Developmental, forensic, and sports psychologists are smaller groups of specialty clinical psychologists who use assessment techniques in subgroup populations to ascertain psychological aspects of a problem and recommend appropriate treatment or accommodations. Industrial/organizational psychologists, often included in the psychologist workforce data, are a small subspecialty of the profession and are more likely to work in an administrative than a therapeutic role.

Figure 1: Rural/Urban Distribution of Psychologists Compared with the General Population in Washington.



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System. Does not include 0.1% of total individuals for whom location was unknown.

Figure 2: Licensed Psychologists by Age Group in Washington, 2017



Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

Size, Distribution, and Demographics of Supply

In April 2017 there were 2,716 psychologists who held an active license in Washington. The mean age of these Washington psychologists was 52 years old, and 62.6% were female. Nearly all (96.0%) had urban addresses.

TABLE 1. Psychologists with Washington State Licenses, 2017

With address in:

Washington	2,295 (84.5%)
Oregon	109 (4.0%)
Idaho	26 (1.0%)
Other	286 (10.5%)
Total	2,716

Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System.

Of the 39 counties in Washington, 22 (56.4%) had 10 or fewer psychologists; and 8 counties (20.5%) had no psychologists.

There are more psychologists of the age 35-39 years and 60-69 years. Those in the latter range are expected to retire in the near future.

TABLE 2. Distribution, Age, and Sex of Psychologists in Washington by Accountable Community of Health, 2017

Psychologists	N	Population	Rate per 100,000	Mean Age	%, (N) >55 Years	%, (N) Female
Statewide*	2,295	7,183,700	31.9	52	45.8% (1,052)	62.6% (1,436)
Accountable Community of Health (ACH) †						
Pierce County	283	844,490	33.5	49	37.8% (107)	60.1% (170)
North Sound	270	1,206,900	22.4	54	53.7% (145)	61.9% (167)
King County	1,159	2,105,100	55.1	51	41.6% (482)	67.6% (783)
Better Health Together	154	587,770	26.2	54	50.6% (78)	51.9% (80)
Cascade Pacific Action Alliance	132	614,750	21.5	55	59.8% (79)	53.8% (71)
Greater Columbia	96	710,850	13.5	53	54.2% (52)	53.1% (51)
Southwest Washington	104	493,780	21.1	54	47.1% (49)	58.7% (61)
Olympic Community of Health	81	367,090	22.1	59	65.4% (53)	53.1% (43)
North Central	16	252,970	6.3	52	43.8% (7)	62.5% (10)

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* Psychologists with Washington State license address only.

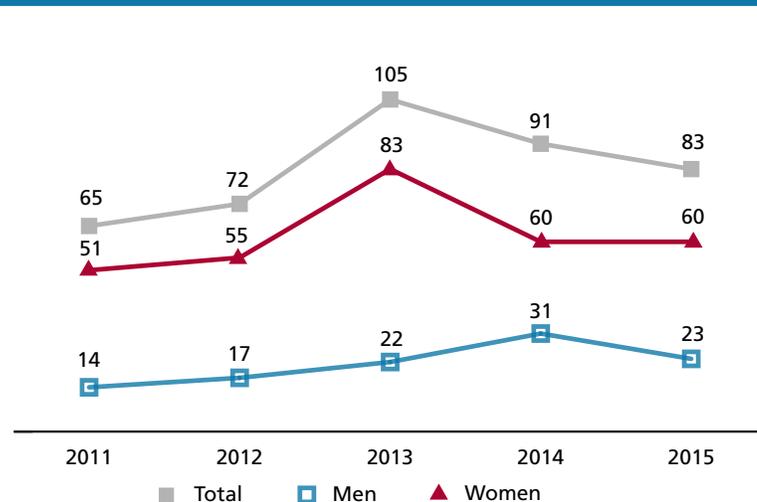
† Counties in multi-county ACH's are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

Education and Training

On completion of a bachelor's degree, to become a professional psychologist one must obtain a doctoral degree (Ph.D., or Psy.D) in psychology from a regionally accredited or equivalent institution. Six training programs offer doctoral degrees in Washington: Antioch

University, Argosy University, Seattle Pacific University, University of Washington, Northwest University (all located in or near Seattle), and Washington State University. Argosy University is no longer accepting new students at the Seattle location and expects its final students in the program to graduate by August 2018. Washington State University is also no longer accepting new students and plans to close the program.

Figure 3: Doctoral Degrees Awarded in Psychology in Washington State, 2011-2015



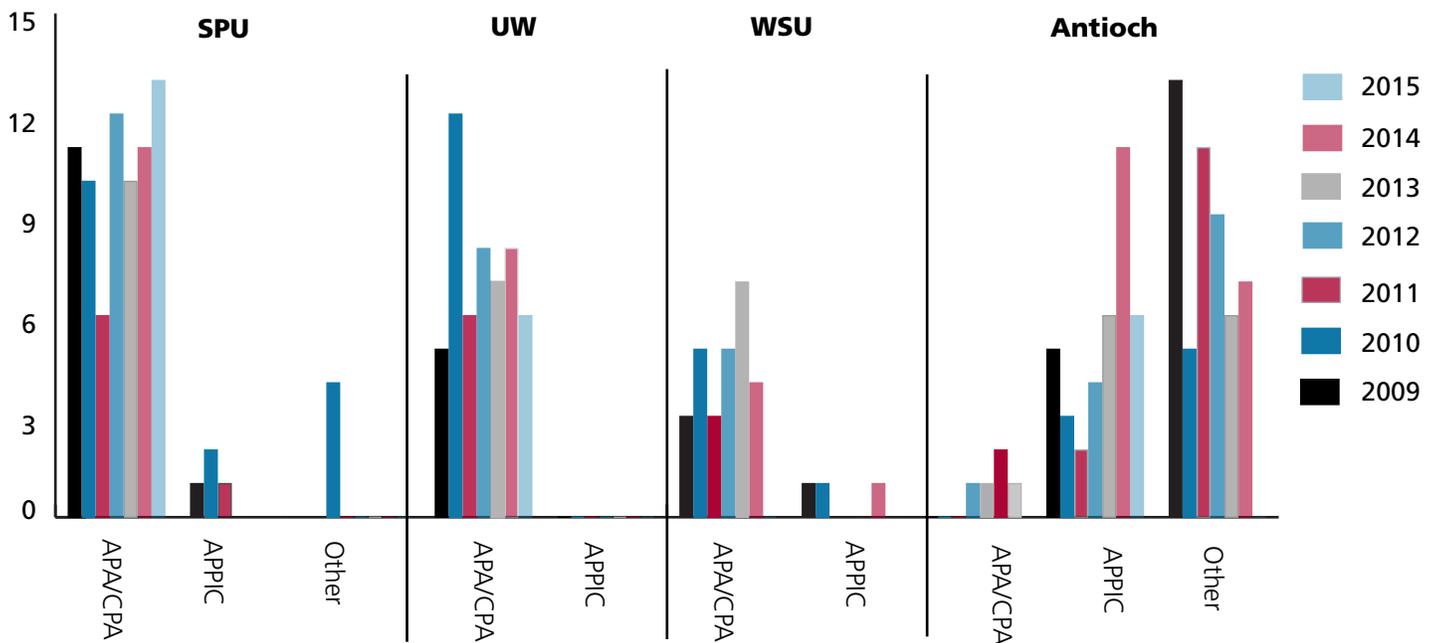
Data source: Integrated Postsecondary Education Data System (IPEDS).

To be eligible for licensure in Washington as an independent mental health clinician, a psychologist must complete a one-year pre-doctoral internship of at least 1,500 hours and an additional 1,500 hours of training through practicums, pre-internship or post-doctoral fellowships. (Washington State Legislature, "Internship", 2009) In total, at least 3,000 hours of supervised experience must be completed as part of or after the didactic education, and at least 300 must be in direct client contact. (Washington State Legislature,

“Practicum”, 2009; Washington State Legislature, “Post-doctoral supervised experience”, 2009) The supervision must be completed by the trainee within 24 months of finishing the educational program.(Washington State Legislature, 2017)

Internships can be approved or accredited by different agencies, and a graduate’s ability to meet credentialing requirements or job qualifications depends on the accreditation level of the completed internship. The most widely accepted accreditation is by the American Psychological Association (APA) or Canadian Psychological Association (CPA). While not an accrediting body, internship site membership in the Association of Psychology Postdoctoral and Internship Centers (APPIC) is also well accepted. Students whose internship is not recognized by the above agencies must demonstrate that the internship met the requirements outlined by statute. (Washington State Department of Health, 2017)

Figure 4: Percentage of Internship Positions Filled by Accreditation Type in Washington State, 2009-2015



Data retrieved from school websites May 3, 2017. Internships displayed here as “Other” are not accredited. Data from Northwest University and Argosy University – Seattle were not available.

For the schools for which internship completion outcomes data were available¹:

- Most internships (79%) completed by Washington clinical/counseling psychology graduates in the past seven years meet APA/CPA/APPIC standards of accreditation; in the past three years, that number rose to 88%.
- 76% of the internships completed were paid.

¹Seattle Pacific University, Antioch University, University of Washington – Seattle Campus

TABLE 3. Association of Psychology Postdoctoral and Internship Centers (APPIC) Members Providing Psychology Internships and Residencies in Washington

Internship	# Full Time Slots Expected Next Class*	APA Accredited
University of Washington, Department of Psychiatry & Behavioral Health	14	X
National Psychology Training Consortium, Cascades Region	9	
Veterans Affairs Puget Sound Health Care System, Seattle Division	9	X
Veterans Affairs Puget Sound Health Care System, American Lake Division	8	X
Madigan Army Medical Center, Department of Behavioral Health	6	X
Western Washington University, Counseling Center	4	
Western State Hospital, Psychology Department	4	X
Fairfax Behavioral Health Psychiatric Hospital, Clinical Psychology	4	
Washington State University, Counseling and Psychological Services	4	X
Walla Walla and Spokane Veteran's Administration Medical Center Psychology Internship	4	X
Central Washington University, Student Medical and Counseling Clinic	3	X
University of Washington, Counseling Center (Seattle)	3	X
Puget Sound Psychiatric Center / Doctoral Clinical Training and Psychiatric Residency	3	
University of Puget Sound, Counseling, Health and Wellness Services	3	X
University of Washington Tacoma, Student Counseling Center	2	
Columbia Valley Community Health, Behavioral Medicine Department	2	X
Pacific Rehabilitation Centers, Behavioral Health Services	0†	

Postdoctoral Program	# Full Time Slots Expected Next Class*	APA Accredited
Confluence Health, Integrated Behavioral Health	6	
Madigan Army Medical Center, Clinical Psychology Residency Program	6	X
Veterans Affairs Puget Sound Health Care System, Seattle Division	13	X
Veterans Affairs Puget Sound Health Care System, American Lake Division	5	
Western State Hospital, Psychology & Center for Forensic Services, Western State Hospital	1	

Data source: APPIC Membership Directory, accessed July 31, 2017.

* "Next Class" determined by start date of next internship cycle per agency, 2017 or 2018.

† Total number of interns for 2016-2017 was 2, have discontinued the program as of 2017-2018 year.

By 2020, the American Psychological Association (APA) intends to require that students of accredited doctoral programs attend only accredited internships.(Hatcher, 2015) While the APA is striving to assist programs to become accredited, the APA requirement may lead to failure of non-accredited APPIC-member internships nationally. One unaccredited internship in Washington reported closure after the 2016-2017 program completion.

Credentialing

On completion of the necessary education and training requirements, candidates must earn a passing score of 500 or higher on the Examination for the Professional Practice in Psychology (EPPP) board exam, which is the recognized standard for the U.S. and Canada. In Washington, they must pass a jurisprudence examination covering professional judgment, knowledge of state laws, and ethics pertaining to the practice of psychology before applying for licensure.

Clinical/counseling psychologists may pursue specialization by becoming board certified. To become board certified, candidates must graduate from an eligible doctoral program, demonstrate licensure, and pursue post-doctoral preparation (training and experience) as needed to meet the standards of the specialty.(American Board of Professional Psychology, 2017)

Clinical Psychology Specialties:

- Clinical Child & Adolescent Psychology
- Clinical Health Psychology
- Clinical Neuropsychology
- Clinical Psychology
- Cognitive & Behavioral Psychology
- Counseling Psychology
- Couple & Family Psychology
- Forensic Psychology
- Geropsychology
- Group Psychology
- Organizational & Business Consulting Psychology
- Police & Public Safety Psychology
- Psychoanalysis in Psychology
- Rehabilitation Psychology
- School Psychology

Practice Characteristics

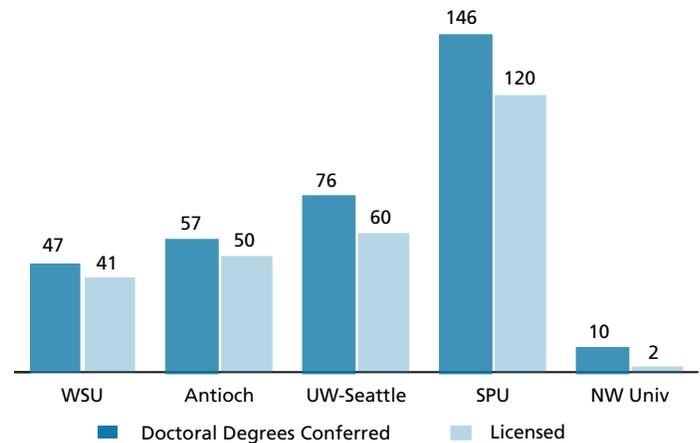
Nearly one in three psychologists is self-employed. (Bureau of Labor Statistics, "Outlook Handbook", 2017) Psychologists may work in government, offices of mental health practitioners, medical clinics and hospitals, and individual and family services. Clinical psychologists focus on the assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders. They are not allowed to prescribe medication in Washington, though a handful of states, including neighboring Idaho, do allow psychologists prescriptive authority. Counseling psychologists generally focus on those with a less clinically severe mental illness as they work through problems at home, workplace, or community.

The 2016 mean annual wage² for clinical, counseling, and school psychologists in Washington was \$69,430. (Bureau of Labor Statistics, "Employment Statistics", 2017) The 10th percentile mean annual wage was \$46,200 and the 90th percentile mean annual wage was \$92,930.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

Competence in primary care psychology has been adopted by the APA to mean "the knowledge, skill, and attitudes – and their integration – that allow an individual to perform tasks and roles as a PC [primary care] psychologist, regardless of service delivery model". (American Psychological Association, 2015) Recognizing that there is limited training related specifically to biomedical service provision in doctoral psychology programs, in 2015, the APA Council of Representatives approved the *Interorganizational Work Group on Competencies for Primary Care Psychology Practice* (Table 4) report delineating the competencies a psychologist needs to be an effective team member in a primary care setting. (American Psychological Association, 2015) Those competencies are:

Figure 5: Number of Psychologists in Washington State with Degrees Conferred and Licensed in 10-year Span, 2004-2016



Data source: Data retrieved from school websites May 3, 2017. Ten-year span ranging from 2004 – 2014, to 2006 – 2016, with the exception of Northwest University reporting over six years rather than ten. Licensure location data not available.

TABLE 4. Psychologist Competencies for Primary Care Settings

Cluster	Competencies
1. Science	Science Related to the Biopsychosocial Approach Research/Evaluation
2. Systems	Leadership/Administration Interdisciplinary Systems Advocacy
3. Professionalism	Professional Values and Attitudes Individual, Cultural and Disciplinary Diversity Ethics in PC Reflective Practice/Self-assessment/Self-care
4. Relationships	Interprofessionalism Building and Sustaining Relationships in PC
5. Application	Practice Management Assessment Intervention Clinical Consultation
6. Education	Teaching Supervision

Data source: American Psychological Association, 2015

²Estimates do not include self-employed workers.

The report also describes each competency's "essential components" and provides examples of how those components could be demonstrated ("behavioral anchors"). In addition to helping training programs better focus on preparing psychologists to work in an integrated setting, these competencies are expected to inform clinical and administrative leaders of the role a psychologist could play in primary care settings.

Demand

State data from the Washington State Employment Security Department (ESD) indicates that the average annual growth rate for clinical, counseling, and school psychologists between 2015 – 2020 will be 2.1% and for 2020 – 2025 will be 1.7%. (Washington State Employment Security Department, 2017) This equates to 89 and 83 annual openings due to growth, respectively. ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations.

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TECHNICAL NOTES

1. Washington State psychologist data are from the Washington State Department of Health, Health Professions Licensing Data System, April 2017, as analyzed by the Washington State Office of Financial Management. All analyses include psychologists ages 18 – 75 years with active license status and expiration of license \geq 2017.
2. Washington population data are from the Washington State Office of Financial Management, 2016 data.
3. Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.
4. Included IPEDS CIP code 42.00 (Psychology); Doctor's Degree, both professional and scholar. Data from 2015 provisional, data from 2011 – 2014 final.
5. Internship (Figure 4) and 10-year Degrees Conferred and Licensed data (Figure 5) compiled from outcomes disclosure summaries downloaded from school websites May 3, 2017.
6. Washington State Employment Security Department, SOC code 19-3031 (Clinical, Counseling, and School Psychologists).

FUNDING

This study was funded through contract # IAA-860-17 between the Washington Workforce Training and Education Coordinating Board and the University of Washington, supported by Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds.

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OCCUPATIONAL PROFILE: SOCIAL WORKERS

In Washington state, social workers' roles may vary widely depending on credentials, specialty, and the configuration of the practice. Washington state licenses two types of social workers: Licensed Advanced Social Worker (LASW) and Licensed Independent Clinical Social Worker (LICSW). The LASW is a non-clinical license, and these professionals might provide case management, community organization and advocacy, and biopsychosocial assessments. They are not allowed to conduct psychotherapy independently, but may provide psychotherapy under supervision. LICSWs are clinical mental health professionals who are allowed to diagnose and treat emotional and mental disorders, and bill for their services independently. (Washington State Legislature, 2013)

Size, Distribution, and Demographics of Supply

In April 2017, there were 134 licensed advanced social workers (LASW) who held an active license in Washington (Table 1). Thirty-eight percent (38.1%) of the LASW's licensed in Washington had mailing addresses in Oregon, suggestive of an opportunity or incentive for Oregon social workers to obtain a Washington LASW license.

The mean age of Washington's LASWs was 49 years old, and 89.6% were female. An additional 232 individuals held a conditional Washington license as a licensed social work associate advanced (LSWAA)—about 72.9% of the total Washington LASW workforce. The mean age of Washington's LSWAAs was 44 years old, and 79.2% were female. One hundred percent of Washington's LASWs and 94.7% of LSWAAs worked in urban settings.

TABLE 1. Licensed Advanced Social Workers (LASW) and Associates (LASWA) with Washington State Licenses, 2017

	LASW	LSWAA
With mailing address in:		
Washington	77 (57.5%)	207 (89.2%)
Oregon	51 (38.1%)	14 (6.0%)
Idaho	3 (2.2%)	1 (0.4%)
Other	3 (2.2%)	10 (4.3%)
Total	134	232

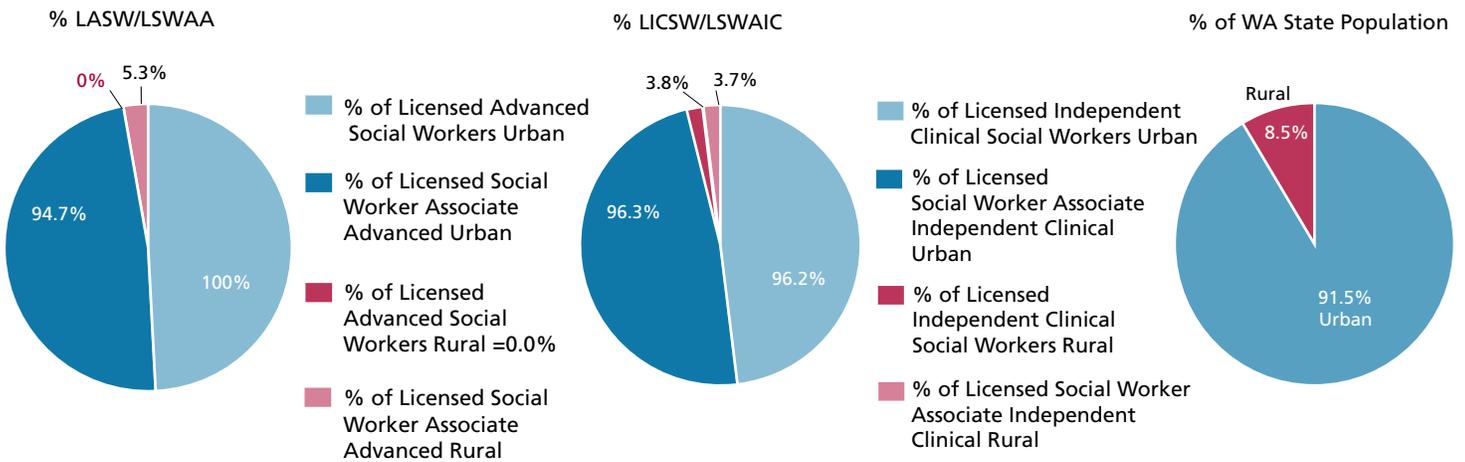
Licensed Clinical Independent Social Workers (LICSW) and (LSWAIC) Associates with Washington State Licenses, 2017

	LICSW	LSWAIC
With mailing address in:		
Washington	3,619 (89.9%)	1,555 (94.8%)
Oregon	149 (3.7%)	34 (2.1%)
Idaho	38 (0.9%)	7 (0.4%)
Other	221 (5.5%)	45 (2.7%)
Total	4,027	1,641

Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System

In April 2017, there were 4,027 licensed independent clinical social workers (LICSWs) who held an active license in Washington. The mean age of Washington's LICSWs was 52 years old, and 82.0% were female. An additional 1,641 individuals held a conditional Washington license as a licensed social work associate independent clinical (LSWAIC) – about 30.1% of the total Washington LICSW workforce. The mean age of Washington's LSWAICs was 39 years old, and 83.0% were female. 96.2% of Washington's LICSW and 96.3% of LSWAICs worked in urban settings.

Figure 1: Rural/Urban Distribution of Social Workers, Social Worker Associates and the General Population in Washington



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System. Does not include the <0.1% of total SWs for whom location was unknown.

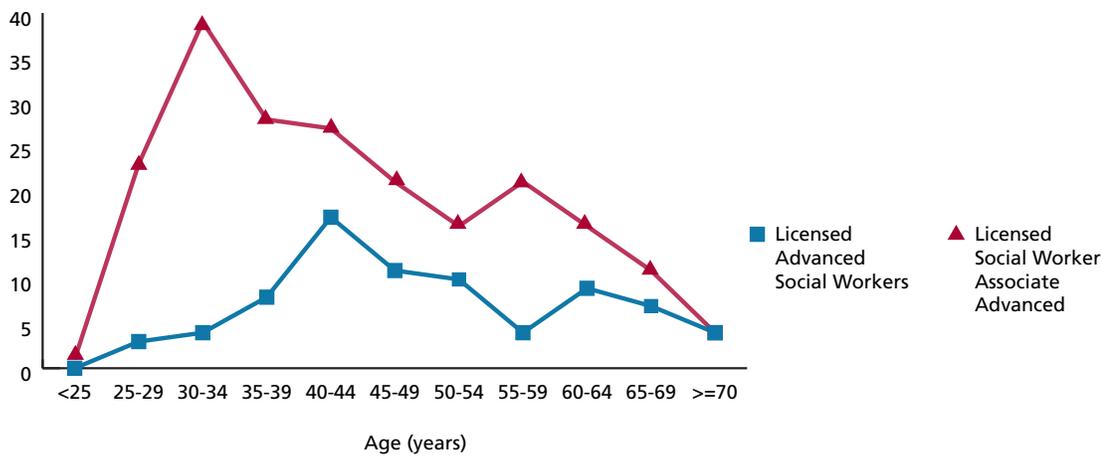


Figure 2: Age Distribution of Licensed Advanced Social Workers and Associates in Washington State, 2017

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

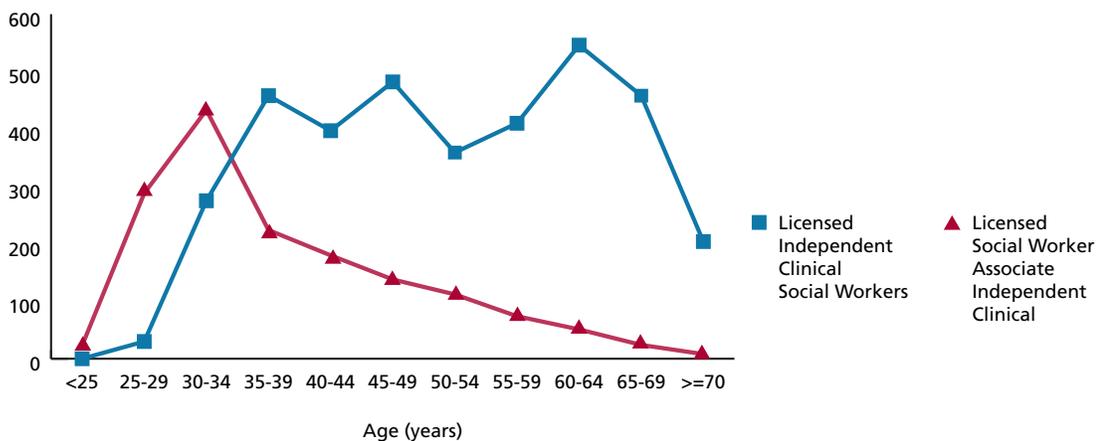


Figure 3: Age Distribution of Licensed Independent Clinical Social Workers and Associates in Washington State, 2017

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

TABLE 2. Distribution, Age, and Sex of Social Workers and Social Worker Associates in Washington by Accountable Community of Health, 2017.

Licensed Advanced Social Worker	N	Population	Rate per 100,000	Mean Age	% (N) > 55 Years	%, (N) Female
Statewide*	77	7,183,700	1.1	49	31.2% (24)	89.6% (69)
By Accountable Community of Health (ACH)†						
Pierce County	6	844,490	0.7	45	16.7% (1)	83.3% (5)
North Sound	15	1,206,900	1.2	52	33.3% (5)	100.0% (15)
King County	31	2,105,100	1.5	48	22.6% (7)	83.9% (26)
Better Health Together	8	587,770	1.4	47	25.0% (2)	75.0% (6)
Cascade Pacific Action Alliance	6	614,750	1.0	56	66.7% (4)	100.0% (6)
Greater Columbia	2	710,850	0.3	60	100.0% (2)	100.0% (2)
Southwest Washington	6	493,780	1.2	50	33.3% (2)	100.0% (6)
Olympic Community of Health	1	367,090	0.3	-	0.0% (0)	100.0% (1)
North Central	2	252,970	0.8	52	50.0% (1)	100.0% (2)
Licensed Social Worker Associate Advanced	N	Population	Rate per 100,000	Mean Age	% (N) > 55 Years	%, (N) Female
Statewide*	207	7,183,700	2.9	44	25.1% (52)	79.2% (164)
By Accountable Community of Health (ACH)†						
Pierce County	22	844,490	2.6	38	4.5% (1)	77.3% (17)
North Sound	31	1,206,900	2.6	43	22.6% (7)	80.6% (25)
King County	76	2,105,100	3.6	41	15.8% (12)	81.6% (52)
Better Health Together	20	587,770	3.4	46	30.0% (6)	80.0% (16)
Cascade Pacific Action Alliance	21	614,750	3.4	48	42.9% (9)	76.2% (16)
Greater Columbia	20	710,850	2.8	48	40.0% (8)	80.0% (16)
Southwest Washington	8	493,780	1.6	57	62.5% (5)	75.0% (6)
Olympic Community of Health	7	367,090	1.9	55	57.1% (4)	71.4% (5)
North Central	2	252,970	0.8	41	-	50.0% (1)
Licensed Independent Clinical Social Worker	N	Population	Rate per 100,000	Mean Age	% (N) > 55 Years	%, (N) Female
Statewide*	3,619	7,183,700	50.4	52	44.7% (1,618)	82.0% (2,969)
By Accountable Community of Health (ACH)†						
Pierce County	349	844,490	41.3	51	41.5% (145)	79.9% (279)
North Sound	444	1,206,900	36.8	54	55.9% (248)	82.0% (364)
King County	1,759	2,105,100	83.6	51	40.6% (714)	84.1% (1,480)
Better Health Together	298	587,770	50.7	51	44.3% (132)	79.2% (236)
Cascade Pacific Action Alliance	188	614,750	30.6	53	47.3% (89)	77.1% (145)
Greater Columbia	238	710,850	33.5	51	42.9% (102)	81.1% (193)
Southwest Washington	147	493,780	29.8	53	48.3% (71)	81.0% (119)
Olympic Community of Health	155	367,090	42.2	57	60.6% (94)	77.4% (120)
North Central	41	252,970	16.2	54	56.1% (23)	80.5% (33)

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Table 2. Continued

TABLE 2. Distribution, Age, and Sex of Social Workers and Social Worker Associates in Washington by Accountable Community of Health, 2017.

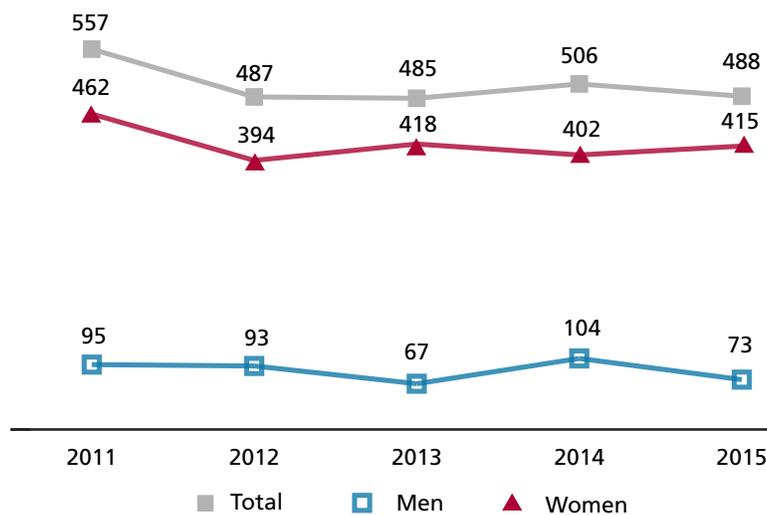
Licensed Social Worker Associate Independent Clinical	N	Population	Rate per 100,000	Mean Age	% (N) > 55 Years	%, (N) Female
Statewide*	1,555	7,183,700	21.6	38	10.1% (157)	83.0% (1,290)
By Accountable Community of Health (ACH)†						
Pierce County	204	844,490	24.2	39	9.8% (20)	89.2% (182)
North Sound	224	1,206,900	18.6	39	10.7% (24)	82.6% (185)
King County	632	2,105,100	30.0	36	6.0% (38)	81.8% (517)
Better Health Together	172	587,770	29.3	40	14.0% (24)	80.8% (139)
Cascade Pacific Action Alliance	95	614,750	15.5	42	14.7% (14)	78.9% (75)
Greater Columbia	88	710,850	12.4	43	17.0% (15)	79.5% (70)
Southwest Washington	64	493,780	13.0	43	17.2% (11)	89.1% (57)
Olympic Community of Health	50	367,090	13.6	44	16.0% (8)	86.0% (43)
North Central	26	252,970	10.3	41	11.5% (3)	84.6% (22)

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* LASWs, LSWAAs, LICSWs, and LSWAICs with Washington State license address only.

† Counties in multi-county ACH's are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

Figure 4: Master's Degrees in Social Work in Washington State, 2011 – 2015



Data source: Integrated Postsecondary Education Data System (IPEDS). 2015 & 2016 Argosy University - Seattle Master of Science in Human Services degree graduates excluded.

Education and Training

In 2016, there were four schools offering master's degrees in social work (MSW) (see Table 3). The University of Washington (UW) – Seattle Campus also awarded 35 doctoral degrees in social work in a program categorized by the school as research/scholarship focused. Eastern Washington University offers a full-time MSW program at their Cheney/Spokane campus, and part-time online/in-person hybrid MSW programs at their Vancouver and Everett campuses, and in Spokane. Walla Walla University's program in Washington is also a hybrid in-person and online model. UW – Seattle offers full-time and part-time in-person MSW tracks. UW – Tacoma offers a part-time in-person track. All of these programs are accredited by the Council on Social Work Education (CSWE).

TABLE 3. Washington Schools Offering Master’s Degrees in Social Work

School	# Graduations 2016	CSWE Accredited
Eastern Washington University	66	X
Walla Walla University	84	X
University of Washington-Seattle Campus	219	X
University of Washington-Tacoma Campus	52	X*

Data source: Integrated Postsecondary Education Data System (IPEDS), 2016 provisional data; Master’s level graduates only.
 * Under the auspices of the University of Washington – Seattle campus program

Credentialing

Washington state requires program accreditation by the Council on Social Work Education (CSWE) for graduates to be eligible for licensure.

While a graduate is gaining the supervised experience necessary to become a licensed social worker, they may apply for conditional licensure as an associate (LSWAA/LSWAIC) by declaring they are working towards full licensure. Associates may provide and be paid for services only under approved supervision. Associate credentials may not be renewed more than six times.

LSWAAs must complete 3,200 hours of postgraduate, supervised experience to be eligible for LASW licensure, including 800 hours of direct client contact.(Washington State Legislature, “Supervised postgraduate experience requirements”, 2017) LSWAICs must complete 4,000 hours of postgraduate, supervised experience over a period of at least three years, including 1,000 hours of direct client contact, and 130 hours of direct supervision by an approved clinical supervisor, to apply for their LICSW.(Washington State Legislature, “Approved supervisor standards”, 2017)

Upon providing proof of education, required supervised experience, and application approval, applicants for a license in social work are required to complete a board examination from the American Association of Social Work Boards (ASWB): the advanced generalist exam for LASW, and the clinical exam for LICSW. Alternatively, applicants who obtained the Board Certified Diplomate in Clinical Social Work from the American Board of Examiners in Clinical Social Work (ABECSW) or the Diplomate in Clinical Social Work (DCSW) or Qualified Clinical Social Work (QCSW) from the National Association of Social Workers (NASW) are considered to have met the education and postgraduate experience requirements to be eligible for the ASWB board exams. Passing exam scores must be sent directly from ASWB to the Department of Health.

Practice Characteristics

Social workers identify people and communities in need, help connect needs to resources, respond to crises in abuse and mental health, implement programs to ensure basic social services, provide psychotherapy, and more. In 2016, 46.6% of all social workers worked in child, family, and school occupations, 25.9% in healthcare, and 18.1% in mental health/substance abuse.(Bureau of Labor Statistics, “Outlook Handbook”, 2017) The largest employers of social workers were providers of individual and family services, state government, ambulatory healthcare services, local government, and hospitals.(Bureau of Labor Statistics, “Outlook Handbook”, 2017)

In behavioral health specifically, social workers who are licensed to provide independent clinical psychotherapy may work in private practice or agency settings. While clinical social workers are most frequently mentioned as providing behavioral health services, other master’s degreed social workers might provide clinical or casework social services under the consultation and supervision of a licensed independent clinical social worker. Social workers may work in healthcare settings to oversee support groups, and help patients understand their diagnoses, find support resources, make necessary adjustments to accommodate their medical condition, and generally provide a holistic viewpoint on a patient’s wellness for a healthcare team. A unique characteristic of LICSWs is their status as the only master’s level mental health provider eligible to bill Medicare for services under current Center for Medicare and Medicaid Services rules.(Centers for Medicare & Medicaid Services, 2017)

The 2016 mean annual wage¹ for mental health and substance abuse social workers in Washington was \$51,980.(Bureau of Labor Statistics, “Employment Statistics”, 2017) The 10th percentile mean annual wage was \$32,140 and the 90th percentile mean annual wage was \$74,800.

¹Estimates do not include self-employed workers.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

Social workers currently play a role in medical settings, and as such, social workers may represent the most currently integrated master's level mental health professionals in the physical health setting. For example, a 2017 University of Washington study examining who served in the Care Manager role in the Washington State Mental Health Integration Program (MHIP) program found that 46.6% of those reporting were social workers.(RuralPREP, 2017) MHIP integrates mental health screening and treatment using the Collaborative Care Model in safety-net primary care settings.

A survey of social workers in integrated primary care settings reported that a majority of their core competencies for behavioral health consultation in these settings was learned on the job.(Horovitz & Manoleas, 2013) The most commonly endorsed useful competencies for the integrated setting were:

- Knowledge of psychotropic medications
- Cultural competence
- Knowledge of family systems
- Psychoeducation
- Motivational interviewing
- Relaxation training
- Team-based care

Further, “Over 80% of respondents rated knowledge of psychosocial sequelae of chronic illness, knowledge about psychotropic medication, skills in team-based care, cultural competence, and psychoeducation as important or very important competency areas at their job.”(Horovitz & Manoleas, 2013) In addition to specific interventions and increased knowledge of psychopharmacology and chronic disease management, training in interdisciplinary team practice was commonly requested. Other needed skills may include having a thorough understanding of psychiatric diagnoses to facilitate confident assessments in fast-paced medical environments, and honing one's interviewing skills.(Reardon, 2010)

The Council on Social Work Education launched the “Social Work and Integrated Care Project” in 2012, and has a robust program to teach integrated care curriculum in more than 30 schools of social work, establish a learning network for students and faculty, and place students in integrated field work sites.(Council on Social Work Education, 2017) Implementation of education curricula to prepare social workers for work in integrated settings is increasing.(Putney, et al., 2017; Rishel & Hartnett, 2017; Held, Mallory, & Cummings, 2017; Mattison, Weaver, Zebrack, Fischer, & Dubin, 2017) However, the lack of available sites for field placement in integrated care settings, an essential part of training for successful integration of social work and physical health, may become a barrier.(Smith-Osborne & Daniel, 2017; Putney, et al., 2017)

Demand

Washington's “early warning” system of health workforce demand changes, the Washington Health Workforce Sentinel Network, allows employers to report workforce shifts and high-priority needs.(Workforce Training & Education Coordinating Board, 2017) In most regions of the state, behavioral health and community health clinic sentinels consistently ranked SWs to be among the top occupations with exceptionally long vacancies and increased demand in their facilities. Reasons for increased demand include Medicaid expansion, new roles with behavioral health integration, and high turnover in safety net sites. Sentinels reported requiring increased training for new and incumbent SWs in areas related to integration and healthcare transformation, including evidence-based practices, use of health information technology, and new documentation requirements.

State data from the Washington State Employment Security Department (ESD) estimates that the social work profession will experience growth (see Table 4).(Washington State Employment Security Department, 2017) ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations.

TABLE 4. Annual Growth Rates and Annual Openings Due to Growth for Social Workers, 2015 – 2020 and 2020 – 2025

SOC Code	Occupational Title	Average Annual Growth Rate 2015 - 2020	Average Annual Growth Rate 2020 - 2025	Average Annual Opening Due to Growth 2015 - 2020	Average Annual Opening Due to Growth 2020-2025
21-1000	Counselors, Social Workers, and Other Community and Social Service Specialists	1.6%	1.3%	856	759
21-1021	Child, Family, and School Social Workers	1.3%	1.2%	116	108
21-1022	Healthcare Social Workers	1.8%	1.6%	69	68
21-1023	Mental Health and Substance Abuse Social Workers	1.7%	1.3%	48	40
21-1029	Social Workers, All Other	0.8%	0.6%	7	5

Data source: Washington State Employment Security Department 2017 Projections.

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TECHNICAL NOTES

- Washington State social worker and social worker associate data are from the Washington State Department of Health, Health Professions Licensing Data System, April 2017, as analyzed by the Washington State Office of Financial Management. All analyses include SW/SWAs ages 18 – 75 years with active license status and expiration of license \geq 2017.
- Washington population data are from the Washington State Office of Financial Management, 2016 data.
- Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.
- Included IPEDS CIP code 44.07 (Social Work) and 51.1503 (Clinical/Medical Social Work), Masters awards only, 1st/2nd major, no imputation variables. 2011 – 2015 Final Release Data, 2016 Provisional Data Release.

FUNDING

This study was funded through contract # IAA-860-17 between the Washington Workforce Training and Education Coordinating Board and the University of Washington, supported by Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds.

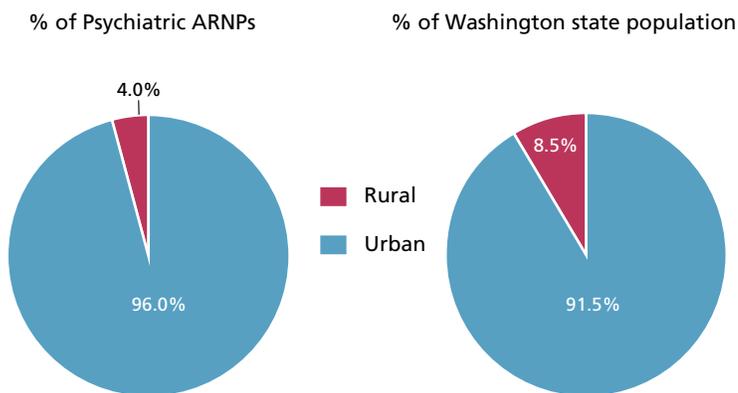
SUGGESTED CITATION

McCarty RL, Skillman SM. Washington State's Behavioral Health Workforce - Occupational Profile: Social Workers. Center for Health Workforce Studies, University of Washington, Dec 2017.

OCCUPATIONAL PROFILE: PSYCHIATRIC ADVANCED REGISTERED NURSE PRACTITIONERS (ARNPs)

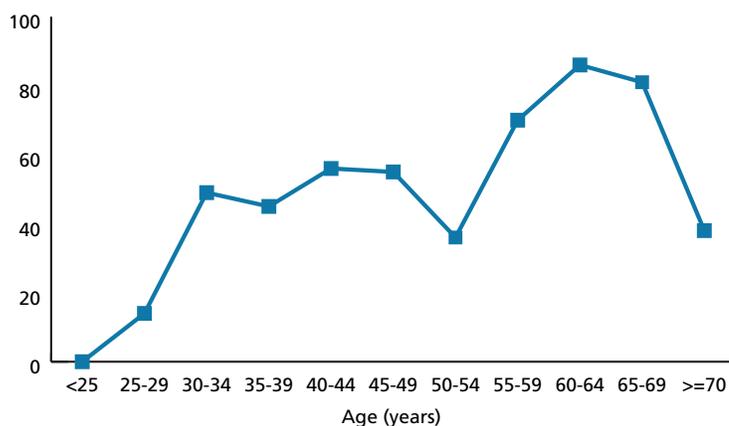
As one of the few health professions able to prescribe psychiatric and substance use disorder pharmaceutical treatments, advanced registered nurse practitioners (ARNPs) with behavioral health certifications assume a variety of clinical roles. In Washington State, they may diagnose mental illnesses, provide psychiatric care, prescribe psychotropic medications, administer risk assessments, and help coordinate treatment between primary care providers and other behavioral health providers. ARNPs may directly provide psychiatric care, or they may serve in the role of a care coordinator or manager.

Figure 1: Rural/Urban Distribution of Psychiatric ARNPs and the General Population in Washington State



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System.

Figure 2: Age Distribution of Licensed Psychiatric ARNPs in Washington State, 2017



Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System.

Size, Distribution, and Demographics of Supply

In April 2017, there were 670 ARNPs who held an active Washington state license with a psychiatric subcategory designation, of which 79.1% had addresses in Washington (Table 1). Psychiatric ARNPs were approximately 8.6% of all ARNPs (including certified nurse midwives, certified nurse specialists, certified registered nurse anesthetists and certified nurse practitioners) and 10.7% of certified nurse practitioners with active Washington licenses in 2017.¹ The mean age of the Washington psychiatric ARNPs was 53 years old, and 87.2% were female. Nearly all (96.0%) had urban addresses.

About half of these nurses (321) held other credentials in Washington in the past, 101 as registered nurse temporary practice permits and 50 as licensed practical nurses, among others. Several also held certifications in mental health professions, including counselor registration (57), agency affiliated counselor registration (13), chemical dependency professional trainee (1), marriage and family

TABLE 1. Psychiatric ARNPs with Washington State Licenses, 2017

With address in:	
Washington	530 (79.1%)
Oregon	37 (5.5%)
Idaho	8 (1.2%)
Other	95 (14.2%)
Total	670

Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System.

¹Mary Sue Gorski, Nursing Consultant Advisor, Washington State Nursing Care Quality Assurance Commission, personal communication, October 30, 2017

counselor certificate (1), mental health counselor certificate or license (13), and licensed independent clinical social worker license (1). The early supplementary credentials and the age distribution showing fewer younger psychiatric ARNPs suggest that the occupation is more advanced in the career pathway. This may raise supply concerns when the 60+ year old ARNPs retire, unless other occupations absorb their role.

TABLE 2. Distribution, Age, and Sex of Psychiatric ARNPs in Washington by Accountable Community of Health

Advanced Registered Nurse Practitioners	N	Population	Rate per 100,000	Mean Age	% (N) >55 Years	% (N) Female
Statewide*	530	7,183,700	7.4	53	51.9 % (275)	87.2% (462)
Accountable Community of Health (ACH) †						
Pierce County	60	844,490	7.1	53	58.3% (35)	86.7% (52)
North Sound	61	1,206,900	5.1	57	67.2% (41)	90.2% (55)
King County	214	2,105,100	10.2	50	44.4% (95)	89.7% (192)
Better Health Together	41	587,770	7.0	54	53.7% (22)	87.8% (36)
Cascade Pacific Action Alliance	38	614,750	6.2	57	65.8% (25)	86.8% (33)
Greater Columbia	43	710,850	6.0	52	46.0% (20)	86.0% (37)
Southwest Washington	31	493,780	6.3	53	48.4% (15)	77.4% (24)
Olympic Community of Health	25	367,090	6.8	55	60.0% (15)	88.0% (22)
North Central	17	252,970	6.7	50	41.2% (7)	64.7% (11)

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* ARNPs with Washington State license address only.

† Counties in multi-county ACHs are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

Education/Training

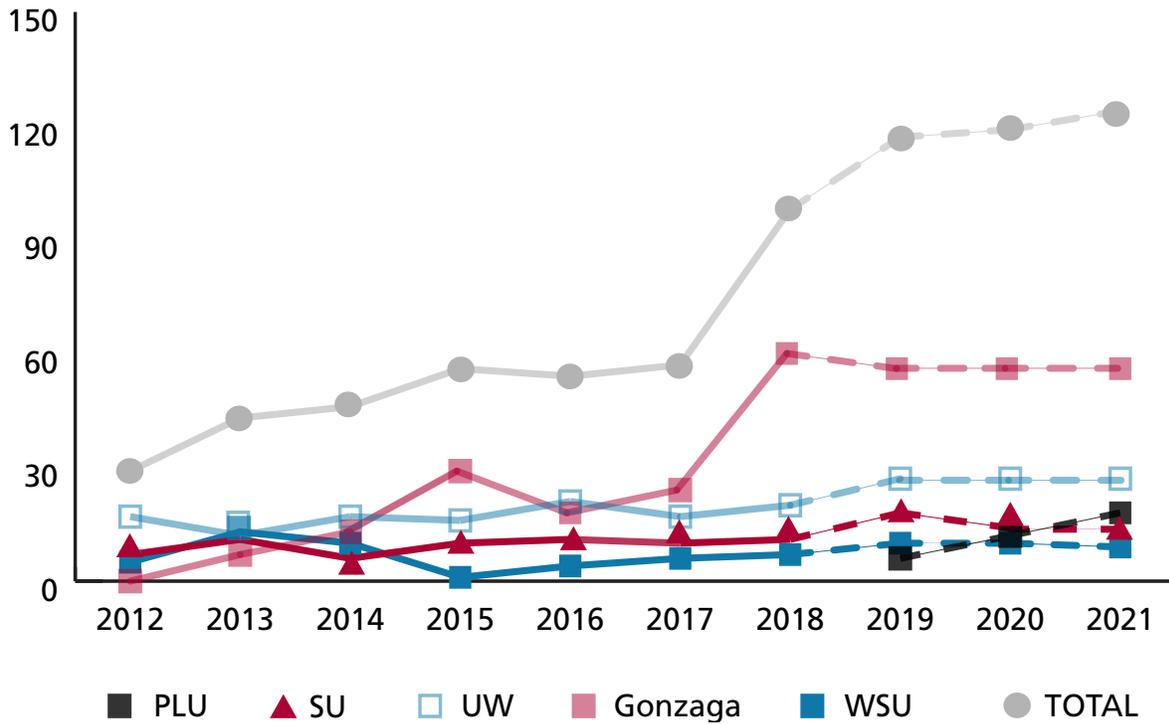
There are five psychiatric nurse practitioner educational programs in Washington accredited by the Commission on Collegiate Nursing Education: Pacific Lutheran University, Seattle University, Gonzaga University, University of Washington, and Washington State University. The Washington State University program has campuses in Spokane, Tri-Cities, and Vancouver. It is a hybrid program model where students are on campus once per month and the programs are open to out-of-state students, but applicants must have a Washington registered nurse license. Gonzaga University’s programs offer online instruction with required in-person immersion experience and evaluation, and are open to enrollment from ten Western states. Since 2013, an average of 31% of Gonzaga graduates were from Washington.² All five universities offer programs leading to the specialty credential of Psychiatric Mental Health Nurse Practitioner (PMHNP). University of Washington and Washington State University also provide post-doctoral certificate programs leading to a PMHNP, and Gonzaga University offers a Master in Science in Nursing program leading to a PMHNP designation. Program enrollments vary based on prerequisite requirements, program faculty capacity, and the availability of preceptors for clinical experiences.

Advanced registered nurse practitioners who received PMHNP education from out-of-state nursing programs are approved for clinical practice placements by the Washington State Nursing Care Quality Assurance Commission. (Washington State Department of Health,

²Rachel Young, Academic Operations Specialist, Gonzaga University, personal communication, October 17, 2017.

2017) In 2015, there were five out-of-state PMHNP students completing their clinical or practice experiences in Washington state, and eight students in 2016.³ Data enumerating the students in Washington enrolled in out-of-state (online) nursing programs are not available.

Figure 3: Washington PMHNP Program Graduates and Projected Graduates, 2012 - 2021



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
PLU								6	12	18
SU	7	11	6	10	11	10	11	18	14	14
UW	17	12	17	16	21	17	20	27	27	27
Gonzaga	n/a	7	13	29	18	24	60	56	56	56
WSU	5	13	10	1	4	6	7	10	10	9
TOTAL	29	43	46	56	54	57	98	117	119	124

- Data were reported by PMHNP programs directly for the purpose of creating this profile
- Italicized are projected totals
- Light blue cells are projected totals carried forward from last reported projection for estimation only
- PLU – program began 2016, first graduates 2019; full program cohort of 18 students expected in 2021
- Gonzaga – data not available (n/a) 2012; added DNP program in 2014 for combined program totals beginning 2018 (gray cells)
- WSU – transitioning from masters to doctorate program in 2012, total includes both programs beginning 2016 (gray cells)

Psychiatric ARNPs are well poised to assume major roles in the integration of physical and behavioral health, having advanced training in both areas. Their small numbers may limit their impact on behavioral health delivery in Washington State—although the projected increase in graduates from educational programs in Washington is promising.

³Mary Sue Gorski, Nursing Consultant Advisor, Washington State Nursing Care Quality Assurance Commission, personal communication, October 19, 2017

When contacted to collect completion data, multiple schools remarked that the greatest limitation to increasing enrollment in their PMHNP programs was lack of supervised clinical placement sites and preceptorships. The Washington State Department of Health also remarked on this challenge in their 2016 Nursing Education Programs Annual School Report.(Washington State Department of Health, “2015-2016 Annual School Report”, 2017) Schools reported that precepting can be burdensome due to unreimbursed expenses incurred and disruption to work flows on site. Clinicians may not feel competent to serve as preceptors, and online training programs are available to help newer preceptors gain confidence in this area. The Washington Nurse Practitioner Education Alliance is exploring solutions to challenges in clinical site placement. The Washington Nurse Care Quality Assurance Commission is reviewing the allowance of potential exceptions to preceptorship approval rules, and the impact it may have on the available pool of qualified preceptors and quality of training.⁴

Credentialing

To be licensed to practice as an ARNP in Washington, one must have a current, unencumbered Registered Nurse (RN) license, provide a university transcript verifying advanced practice preparation, provide proof of current national advanced practice certification through a commission-approved certifying body, and if endorsing as a licensed ARNP from out-of-state, verify completion of at least 250 hours of advanced nursing practice in the two years prior to application.

National certifications are available for psychiatric mental health nurse practitioners. Nurses at the masters or doctoral level may be clinical nurse specialists (CNS) or nurse practitioners (NP) and can become board certified through the American Nurses Credentialing Center (ANCC) as a psychiatric specialist (PMHCNS-BC or PMHNP-BC). The ANCC discontinued issuance of new PMHCNS credentials in late 2017, but will continue renewing the PMHCNS credential for those already in practice. A pediatric subspecialty (Pediatric Primary Care Mental Health Specialist [PMHS]) is available through the Pediatric Nurse Certification Board.(American Psychiatric Nurses Association; American Nurses Association, 2014)

Practice Characteristics

Psychiatric mental health nursing is a specialty within nursing. While psychiatric ARNPs may offer primary care services to the psychiatric population, their clinical experience is focused on behavioral/mental health conditions.

As independent practitioners, psychiatric ARNPs can assess and diagnose patients, prescribe psychotropic medications, and provide therapy and community interventions, case management, consultation and liaison services, and clinical supervision. They can be self-employed in private practice, or employed in outpatient, inpatient, crisis, and residential clinical agencies, and in primary care, forensic, occupational, and community-based settings.(American Psychiatric Nurses Association; American Nurses Association, 2014)

In 2014, 5.6% (7,034 total) of practicing NPs in the U.S. specialized in psychiatry/mental health.(U.S. Department of Health and Human Services, Health Resources and Services Administration, 2014) When examined by year of graduation in a 2012 National Sample Survey of Nurse Practitioners, the distribution of ARNPs working in the psychiatric specialty area remained fairly consistent, ranging from 4.4 to 6.6%.(U.S. Department of Health and Human Services, Health Resources and Services Administration, 2014)

The national median annual wages for all ARNPs, not just psychiatric ARNPs, was \$100,910 in May 2016.(Bureau of Labor Statistics, “Employment Statistics”, 2017) In Washington State, the annual mean wage for nurse practitioners was \$107,400 in May 2016.⁵ The 10th percentile mean annual wage was \$77,630 and the 90th percentile mean annual wage was \$135,620.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

With their current education and scope of practice, psychiatric ARNPs may provide consultative services to primary care practitioners and/or provide direct care in primary care or behavioral health integrated settings. Their scope of practice also allows for direct telepsychiatric care and telebehavioral health consultative service for evaluating, prescribing for, and monitoring behavioral health conditions remotely.

⁴Mindy Schaffner, Associate Director, Washington State Nursing Care Quality Assurance Commission, personal communication, November 28, 2017

⁵Estimates do not include self-employed workers.

In 2016, the Comprehensive Addiction and Recovery Act extended the privilege of prescribing buprenorphine in office-based settings to qualifying ARNPs until October 1, 2021. To be eligible to qualify, ARNPs must complete 24 hours of additional training, complete a waiver notification form, and be assigned a special identification number by the Drug Enforcement Agency. Once approved, ARNPs may prescribe for up to 30 patients in one year.

Demand

Washington's "early warning" system of health workforce demand changes, the Washington Health Workforce Sentinel Network, allows employers to report workforce shifts and high-priority needs. (Workforce Training & Education Coordinating Board, 2017) Nurse practitioners periodically appear in the top five occupations with exceptionally long vacancies reported by sentinels in a variety of healthcare settings. Emerging roles in integrated settings that require a complex skills mix and the maturity of an experienced, independent ARNP can be difficult to fill. Sentinels reported recruiting psychiatric ARNPs as a behavioral health facility medical director and as consultative psychiatric service providers, roles that were previously held by psychiatrists. Too few qualified candidates, recruitment and retention issues such as rural practice or part-time schedule, and inability to offer a competitive salary are some of the factors contributing to recruitment difficulty.

State data from the Washington State Employment Security Department (ESD) indicates that the average annual growth rate for nurse practitioners (ARNPs excluding nurse anesthetists and nurse midwives), including, but not limited to psychiatric ARNPs, between 2015 – 2020 will be 3.2% and for 2020 – 2025 will be 2.8%. (Washington State Employment Security Department, 2017) This equates to 93 and 95 annual openings due to growth, respectively. ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations. Data describing psychiatric ARNP growth projections specifically are not available.

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TECHNICAL NOTES

- Washington State ARNP data are from the Washington State Department of Health, Health Professions Licensing Data System, April 2017, as analyzed by the Washington State Office of Financial Management. All analyses include ARNPs ages 18 – 75 years with active license status and expiration of license \geq 2017.
- % psychiatric ARNPs of total ARNPs calculated by subtracting 2017 psychiatric ARNP total from 2016 ARNP total (Andrilla, Skillman, & Marshall, 2016), then calculating percentage.
- Washington population data are from the Washington State Office of Financial Management, 2016 data.
- Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.
- Educational program completion data provided by schools and compiled by the Center for Health Workforce Studies.
- Washington State Employment Security Department, SOC code 29-1171 (Nurse Practitioners).

FUNDING

This study was funded through contract # IAA-860-17 between the Washington Workforce Training and Education Coordinating Board and the University of Washington, supported by Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds.

SUGGESTED CITATION

McCarty RL, Skillman SM. Washington State's Behavioral Health Workforce - Occupational Profile: Psychiatric Advanced Registered Nurse Practitioners (ARNPs). Center for Health Workforce Studies, University of Washington, Dec 2017.

OCCUPATIONAL PROFILE: MENTAL HEALTH COUNSELORS

In Washington state, mental health counseling refers to the application of principles of human development, learning theory, psychotherapy, group dynamics, and etiology of mental illness and dysfunctional behavior to individuals, couples, families, groups, and organizations, for the purpose of treatment of mental disorders and promoting optimal mental health and functionality. Mental health counseling also includes, but is not limited to, the assessment, diagnosis, and treatment of mental and emotional disorders, as well as the

application of a wellness model of mental health. (Washington State Legislature, 2001) Mental health counselors (MHCs, also referred to as LMHCs) are usually master's level professionals who use a variety of therapeutic counseling approaches, and may specialize in the treatment of specific population groups (e.g., elderly, college students, children, incarcerated).

Mental health counselor associates (MHCAs, or LMHCAs) are individuals who have completed the required education to become an MHC and are in the process of completing the extensive supervised practice hours (see below) required to obtain an MHC license and practice independently.

MHCs on the integrated behavioral health/physical health team may work with primary care providers to deliver direct counseling and therapy for patients and their families. In some settings these individuals perform care management. (Skillman, Snyder, Frogner, & Patterson, 2016)

Size, Distribution, and Demographics of Supply

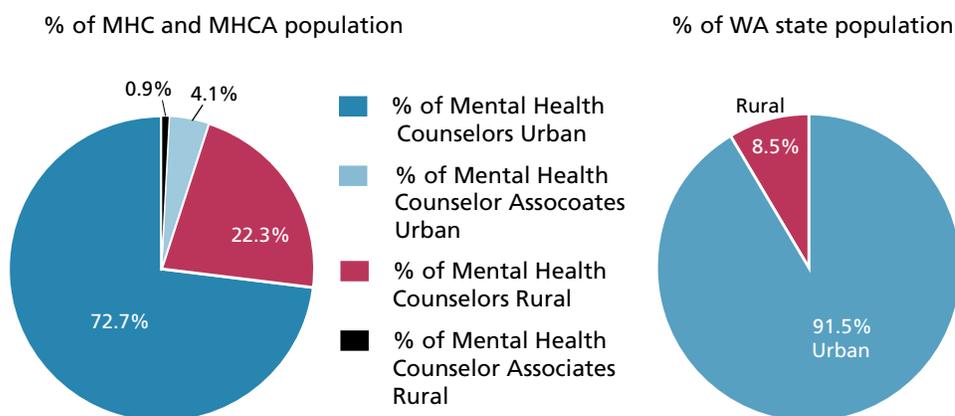
In April 2017, there were 6,531 mental health counselors (MHCs) who held an active license in Washington (Table 1). The mean age of Washington's MHCs was 52 years old, and 76.2% were female.

TABLE 1. Mental Health Counselors (MHC) and Counselor Associates (MHCA) with Washington State Licenses, 2017

	MHC	MHCA
With address in:		
Washington	5,923 (90.7%)	1,790 (95.7%)
Oregon	226 (3.5%)	37 (2.0%)
Idaho	65 (1.0%)	11 (0.6%)
Other	317 (4.9%)	32 (1.7%)
Total	6,532	1,870

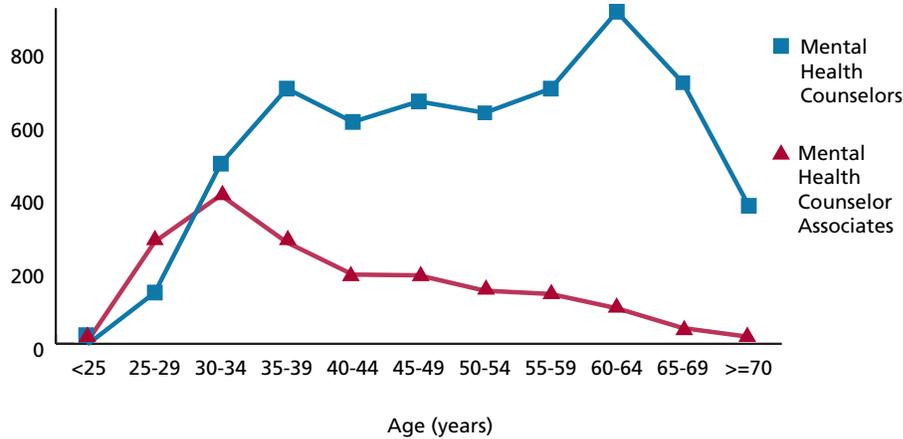
Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System.

Figure 1: Rural/Urban Distribution of Mental Health Counselors (MHCs) and Associates (MHCAs) and the General Population in Washington



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System. Does not include 0.1% of total MHCs for whom location was unknown.

Figure 2: Age Distribution of Licensed Mental Health Counselors and Mental Health Counselor Associates in Washington State, 2017



Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

An additional 1,870 individuals held a conditional Washington license as a mental health counselor associate (MHCA)—about 23.2% of the total Washington MHC workforce. The mean age of Washington’s MHCAs was 41 years old, and 74.0% were female.

Nearly all (94.6%) of Washington’s MHCs and 95.9% of MHCAs had urban addresses.

TABLE 2. Distribution, Age, and Sex of Mental Health Counselors and Counselor Associates in Washington by Accountable Community of Health

Mental Health Counselors	N	Population	Rate per 100,000	Mean Age	%, (N) >55 Years	%, (N) Female
Statewide*	5,923	7,183,700	85.5	52	45.5% (2,694)	76.2% (4,513)
By Accountable Community of Health (ACH) †						
Pierce County	503	844,490	59.6	52	45.1% (227)	75.7% (381)
North Sound	920	1,206,900	76.2	52	47.2% (434)	78.2% (719)
King County	2,373	2,105,100	112.7	51	43.4% (1,030)	76.2% (1,808)
Better Health Together	585	587,770	99.5	50	43.8% (256)	76.2% (446)
Cascade Pacific Action Alliance	492	614,750	80.0	54	55.1% (271)	77.0% (379)
Greater Columbia	364	710,850	51.2	50	41.8% (152)	73.6% (268)
Southwest Washington	254	493,780	51.4	49	37.4% (95)	72.8% (185)
Olympic Community of Health	305	367,090	83.1	55	58.7% (179)	75.7% (231)
North Central	127	252,970	50.2	50	39.4% (50)	75.6% (96)

Mental Health Counselors Associates	N	Population	Rate per 100,000	Mean Age	%, (N) >55 Years	%, (N) Female
Statewide*	1,790	7,183,700	24.9	41	16.5% (295)	74% (1,324)
By Accountable Community of Health (ACH) †						
Pierce County	190	844,490	22.5	43	22.1% (42)	70.0% (133)
North Sound	296	1,206,900	24.5	41	15.2% (45)	75.0% (222)
King County	779	2,105,100	37.0	40	13.5% (105)	72.8% (567)
Better Health Together	123	587,770	20.9	38	15.4% (19)	79.7% (98)
Cascade Pacific Action Alliance	139	614,750	22.6	45	25.2% (35)	79.9% (111)
Greater Columbia	77	710,850	10.8	40	10.4% (8)	71.4% (55)
Southwest Washington	79	493,780	16.0	42	21.5% (17)	72.2% (57)
Olympic Community of Health	84	367,090	22.9	44	22.6% (19)	79.8% (67)
North Central	23	252,970	9.1	43	21.7% (5)	60.9% (14)

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* MHCs and MHCAs with Washington State license address only.

† Counties in multi-county ACHs are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

Education/Training

Universities in Washington may offer education programs in counseling through psychology or education schools or departments. Some programs prepare graduates to pursue clinical counseling work as a licensed mental health counselor, others to pursue a marriage and family therapist license, and others to pursue school psychologist credentials. These are overlapping fields but are credentialed separately. The available data do not always distinguish graduates' program tracks, but about 17 schools in Washington offer masters in counseling programs focused on preparing graduates to acquire an MHC license. Washington State University's master and doctoral programs are closing upon graduation of currently enrolled students. Figure 3 and Table 3 provide estimates of graduates presumed to pursue MHC careers.

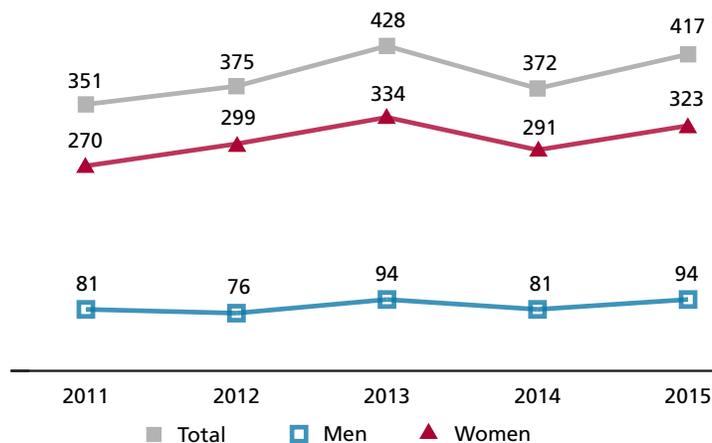
Credentialing

Graduation from an accredited counseling program is not required for licensure as a mental health counselor in Washington. (Washington State Department of Health, 2017) However, applicants must provide proof of having studied core content areas required for licensure. The content areas include diagnosis, counseling treatment, ethics, research, multicultural concerns, substance abuse, and other areas.

The most recognized accreditation organization for these programs is the Council for Accreditation of Counseling and Related Educational Programs (CACREP). There are presently six accredited mental health counseling programs in Washington: Central Washington University, City University of Seattle, Western Washington University, Eastern Washington University, Antioch University, and Gonzaga University. Seattle University is in the process of gaining CACREP accreditation for a mental health counseling program. (Council for Accreditation of Counseling & Related Educational Programs, 2017)

After completing one's education but prior to becoming an independent MHC, graduates obtain conditional licensure as an MHCA while gaining the supervised experience necessary to be eligible for full licensure. Associates may provide and be paid

Figure 3: Master's Degree in Counseling Professions in Washington State, 2011- 2015



Data Source: Integrated Postsecondary Education Data System (IPEDS).

TABLE 3. Washington Schools Offering Master-Level Degrees in Counseling Professions, 2016

School	# Graduations 2016	CACREP Accredited
Antioch University Seattle	28	X
Argosy University – Seattle	14	
Bastyr University	15	
Central Washington University	9	X
City University of Seattle*	13	X
Eastern Washington University	22	X
Gonzaga University	51	X
Heritage University†	0	
Northwest University	37	
Saint Martin's University§	29	
Seattle University	20	In process
The Seattle School of Theology and Psychology	61	
University of Puget Sound	9	
Walla Walla University	7	
Washington State University‡	2	
Western Washington University	5	X
Whitworth University	4	

Data source: Integrated Postsecondary Education Data System (IPEDS), 2016 provisional data; Council for Accreditation of Counseling and Related Educational Programs (CACREP) online directory (accessed July 2017), Masters in Psychology and Counseling Accreditation Council online directory (accessed July 2017).

* Total graduates include Marriage, Couple and Family Counseling Program students who may apply for Marriage and Family Therapy license.

† Program under evaluation.

‡ Program closed to new students, final master's students graduated May 2017 and final doctoral students will graduate no later than July 2022.

§ Also MPCAC (Masters in Psychology and Counseling Accreditation Council) accredited.

for services only under approved supervision. As an MHCA, they must obtain a minimum of 36 months of full-time counseling or 3,000 hours of postgraduate mental health counseling under the supervision of an approved licensed MHC or equally qualified licensed mental health practitioner in an approved setting.(Washington State Legislature, 2017) At least 100 hours must be in immediate supervision with an approved licensed mental health counselor or equally qualified licensed mental health practitioner, and at least 1,200 hours must be direct counseling with individuals, couples, groups or families. Supervisors must complete a verification form and make statements as to the applicant’s qualifications. The associate credential can only be renewed six times.

In addition to completing their required supervised training, applicants must pass one of the two National Board of Certified Counselors (NBCC) exams: National Counselor Exam (NCE) or National Clinical Mental Health Counselor Exam (NCMHCE). Passing exam scores must be sent directly from NBCC to the Department of Health.

Practice Characteristics

Nationally, settings with the highest level of employment for MHCs are individual and family services, outpatient care centers, residential care facilities, hospitals, and state and local governments.(Bureau of Labor Statistics, “Outlook Handbook”, 2017) They also work in private practice.

The 2016 mean annual wage¹ for mental health counselors in Washington was \$46,200.(Bureau of Labor Statistics, “Employment Statistics”, 2017) The 10th percentile mean annual wage was \$29,290 and the 90th percentile mean annual wage was \$64,710.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

MHCs in the integrated behavioral health/physical health team may work with primary care providers to deliver direct counseling and therapy for patients and their families. In some settings these individuals perform care management.(Skillman, Snyder, Frogner, & Patterson, 2016)

A white paper from the American Mental Health Association describes key principles and skills ideally suited for clinical mental health counselors in the integrated medical model.(Otis & Miller, 2016) MHCs should:

- Provide brief, solution-focused interventions which are evidence-based and improve patient function
- Obtain strong generalist training to treat patients of various ages
- Obtain training in health psychology, family therapy, brief therapy, behavioral medicine, child development
- Obtain knowledge of common chronic illnesses, including symptoms, mechanisms, common co-occurring mental health problems and treatment
- Obtain knowledge of biological components of health and disease
- Obtain knowledge of how memory, perception, cognition, emotions, and motivation can influence health
- Obtain knowledge of child and adult psychotropic medications, their uses and common side effects
- Know how to monitor patient progress and coordinate care
- Obtain knowledge in population-based interventions in addition to disease-specific interventions
- Understand when to refer complex patients

Examples of specific services which MHCs may perform in integrated primary care settings include trauma-informed care, improving compliance in diabetes treatment, suicide ideation and risk assessment, and depression screening.

Demand

Washington’s “early warning” system of health workforce demand changes, the Washington Health Workforce Sentinel Network, allows employers to report workforce shifts and high-priority needs.(Workforce Training & Education Coordinating Board, 2017) Across the state, behavioral health and community health clinic sentinels consistently ranked MHCs to be among the top occupations with exceptionally long vacancies and increased demand in their facilities. As stated by one Sentinel:

¹Estimates do not include self-employed workers.

“Some Mental Health Counselors have become Care Authorizers under managed care and have become employed under ACH. This has had some impact as the pay is higher in those organizations than in Community Mental Health. Also, organizations that did not historically provide these services are now doing integrated care and creating more positions for the job market. There have also been a flood of new contracts available. As we compete and obtain additional funding, there is an increase in demand for these counselors.” (Workforce Training & Education Coordinating Board, 2017)

Rural sentinels reported difficulty recruiting and retaining many occupations, including MHCs. Sentinels reported requiring increased training for new and incumbent MHCs in areas related to integration and healthcare transformation, including evidence-based practices, use of health information technology, treatment of co-occurring disorders, and new documentation requirements.

The Washington State Employment Security Department (ESD) estimates that the average annual growth rate for mental health counselors between 2015 – 2020 will be 1.7% and for 2020 – 2025 will be 1.3%. (Washington State Employment Security Department, 2017) This equates to 87 and 81 annual openings due to growth, respectively. ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations.

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TECHNICAL NOTES

- Washington State mental health counselor and mental health counselor associate data are from the Washington State Department of Health, Health Professions Licensing Data System, April 2017, as analyzed by the Washington State Office of Financial Management. All analyses include MHC/MHCAs ages 18 – 75 years with active license status and expiration of license \geq 2017.
- Washington population data are from the Washington State Office of Financial Management, 2016 data.
- Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.
- Included IPEDS CIP code 51.1508 (Mental Health Counseling/Counselor), 42.28 (Clinical, Counseling and Applied Psychology), 13.1101 (Counselor Education/School Counseling and Guidance Services [for Gonzaga University, Heritage University, University of Puget Sound, Seattle University when only code choice available]); inclusion of 42.28 in analysis instead of 13.1101 where both were listed; Masters awards only, 1st/2nd major, no imputation variables. 2011 – 2015 Final Release Data, 2016 Provisional Data Release.
- Washington State Employment Security Department, SOC code 21-1014 (Mental Health Counselors).

FUNDING

This study was funded through contract # IAA-860-17 between the Washington Workforce Training and Education Coordinating Board and the University of Washington, supported by Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds.

SUGGESTED CITATION

McCarty RL, Skillman SM. Washington State's Behavioral Health Workforce - Occupational Profile: Mental Health Counselors. Center for Health Workforce Studies, University of Washington, Dec 2017.

OCCUPATIONAL PROFILE: MARRIAGE AND FAMILY COUNSELORS/THERAPISTS

In Washington state, marriage and family therapy refers to the diagnosis and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of relationships, including marriage and family systems. Marriage and family therapy involves the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders. (Washington State Legislature, 2001) Marriage and family therapists (MFTs, also referred to as LMFTs) are usually master's level professionals whose treatment is focused at a narrower scope than mental health counselors; when treating couples and families, MFTs direct their interventions from

a social and relational context and focus on the impact of family, school, and workplace on an individual's well-being. Marriage and family therapist associates (MFTA or LMFTA) are graduates who are still gaining the supervised experience necessary to obtain an MFT license.

MFTs on the integrated behavioral health/physical health team provide support to primary care providers by consulting on behavioral health issues and their impact on families, and connecting patients and families with community resources to facilitate care and promote overall positive behaviors toward well-being. They can also assist with patient diagnoses and treatment plan implementation, and provide direct therapy. (Skillman, Snyder, Frogner, & Patterson, 2016)

Size, Distribution, and Demographics of Supply

In 2017, there were 1,528 marriage and family therapists (MFT) who held an active license in Washington (Table 1). The mean age of the Washington MFTs was 51 years old, and 76.9% were female.

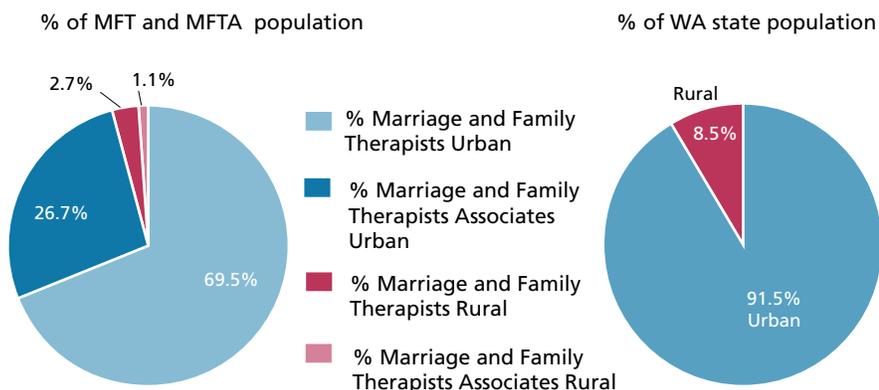
An additional 563 individuals held a conditional Washington license as a marriage and family therapist associate (MFTA) in 2014—about 27.8% of the

TABLE 1. Marriage and Family Therapists (MFT) and Counselor Associates (MFTA) with Washington State Licenses, 2017

	MFT	MFTA
With address in:		
Washington	1,387 (90.8%)	535 (95.0%)
Oregon	46 (3.0%)	11 (2.0%)
Idaho	3 (0.2%)	3 (0.5%)
Other	92 (6.0%)	14 (2.5%)
Total	1,528	563

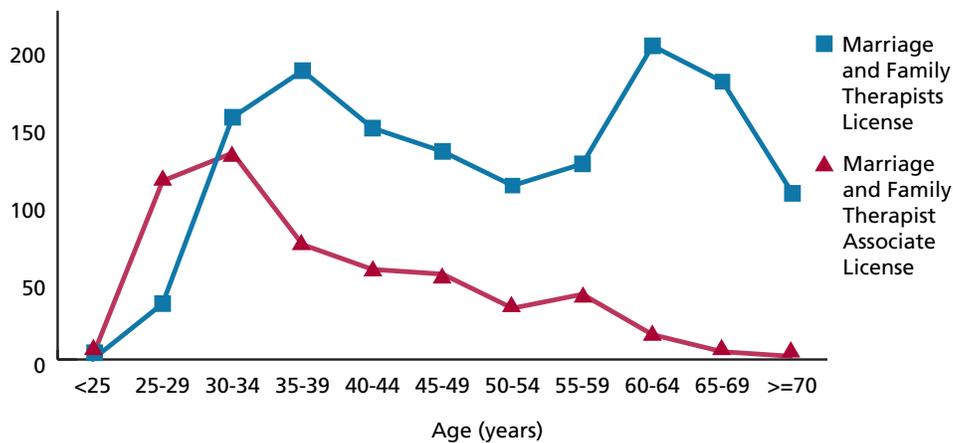
Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System.

Figure 1: Rural/Urban Distribution of Marriage and Family Therapists (MFT) and Associates (MFTA) and the General Population in Washington



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System.

Figure 2: Age Distribution of Licensed Marriage and Family Therapists and Marriage and Family Therapist Associates in Washington State, 2017



Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System.

total Washington MFT workforce. The mean age of these Washington MFTAs was 39 years old, and 79.3% were female.

Nearly all (96.2%) of Washington's marriage and family therapists and associates had urban addresses.

Associates are younger than independent MFTs, which is unsurprising since they are earlier in their career path. There are two peaks in the number of licensed MFTs: aged 35-39, and aged 60-64. Those in the latter group will likely be retiring in the near future.

TABLE 2. Distribution, Age, and Sex of Marriage and Family Therapists and Therapist Associates in Washington by Accountable Community of Health, 2017

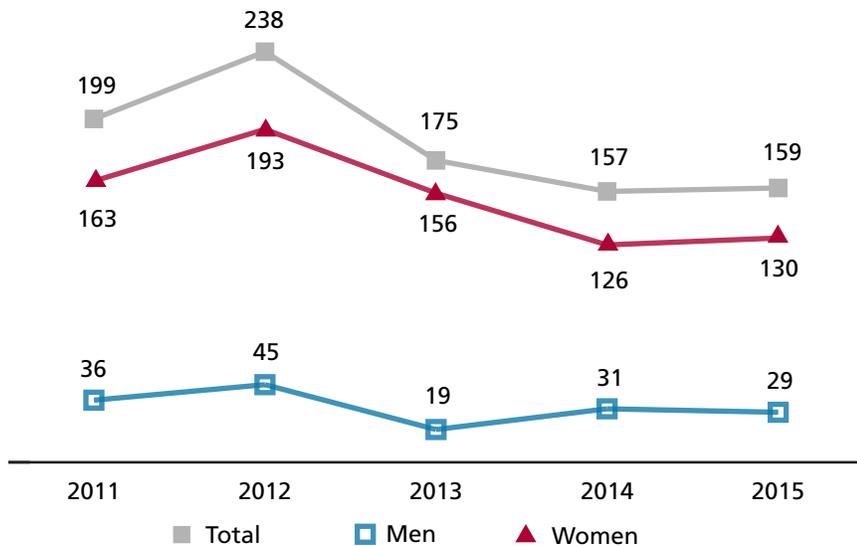
Marriage and Family Therapists	N	Population	Rate per 100,000	Mean Age	%, (N) >55 Years	%, (N) Female
Statewide*	1,387	7,183,700	19.3	51	44.3% (614)	76.9% (1,066)
By Accountable Community of Health (ACH) †						
Pierce County	204	844,490	24.2	49	35.8% (73)	75.5% (154)
North Sound	227	1,206,900	18.8	53	51.1% (116)	78.9% (179)
King County	599	2,105,100	28.5	50	40.7% (244)	79.8% (478)
Better Health Together	63	587,770	10.7	56	61.9% (39)	61.9% (39)
Cascade Pacific Action Alliance	91	614,750	14.8	54	57.1% (52)	71.4% (65)
Greater Columbia	39	710,850	5.5	48	30.8% (12)	69.2% (27)
Southwest Washington	56	493,780	11.3	47	26.8% (15)	80.4% (45)
Olympic Community of Health	91	367,090	24.8	56	61.5% (56)	73.6% (67)
North Central	17	252,970	6.7	48	41.2% (7)	(70.6%) 12
Marriage and Family Therapists Associates						
Statewide*	535	7,183,700	7.4	39	12.1% (65)	79.3% (424)
By Accountable Community of Health (ACH) †						
Pierce County	86	844,490	10.2	37	7.0% (6)	77.9% (67)
North Sound	72	1,206,900	6.0	40	15.3% (11)	80.6% (58)
King County	239	2,105,100	11.4	38	10.5% (25)	79.1% (189)
Better Health Together	36	587,770	6.1	37	11.1% (4)	80.6% (29)
Cascade Pacific Action Alliance	44	614,750	7.2	42	18.2% (8)	86.4% (38)
Greater Columbia	8	710,850	1.1	35	12.5% (1)	62.5% (5)
Southwest Washington	16	493,780	3.2	40	18.8% (3)	62.5% (10)
Olympic Community of Health	28	367,090	7.6	44	21.4% (6)	82.1% (23)
North Central	6	252,970	2.4	39	16.7% (1)	83.3% (5)

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* MFTs and MFTAs with Washington State license address only.

† Counties in multi-county ACH's are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

Figure 3: Master's Degrees in Marriage and Family Therapy Professions in Washington State, 2011 - 2015



Data source: Integrated Postsecondary Education Data System (IPEDS). Institutions' program coding selections likely result in overestimation of MFT graduates due to inclusion of other programs in larger selected categories.

Education and Training

Universities in Washington may offer marriage and family therapy programs through psychology or education schools or departments. Some programs prepare graduates for clinical counseling work as a licensed marriage and family therapist, others for a mental health counselor license, and others towards school psychologist credentials. These are overlapping fields, but are credentialed separately. While available education data do not always distinguish graduates' program track, six schools in Washington offer masters in marriage and family therapy or counseling programs focused on preparing graduates to acquire a Marriage and Family Therapist license (Table 3). A seventh school, Gonzaga University, offers a master's program in Marriage and Family Counseling, but the program student handbook suggests students apply for a mental health counseling license, not marriage and family therapy license, and therefore their graduates were not included. (Table 3 and Figure 3)

TABLE 3. Washington Schools Offering Master-Level Degrees in Marriage and Family Therapy, 2017

School	# Graduations 2016	COAMFTE Accredited
City University of Seattle*	13	
Whitworth University†	10	
Antioch University Seattle	9	X
Pacific Lutheran University	24	X
Seattle Pacific University	28	X
Seattle University	26	X

Data sources: Integrated Postsecondary Education Data System (IPEDS), 2016 provisional data; American Association for Marriage and Family Therapy Directory of MFT Training Programs, August 2017; Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) directory (accessed August 2017). Central Washington University's program was excluded as it was described as preparing graduates for Certified Family Life Educator or Certified Child Life Specialist professions.

* City University's counseling program with a Marriage, Couple and Family emphasis is CACREP accredited (Council for Accreditation of Counseling and Related Educational Programs), but the student handbook specifically details preparation for Washington state MFT licensure. Total graduates include Clinical Mental Health Counseling Program students who may apply for Mental Health Counseling license.

† Whitworth University's 2017 student handbook states that the MFT program is pursuing COAMFTE accreditation.

Credentialing

Applicants for an MFT license must have a master's or doctorate degree in marriage and family therapy or an equivalent course of study from an approved behavioral science school. (Washington State Department of Health, 2017) A total of 45 semester hours or 60 quarter credits are required in all eight of the following areas study, and at least 27 semester credits or 36 quarter credits are required in the first five areas: marital and family systems, marital and family therapy, individual development, psychopathology, human sexuality, research, professional ethics and law, and one elective course.

In Washington state, applicants who have obtained clinical membership status in the American Association for Marriage and

Family Therapy (AAMFT) are considered to have met the educational requirements for licensure when verification is sent directly from the AAMFT to the Department of Health. A passing score on the board examination overseen by the Association of Marital and Family Therapy Regulatory Boards is also required for licensure.(Association of Marital & Family Therapy Regulatory Boards, 2017)

To gain the supervised experience necessary to become a licensed independent MFT, graduates apply for conditional licensure as a marriage and family therapist associate. Associates may provide and be paid for services only under approved supervision. The associate credential can only be renewed six times.

Applicants for MFT licensure must complete at least 3,000 hours of supervised postgraduate experience, 1,000 of which must be direct client contact, over at least two calendar years. (Washington State Legislature, 2017) At least 500 hours must be gained in diagnosing and treating couples and families, along with at least 200 hours of qualified supervision with an approved supervisor. At least 100 of the 200 hours must be one-on-one supervision, and the remaining hours may be in one-on-one or group supervision.

Of the total supervision requirement, 100 hours must be with a licensed marriage and family therapist who has at least five years of clinical experience. The other 100 hours may be with an equally qualified licensed mental health practitioner. Applicants who have completed a master's program accredited by the Commission on Accreditation for Marriage and Family Therapy Education of the American Association for Marriage and Family Therapy (COAMFTE) will be credited with 500 hours of direct client contact and 100 hours of formal meetings with an approved supervisor. Post-graduate supervised experience must be verified by an approved supervisor, on forms the Department of Health provides.

Practice Characteristics

Nationally, industries with the highest level of employment for MFTs are individual and family services, outpatient care centers, offices of other health practitioners, state governments, and residential care facilities.(Bureau of Labor Statistics, "Outlook Handbook", 2017) MFTs also work in private practice.

The 2016 mean annual wage¹ for MFTs in Washington was \$55,870 in May 2016.(Bureau of Labor Statistics, "Employment Statistics", 2017) The 10th percentile mean annual wage was \$34,170 and the 90th percentile mean annual wage was \$96,260.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

Generally, MFTs working in an integrated setting offer a mental health diagnosis, recommendations for or development of a patient support system; assessment and enhancement of patient motivation, patient education, and suggestions to optimize medication management.(Teater, 2011) To provide high quality care, MFTs should be able to understand the medical diagnosis, medical conditions, medications, specialty referrals, and physical changes that may impact therapy.

MFTs who wish to specialize in working in an integrated medical setting can pursue a post-graduate certificate in medical family therapy (MedFT). Seattle Pacific University is one of the few universities offering this program nationally, in both a post-graduate and master's track format.

The Commission on Accreditation of Marriage and Family Therapy Education's (COAMFTE) has not yet established the core competencies for the MedFT, and certificate curricula are not standardized. However, common characteristics of these programs include placement of MedFTs in primary care settings to learn medical culture, focus on those affected by chronic illness, trauma, disability or loss, and a theme of collaboration.(Tyndall, Hodgson, Lamson, White, & Knight, 2012) A biopsychosocial model of wellness is promoted in both standard marriage and family therapy and MedFT. Particularly in MedFT, the biological/physiological underpinnings of health should be understood.(Edwards & Patterson, 2006) Additional skills which MFTs need for working in the integrated setting include providing mental health services in a shorter time frame, learning electronic health record systems, and being able to read medical notes. MFTs should be prepared to encourage the patient to self-advocate in the medical setting.(Hodgson & Marlowe, 2011)

¹Estimates do not include self-employed workers.

Demand

Washington's "early warning" system of health workforce demand changes, the Washington Health Workforce Sentinel Network, allows employers to report workforce shifts and high-priority needs. (Workforce Training & Education Coordinating Board, 2017) Behavioral health and community health clinic sentinels mentioned MFTs to be among occupations with exceptionally long vacancies and increased demand in their facilities. Rural sentinels reported difficulty recruiting and retaining many occupations, including MFTs. Safety net sites reported low pay, on-call intensive work demands, and onerous paperwork requirements as reasons for long vacancies. They also expressed difficulty finding dual licensed (MH/SUD) treatment clinicians.

State data from the Washington State Employment Security Department (ESD) estimates that the average annual growth rate for mental health counselors between 2015 – 2020 will be 1.3% and for 2020 – 2025 will be 1.3%. (Washington State Employment Security Department, 2017) This equates to 9 annual openings due to growth, each. ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations.

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TECHNICAL NOTES

- Washington State marriage and family therapist and marriage and family therapist associate data are from the Washington State Department of Health, Health Professions Licensing Data System, April 2017, as analyzed by the Washington State Office of Financial Management. All analyses include MFT/MFTAs ages 18 – 75 years with active license status and expiration of license \geq 2017.
- Washington population data are from the Washington State Office of Financial Management, 2016 data.
- Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.
- Included IPEDS CIP code includes 51.1505 (Marriage and Family Therapy/Counseling), 42.2811 (Family Psychology), and 42 (Psychology); excludes 19.0704 (Family Systems) and 42.28 (Clinical, Counseling and Applied Psychology) [42.28 coded as Mental Health Counselor designation]), Masters awards only, 1st/2nd major, no imputation variables. 2011 – 2015 Final Release Data.
- Washington State Employment Security Department, SOC code 21-1013 (Marriage and Family Therapists).

FUNDING

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SUGGESTED CITATION

McCarty RL, Skillman SM. Washington State's Behavioral Health Workforce - Occupational Profile: Marriage and Family Counselors/Therapists. Center for Health Workforce Studies, University of Washington, Dec 2017.

OCCUPATIONAL PROFILE: CHEMICAL DEPENDENCY PROFESSIONALS

Chemical dependency professionals (CDPs) are certified in chemical dependency counseling, described in Washington code as “assessment and diagnosis of chemical dependency, chemical dependency treatment planning and referral, patient and family education in the disease of chemical dependency, individual and group counseling with alcoholic and drug addicted individuals, relapse prevention counseling, and case management, all oriented to assist alcoholic and drug addicted patients to achieve and maintain abstinence from mood-altering substances and develop independent support systems”. (Washington State Legislature, 1998) These professionals provide direct counseling to patients and families, assist patients with developing positive means to manage their addiction, and provide community support resources for recovery.

Chemical dependency professional trainees (CDPTs) are individuals who have attested that they are in the process of completing the education and supervised experience requirements to obtain the full CDP certification.

TABLE 1. Chemical Dependency Professionals (CDPs) and Trainees (CDPTs), 2017

	CDP	CDPT
With address in:		
Washington	2,629 (95.9%)	1,522 (96.9%)
Oregon	42 (1.5%)	31 (2.0%)
Idaho	20 (0.7%)	10 (0.6%)
Other	49 (1.8%)	8 (0.5%)
Total	2,740	1,571

Data sources: Washington State Department of Health, 2017 Health Professions Licensing Data System.

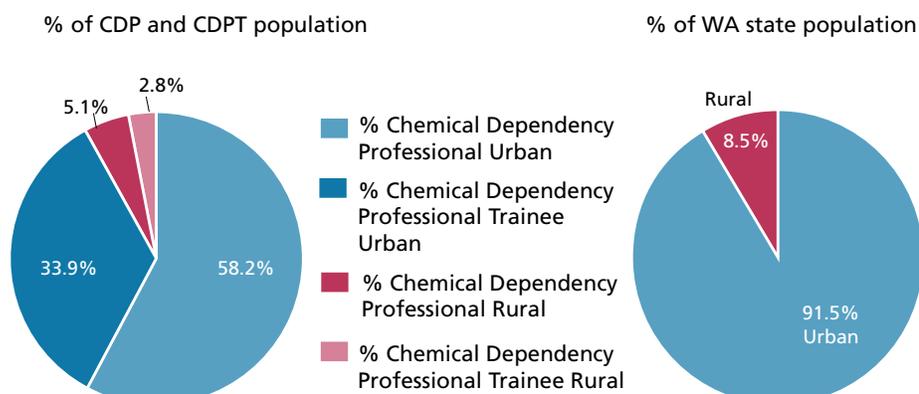
Chemical dependency treatment is important to integrated behavioral health/primary care, given the frequency of substance misuse co-occurring with mental health disorders and medical needs. (Skillman, Snyder, Frogner, & Patterson, 2016)

Size, Distribution, and Demographics of Supply

In April 2017, there were 2,740 CDPs who held an active license in Washington (Table 1). The mean age of Washington's CDPs was 51 years old, and 64.9% were female.

An additional 1,571 individuals held a conditional Washington license as a CDPT. The mean age of the Washington CDPTs was 41 years old, and 69.5% were female. Relative to other behavioral health occupations, a high percentage (36.7%) of the CDP workforce were trainees. This may be in part because trainees are credentialed prior to completing their chemical dependency core education (see *Credentialing*). CDPTs must complete their educational and supervised experience requirements to become a fully licensed CDP within five years of initial registration as a CDPT.

Figure 1: Rural/Urban Distribution of Chemical Dependency Professionals (CDPs) and Trainees (CDPTs) and the General Population in Washington



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System.

Nearly all (92.1%) of Washington's CDPs and CDPTs had urban addresses.

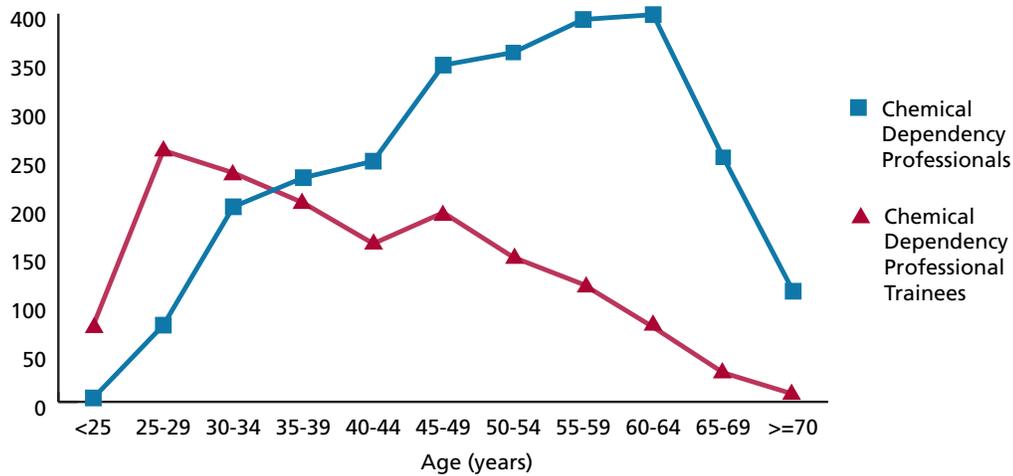


Figure 2:
Age Distribution of Chemical Dependency Professionals and Chemical Dependency Professional Trainees in Washington State, 2017

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System

TABLE 2. Distribution, Age, and Sex of Chemical Dependency Professionals and Trainees in Washington by Accountable Community of Health, 2017

Chemical Dependency Professionals	N	Population	Rate per 100,000	Mean Age	%, (N) >55 Years	%, (N) Female
Statewide*	2,629	7,183,700	36.6	51	44.1% (1,159)	64.9% (1,705)
By Accountable Community of Health (ACH) †						
Pierce County	295	844,490	34.9	53	47.5% (140)	61.0% (180)
North Sound	430	1,206,900	35.6	52	48.6% (209)	66.5% (286)
King County	670	2,105,100	31.8	51	41.3% (277)	63.3% (424)
Better Health Together	357	587,770	60.7	50	38.9% (139)	68.1% (243)
Cascade Pacific Action Alliance	283	614,750	46.0	51	41.0% (116)	66.1% (187)
Greater Columbia	229	710,850	32.2	53	48.5% (111)	64.2% (147)
Southwest Washington	129	493,780	26.1	51	42.6% (55)	67.4% (87)
Olympic Community of Health	163	367,090	44.4	53	49.7% (81)	63.2% (103)
North Central	73	252,970	28.9	51	42.5% (31)	65.8% (48)
Chemical Dependency Professional Trainees	N	Population	Rate per 100,000	Mean Age	%, (N) >55 Years	%, (N) Female
Statewide*	1,522	7,183,700	21.2	41	15.5% (236)	69.5% (1,058)
By Accountable Community of Health (ACH) †						
Pierce County	163	844,490	19.3	41	16.0% (26)	71.2% (116)
North Sound	229	1,206,900	19.0	41	17.0% (39)	71.2% (163)
King County	421	2,105,100	20.0	40	15.4% (65)	67.7% (285)
Better Health Together	176	587,770	29.9	40	14.8% (26)	75.6% (133)
Cascade Pacific Action Alliance	216	614,750	35.1	42	15.7% (34)	64.4% (139)
Greater Columbia	97	710,850	13.6	40	13.4% (13)	71.1% (69)
Southwest Washington	86	493,780	17.4	40	10.5% (9)	73.3% (63)
Olympic Community of Health	108	367,090	29.4	42	19.4% (21)	64.8% (70)
North Central	26	252,970	10.3	42	11.5% (3)	76.9% (20)

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* CDPs and CDPTs with Washington State license address only.

† Counties in multi-county ACH's are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

TABLE 3. Colleges in Washington State Offering a Certificate Program Leading toward CDP Certification, 2017.

School	Associate Degree	Certificate
Bellevue College		x
Centralia College	x	
Clark College	x	x
Clover Park Technical College	x	x
Eastern Washington University†		x
Edmonds Community College‡	x	x
Grays Harbor College	x	x
Highline College	x	
Lower Columbia College	x	x
Northwest Indian College	x	
Olympic College‡	x	x
Peninsula College	x	
Pierce College-Fort Steilacoom	x	x
Seattle Central College		x
Skagit Valley College	x	x
Spokane Falls Community College‡	x	x
Tacoma Community College	x	x
Wenatchee Valley College	x	x
Yakima Valley Community College	x	x

Data sources: Addiction Technology Transfer Center Network Directory of Addiction Study Programs; CareerOneStop.org; institution websites.
 † Also offers a bachelor's degree in interdisciplinary addiction studies.
 ‡ Offer "fast-track" alternative pathway training for certification.

Education and Training

In 2017, about nineteen schools in Washington offered a specific certification program of study designed for students who are completing state-defined requirements to become a CDP. Some associate and baccalaureate programs in social work, human services, or applied psychology may also prepare students to become a CDP. Schools may also offer certificate programs that meet or exceed the 45-credit chemical dependency-specific educational requirements for the CDP credential, but do not result in an associate degree.

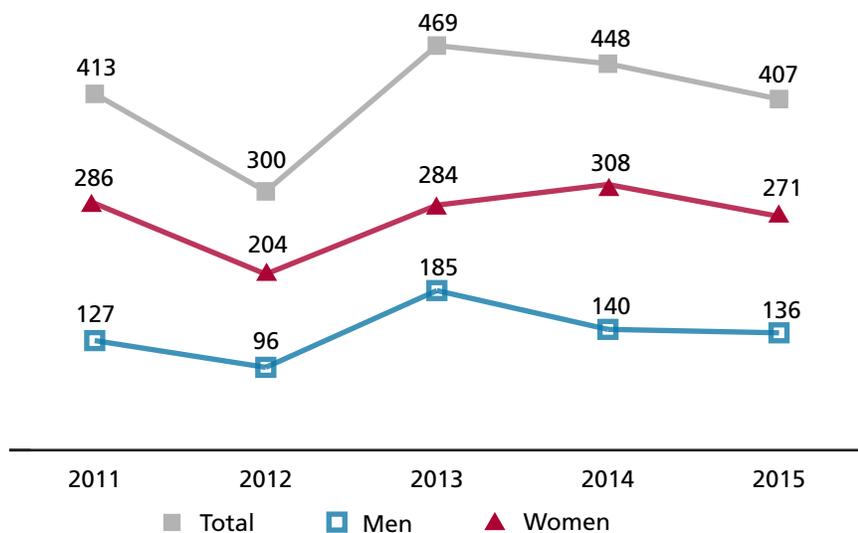
Applicants to CDP-preparation programs who have no post-secondary education or experience must complete an associate degree in a human service-related field, or 90 quarter/60 semester college credits from an approved school. At least 45 quarter/30 semester credits must be completed in courses relating to the chemical dependency profession in 23 topics listed in Washington Administrative Code (WAC) 246-811-030.(Washington State Legislature, "Educational requirements", 2016)

"Alternative pathway" practitioners hold an active license as an advanced registered nurse practitioner, psychologist, marriage and family therapist, mental health counselor, advanced social worker, independent clinical social worker, osteopathic physician, osteopathic physician assistant, or physician assistant. Once certified as a CDP, they

are commonly referred to as "dual credentialed" providers.(Washington State Department of Health, 2017) To apply for a CDP credential, they must complete training equaling 15 quarter/10 semester college credits in courses specific to the assessment and treatment of people with alcohol and drug addiction, in addition to their underlying health profession education.

Four of the colleges in Table 3 reported offering a "fast-track" program to specifically address the education topics outlined for the alternative pathway. One challenge is that community colleges in Washington are open enrollment institutions, and so would be required to allow any student regardless of education to enroll in these classes or develop a selective admissions process, which costs money and time.

Figure 3: Associate Degrees and Certificates Conferred by Training Programs towards Chemical Dependency Professional Certification in Washington State, 2011 - 2015



Data source: Integrated Postsecondary Education Data System (IPEDS). Institutions' program coding selections likely result in overestimation of CDP program completions due to inclusion of other programs in larger selected categories.

While most of the colleges offer courses that embed the education topics required for the alternative pathway, they total more than 15 credits. For example, a licensed mental health professional can complete the education topics at Bellevue College in courses that total 22 credits.¹

Credentialing

To be certified as a CDPT, applicants must declare that they are enrolled in an approved school and are gaining the experience necessary to apply for a CDP certification. The CDPT certificate can only be renewed four times, and each time the trainee must submit a signed declaration of their progress towards the CDP credential.

TABLE 4. Supervision Requirements for Washington Chemical Dependency Professional Certification

Degree	Supervision Hours Required
Associate	2,500
Baccalaureate	2,000
Master/doctoral	1,500
Licensed healthcare professional	1,000
Topic	
Initial face-to-face client contact under direct observation of supervisor	50
Clinical evaluation	200
With face-to-face patient contact	100
Face-to-face counseling of individuals, groups, families, couples	600
Professional responsibilities/ethics	50

In addition to instructional education, applicants for the CDP credential must complete supervised experience commensurate with their education attainment (Table 4). Approved supervisors (defined by WAC 246-811-049) are certified CDPs or are providers who have at least 4,000 additional hours of experience in chemical dependency treatment (e.g., addiction specialty physician). (Washington State Legislature, "Approved supervisors", 2016)

Alternative pathway practitioners are required to be supervised by a certified CDP during the supervised experience portion of their training. These requirements may be alternatively met if the applicant is certified by one of 12 nationally recognized addiction medicine/addiction counseling organizations listed in WAC 246-811-078 (e.g. National Association of Alcoholism and Drug Abuse Counselors, American Society of Addiction Medicine). (Washington State Legislature, "National certification", 2016) To assess the potential impact of this new pathway to CDP credentialing, in 2016 the Washington State Society for Clinical Social Work surveyed ten mental health organizations/associations which included psychiatrists, psychologists, licensed independent social

workers, marriage and family therapists, mental health counselors, and advanced registered nurse practitioners. In the 334 responses received, providers who were eligible for the alternative pathway revealed that 71.0% never intended to pursue a CDP credential because they could not be away from their current practice to achieve the required work/supervision hours, lacked a convenient place to complete supervised hours, or felt costs were too high. Nearly half of the respondents endorsed the promotion of abstinence-only chemical dependency treatment as a barrier to interest in pursuing the CDP credential.²

CDPs in Washington are required to pass the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) level one or higher exam, or the Intentional Certification and Reciprocity Consortium (ICRC) level two or higher exam. All certification requirements must be met before applicants can be approved to sit for the examination. Applicants credentialed in other states with equivalent standards are not required to take the exam.

Practice Characteristics

In Washington, more than 60% of chemical treatment agencies in 2012 were independent community-based agencies or local branches of multi-site health care organizations. (Rodriguez, 2016) Eighty-six percent of the agencies provided outpatient services and 26% provided residential services. Chemical dependency (CD) treatment-only agencies reportedly have a significantly higher proportion of CDPs than both agencies offering both mental health (MH) and CD treatment (74% versus 65%), but showed a significantly lower proportion of CDPTs than agencies providing both MH and CD (19% versus 27%). (Rodriguez, 2016) This may suggest that newer professionals in the field are more commonly employed in blended mental health/chemical dependency settings. In chemical

¹Paul Weatherly, Bellevue College, personal communication, October 30, 2017

²Laura Groshong, Washington State Society for Clinical Social Work, personal communication, October 10, 2017

dependency agency settings, six percent of the clinical staff were reported to be dual certified, and dual certified professionals were more likely to work in blended MH/CD settings. (Rodriguez, 2016)

A 2005 survey sponsored by the former Washington Division of Alcohol and Substance Abuse (DASA, now the Division of Behavioral Health and Recovery) described the substance abuse treatment workforce in Washington.(Knudsen, Gallon, & Gabriel, 2006) At that time, 51.9% of clinicians were 50 years of age or older, similar to our current licensure data findings. However, 48.0% of those surveyed clinicians reported substance abuse treatment as a second career, and clinicians with less than four years of experience were distributed fairly evenly across the 20 – 60 years of age spectrum. Forty-eight percent of reporting clinicians were in recovery themselves. These clinicians tended to be older, had more experience, but lower degree status and salary, and were less likely to plan to leave the treatment field than non-recovering clinicians.

Changes made during the 2017 legislative session allowed credentialed CDPs or CDPTs to practice outside of a Division of Behavioral Health and Recovery-approved substance use disorder agency.(Washington State Legislature, “SSB 5779”, 2017) Previously, CDPs and CDPTs were only allowed to practice in an approved substance use disorder treatment facility, unless they were dual certified.

The 2016 mean annual wage for substance abuse and behavioral disorder counselors in Washington was \$39,030.³ The 10th percentile mean annual wage was \$25,850 and the 90th percentile mean annual wage was \$54,460.(Bureau of Labor Statistics, “Employment Statistics”, 2017) State data from a 2009 CDP survey reported that CDPs working in publicly funded treatment agencies were paid less than their counterparts in private facilities.(Rodriguez & Axelsson, 2011)

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

In the integrated team, CDPs may provide direct counseling to patients and families, assist patients with developing positive means to manage their addiction, and provide community support resources for recovery.(Skillman, Snyder, Frogner, & Patterson, 2016)

A focus within some CDP education and training has been treating those with co-occurring mental health and substance use disorders, an area which has been gaining further attention as integration moves forward. (SAMHSA, 2005; Minkoff & Cline, 2006) As the addiction specialist on an integrated team, CDPs must be prepared to provide leadership and clinical supervision over the substance abuse aspect of patient care, especially given the dearth of chemical dependency treatment education and supervised clinical work provided in most health professions training programs.(Goplerud, Hagle, & McPherson, 2017)

Washington’s Division of Behavioral Health and Recovery published a summary report of CDPs in 2011 which suggested that CDPs would need higher-level skills to implement evidence-based practices, better case management, and integration of CD treatment with primary care.(Rodriguez & Axelsson, 2011). Especially with the legislation passed in 2017 to expand where CDPs may practice, they must expand their roles to include prevention and early intervention to help those with risky drug and alcohol behavior, and to implement interventions such as SBIRT (Screening, Brief Intervention, and Referral to Treatment), medication-assisted treatment, technology-assisted care, and other evidence-based interventions that may be better suited for an integrated environment.(Sacks, et al., 2015) Integration requires providing CDP staff with education on common disease processes, differing practice styles between provider types, and confidentiality issues.(SAMHSA-HRSA Center for Integrated Health Solutions, 2013)

Demand

The Washington State Employment Security Department (ESD) estimates that the average annual growth rate for Substance Abuse and Behavioral Disorder Counselors between 2015 – 2020 is 1.9% and for 2020 – 2025 will be 1.7%.(Washington State Employment Security Department, 2017) This equates to 74 and 72 annual openings for CDPs over 5 years due to growth, respectively. ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations.

Washington’s “early warning” system of health workforce demand changes, the Washington Health Workforce Sentinel Network, allows employers to report workforce shifts and high-priority needs.(Workforce Training & Education Coordinating Board, 2017) More than half of sentinels from BH settings across the state reported exceptionally long vacancies and increased demand for CDPs in late

³Estimates do not include self-employed workers.

2017. Reasons reported for these difficulties included increased demand for CDPs since Medicaid expansion, movement of addiction treatment into managed care settings, and difficulty offering competitive salaries. Psychiatric/substance abuse hospitals frequently reported similar challenges in finding enough qualified applicants for CDP positions, and Federally Qualified Health Centers (FQHCs) also reported exceptionally long vacancies for CDP positions. Changes in onboarding were reported specifically for CDPs moving into the managed care arena, requiring proficiency in areas that may not have been previously required (e.g., Medicaid documentation, evidence-based brief interventions).

A 2011 state assessment reported that between 2004 and 2010 the number of admissions in publicly funded treatment agencies (intensive inpatient, recovery house, long-term residential, outpatient, and opiate treatment programs) in the state increased by 31% while the number of CDPs only rose by 19%.(Rodriguez & Axelsson, 2011) The authors further estimated that expanded Medicaid coverage would result in an additional 41,000 chemical dependency patients seeking publically funded alcohol and drug treatment, requiring an additional 774 CDPs to serve them. Roughly half of the agencies accredited to provide chemical dependency treatment did not serve Medicaid and low income patients.

Few recent studies of CDP demand exist, but at the time of the 2005 DASA survey, 79% of all planned hires in agencies where chemical dependency treatment was provided were CDPs, counselors, and clinicians.(Knudsen, Gallon, & Gabriel, 2006) The most frequently cited reason for difficulties filling open positions was an insufficient number of applicants meeting minimum qualifications (experience, training, and certification).

DASA also produced a staffing report of chemical dependency treatment facilities covering 1991 to 2006.(Rodriguez, 2008) The total number of CDP-certified staff increased from 1991 to 2000, but decreased in 2003 and 2006. This report compared trends in staffing patterns between contract and non contract facilities (contract facilities receive state or federal funds through state contract or through a county sub contract; non contract facilities do not) and found that a higher percentage of all FTE staff in non-contract facilities were CDP-certified compared to contract facilities (ranging from 7% more in 1991 to 16.3% in 2006). This may be in part because of pay disparity for CDPs between the two facility types. In the 2006 report, salary was identified as the number one barrier to entering the substance abuse treatment field.(Knudsen, Gallon, & Gabriel, 2006)

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TECHNICAL NOTES

- Washington State chemical dependency professional and chemical dependency professional trainee data are from the Washington State Department of Health, Health Professions Licensing Data System, April 2017, as analyzed by the Washington State Office of Financial Management. All analyses include CDPs/CDPTs ages 18 – 75 years with active credential status and expiration of credential \geq 2017.
- Washington population data are from the Washington State Office of Financial Management, 2016 data.
- Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.
- Included IPEDS CIP code 51.1501 (Substance Abuse/Addiction Counseling), 51.1599 (Mental and Social Health Services and Allied Professions); when both categories available for one institution, reported 51.1501 category; included Certificates below baccalaureate level and associate degrees, 1st/2nd major, no imputation variables. 2011 – 2015 Final Release Data.
- Washington State Employment Security Department, SOC code 21-1011 (Substance Abuse and Behavioral Disorder Counselors).

FUNDING

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SUGGESTED CITATION

McCarty RL, Skillman SM. Washington State's Behavioral Health Workforce - Occupational Profile: Chemical Dependency Professionals. Center for Health Workforce Studies, University of Washington, Dec 2017.

OCCUPATIONAL PROFILE: CERTIFIED PEER COUNSELORS

Support from others who have lived experience with a mental health or substance use disorder (SUD) has become an important behavioral health (BH) service. The occupation of peer counselor fills this role on BH teams. Peer counselors create bridges between consumers of health services and their providers, and can increase treatment engagement and adherence by creating personal, sustained relationships with patients or clients. In BH settings, peer counselors can directly help persons with behavioral health conditions establish positive health management techniques that promote well-being and recovery.

In Washington state, only peer counselors who identify as having lived experience with mental health challenges (or is the caregiver of a child with mental health system involvement) and who are certified by the Division of Behavioral Health and Recovery (DBHR) and credentialed by the Department of Health (DOH) can have their services reimbursed through Medicaid funds. Other peer counselors in Washington, such as those with SUD or criminal justice system lived experiences alone, are not eligible for reimbursement with Medicaid funds, but they can provide services and can be paid by other funding sources (grants, donations, or volunteerism). It is

more difficult to enumerate and describe the peer counselors who are not certified or credentialed through DBHR. This profile will describe both general peer counselor roles and the pathway to become credentialed as a DBHR-certified peer counselor (DBHR-CPC).

TABLE 1. Washington State Division of Behavioral Health and Recovery Certified Peer Counselors, 2017

With address in:	
Washington	2,358 (99.4%)
Oregon	5 (0.2%)
Idaho	4 (0.2%)
Other	5 (0.2%)
Total	2,372

Data sources: Washington State Office of Financial Management

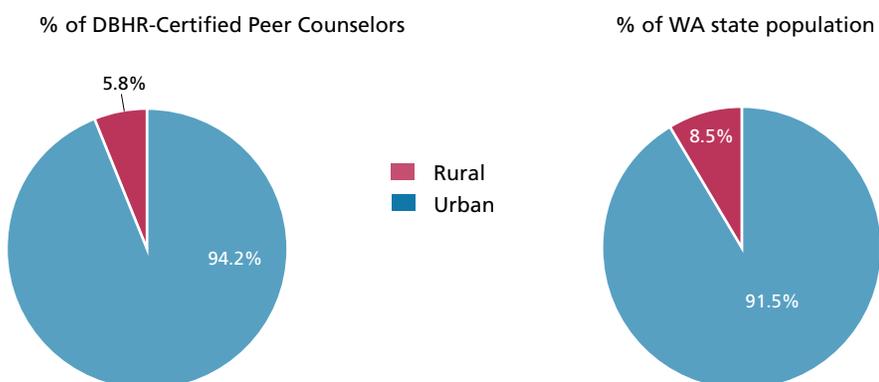
Size, Distribution, and Demographics of Supply of DBHR-Certified Peer Counselors

In April 2017, there were 2,372 DBHR-CPCs who held an active Washington state certification, 99.4% of which had addresses in Washington (Table 1).

Education and Training

Many organizations provide peer support training for people with mental illness or substance use disorders (SUD), and there is no single accepted curriculum to train these peer counselors. While non-DBHR certified peer counselors may be providing services in Washington, this section is focused on DBHR-CPCs whose services can be reimbursed with Medicaid funds.

Figure 1: Rural/Urban Distribution of Division of Behavioral Health and Recovery Certified Peer Counselors and the General Population in Washington



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System.

The training to become a DBHR-CPC in Washington is managed by the Office of Consumer Partnerships. (Washington State Department of Social & Health Services, January 2017) To be eligible for the standard DBHR-CPC training, one must:

- Be a consumer of mental health services, and be in mental health recovery (self-assessed) for at least one year, and be willing to share that personal story and skills

- Be 18 years of age or older
- Have a high school diploma or equivalent, or be granted an exception
- Demonstrate proficiency in reading comprehension and writing skills
- Demonstrate qualities of leadership

The education requirement for becoming a DBHR-CPC is a high school diploma or equivalent. (Washington State Department of Social and Health Services, January 2017) A recent national survey of peer counselors, however, reported that 46.0% of respondents had some college or an associate degree, and 39.4% had a bachelor's degree or beyond. (Cronise, Teixeira, Rogers, & Harrington, 2016)

CPC applicants are required to complete an online training as a prerequisite to applying to attend an in-person training session. The online program is a 10-12 hour course administered by the Behavioral Health Workforce Collaborative at Washington State University.

On completion of the online training, applicants submit an application packet and the prerequisite course certificate of completion to be considered for in-person training. There are usually waitlists, and applicants are selected to attend based on criteria such as current employment in a Medicaid-funded mental health agency, regional priorities, and application scoring. If selected, applicants attend an in-person classroom training session offered by DBHR or regional behavioral health organizations (BHOs). State CPC trainings occur twice per year, once in the east and once in the west of the state. Regional trainings number about 12 per year and may be restricted to BHO residents only. DBHR plans to increase the number of certifications by 15-20% in 2018 (from approximately 350 to 410 individuals trained annually) by increasing the number of trainings and the capacity per training.¹

The in-person training involves about 40 hours spent studying the peer counselor manual, participating in individual and group training activities, and completing skill checks which must be satisfactorily passed. (Washington State Department of Social and Health Services, 2017) The CPC test is administered by Washington State University at the end of the in-person training or shortly afterwards in a nearby location. The test includes multiple choice and oral sections. Applicants have up to five attempts to pass the test before being certified. On passing, applicants receive a letter from DBHR confirming certification requirements have been met.

The curriculum used in the in-person training was prepared by the Washington Institute for Mental Health Research and Training. (Washington Institute for Mental Health Research & Training, 2009) It describes the public mental health system and the role of the DBHR-CPC, and focuses on recovery principles and core skills including communication, telling one's story, ethics, goal setting, documentation, and working in groups. Training is largely focused on trauma-informed practices and cross-cultural partnerships.

TABLE 2. Distribution of DBHR-Certified Peer Counselors in Washington by Accountable Community of Health, 2017

DBHR-Certified Peer Counselors	N	Population	Rate per 100,000
Statewide*	2,346	7,183,700	32.7
By Accountable Community of Health (ACH)†			
Pierce County	518	844,490	61.3
North Sound	253	1,206,900	21.0
King County	538	2,105,100	25.6
Better Health Together	207	587,770	35.2
Cascade Pacific Action Alliance	267	614,750	43.4
Greater Columbia	128	710,850	18.0
Southwest Washington	242	493,780	49.0
Olympic Community of Health	76	367,090	20.7
North Central	117	252,970	46.3

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* DBHR-Certified Peer Counselors with Washington State certification address only.

† Counties in multi-county ACH's are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

¹Patricia Marshall, Washington State Department of Social and Health Services Peer Support Program Manager, personal communication, October 30, 2017

There are also family and youth specialty trainings as well as trainings in Spanish. In 2018, DBHR will be adding SUD peer counselor training for targeted SUD recovery support as part of the State Targeted Response to the Opioid Crisis Grant (“Opioid STR”) efforts. (Washington State Department of Social and Health Services, March 2017) The training and testing are free to the trainees, and food and board are provided for state-level trainings. Program administration costs are supported by grants (Mental Health Block Grant [adults], Opioid STR Grant [SUD]), T.R. Litigation settlement funds (T.R. v. DREYFUS, 2013), and regional Behavioral Health Organization (BHO) funds.

Credentialing

Once certified, potential employers may require that the DBHR-CPC become credentialed as an Agency Affiliated Counselor (AAC) if the agency provides Medicaid billable services. AACs may only work in approved facilities (see WAC 246-810-016), and must notify the Department of Health within 30 days if they leave or change agencies. (Washington State Legislature, 2011) They may not provide counseling services except through their agency of employment. Prior criminal history may be a barrier to employment as a DBHR-CPC in some agencies, or in getting an agency affiliated counselor license, but would not prevent a person from becoming a DBHR-CPC.

The services which AACs may provide include screening of functional impairment, and guidance in life situations and skill development. However, AAC service provision is limited by the functional impairment of the patient. If the patient’s impairment meets certain criteria, the AAC is legally required to refer to a licensed mental health professional or medical provider, or attain written refusal from the patient to participate in the referral. Even with written refusal, AACs may not be a sole treatment provider for individuals with serious functional impairment.

Practice Characteristics

While Medicaid reimbursement opportunities in Washington are limited to DBHR-CPCs who acquire the AAC credential, peer counselors trained in other programs may also provide services. For example, across the nation, peer counselors work in myriad roles and settings. (Blash, Chan, & Chapman, 2015; Cronise, Teixeira, Rogers, & Harrington, 2016) Peer counselors serve as recovery navigator/coaches, case managers, outreach coordinators, family support, and health and wellness coaches, to name a few. They may provide activities which promote recovery, self-advocacy, community living skills, and support formation. Peer counselor services may be provided individually or in groups, in-person or by telephone.

Peer counselors can be used in community mental health centers, rehabilitation centers, hospitals, schools, adult and juvenile justice systems, the foster care system, and other settings. They may also work in community settings and non-profits, on crisis lines, and in peer-run recovery organizations. Peer counselors may provide a bridge for those leaving inpatient or incarceration facilities and transitioning back into the community. As AACs, their services can be paid for in approved agencies.

Employment of peer counselors may improve an agency’s credibility with its consumers, provide informal perspective and quality control, and provide first-hand insights into treatment limitations, appropriateness, and outcomes. (Blash, Chan, & Chapman, 2015)

The U.S. Bureau of Labor Statistics does not collect data specifically on peer support specialists, but counts them among community health workers. In Washington, the annual mean wage for community health workers was \$39,980 in May 2016.² The 10th percentile mean annual wage was \$24,780 and the 90th percentile mean annual wage was \$60,830.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

Research literature on emerging roles of peer counselors provides examples of where peer counselors may serve on teams with traditional mental health and substance use treatment providers, such as with assertive community treatment (ACT) teams, crisis stabilization units, mobile crisis teams, medication-assisted recovery services (MARS), and peer-bridger programs.

Peer counselors may become their agency’s community resource expert in topics like housing, employment, and parenting/childcare. They often possess valued skills such as training in motivational interviewing, WRAP (Wellness Recovery Action Plan), trauma informed

²Estimates do not include self-employed workers.

care, life skills, dialectical-behavioral therapy and other modalities. They can model strength-based language within the agency.

There is a perceived lack of internal support for peer counselors within agencies, and this may result in higher turnover.(Gates & Akabas, 2007) Agencies may not understand how best to use peer counselors, and stigma or differing treatment philosophies can create barriers to acceptance and respect on the integrated team. Providing a supervisor who is a certified peer counselor and providing internal meetings of the peer counselor employees may help support their connectedness to their agency.(Silver & Nemece, 2016) Clearly defined roles and job descriptions, as well as boundaries, can improve the work environment for peer counselors. Investing in continuing education, particularly in community settings, is also a positive way for agencies to demonstrate support.(Gates & Akabas, 2007)

Demand

Data on the demand for peer counselors in behavioral health is lacking.(Blash, Chan, & Chapman, 2015) Behavioral health workforce shortages and the provision of Medicaid billable services may increase the appeal for their use.(Blash, Chan, & Chapman, 2015; Cronise, Teixeira, Rogers, & Harrington, 2016; Myrick & Del Vecchio, 2016; Silver & Nemece, 2016) Further research is recommended on the number of peer providers trained, employed, and who advance in the field.

Washington's "early warning" system of health workforce demand changes, the Washington Health Workforce Sentinel Network, allows employers to report workforce shifts and high-priority needs.(Workforce Training & Education Coordinating Board, 2017) Some sentinels in behavioral health clinics report exceptionally long vacancies for peer counselors. The most commonly reported barriers to hiring are lack of funding, salary constraints, and finding qualified and professional candidates.

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Workforce Training & Education Coordinating Board. (2017). *Findings as reported by facility type*. Retrieved from Washington State Health Workforce Sentinel Network: <http://www.wtb.wa.gov/HealthSentinel/findings-facility.asp>.

TECHNICAL NOTES

1. Washington State DBHR-Certified Peer Counselors data are from the Washington State Office of Financial Management. All analyses include DBHR-Certified Peer Counselors ages 18 – 75 years with active credential status and expiration of credential \geq 2017.
2. Washington population data are from the Washington State Office of Financial Management, 2016 data.
3. Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.

FUNDING

This study was funded through contract # IAA-860-17 between the Washington Workforce Training and Education Coordinating Board and the University of Washington, supported by Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds.

SUGGESTED CITATION

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OCCUPATIONAL PROFILE: COMMUNITY HEALTH WORKERS

Community Health Workers (CHWs) are frontline public health workers who apply their unique understanding of the experience, language, and culture of a particular population—for example, an immigrant population—to bridge the gap between the community and health care, government, and social service systems. (Washington State Department of Health, 2015) A defining feature of CHWs is their position of trust within and/or unusually close understanding of their communities. (Community Health Worker Task Force, 2016) CHWs work in a variety of health and social service roles (e.g., patient navigator, care coordinator, patient advocate) to connect clients/patients to community resources, do outreach work, and provide peer counseling, health education, case management, or other similar tasks. This profile describes CHWs across their varied roles. Their role specifically in behavioral health and integrated behavioral health – physical health settings is still emerging.

TABLE 1. Sample of Community Health Workers Demographic Characteristics in Washington, 2015

Characteristic	Percentage
Female	86%
Age	
25 – 44 years	33%
45 – 64 years	47%
Ethnicity/Race	
Non-Hispanic white	49%
Hispanic	34%
Non-Hispanic blacks, Asians, Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives	1 – 8 %
Education	
High school degree or less	10%
Some college	29%
College degree	61%
Identified as having a disability	12%
Lesbian, gay, bisexual, or transgendered	5%

Data Source: Community Health Worker Training Program Evaluation Report, October 2015

Size, Distribution, and Demographics of Supply of DOH-Trained Community Health Workers

There is no certification for CHWs in Washington and they may receive training from a variety of programs. The Department of Health (DOH) sponsors a CHW Training Program that tracks and evaluates outcomes for their participants. While these data are not exhaustive, they provide a snapshot of CHWs in Washington.

As of July 2017, there were 1,473 Washington residents who had completed the DOH-sponsored CHW Core Competency course. One hundred twenty-four had completed a Behavioral Health specific add-on training. One evaluation source provided an estimate of 9.4% of CHW staff doing work in a behavioral health agency. (Washington State Department of Health, 2015)

The DOH CHW Training Program summarized demographics from a sample of program participants in 2015 (see Table 1). (Washington State Department of Health, 2015) More than half (61%) of the DOH CHW training participants reported having a college degree or more. This finding requires confirmation since these data come from a small sample of the state-trained CHWs, but if true, suggests that CHWs may occupy a range of roles in their work settings. Most participants

in the DOH CHW Training Program already worked as a CHW or related professional and attended the training at their employer's request.

Table 2 describes the number of CHW training program registrants who lived in each Washington Accountable Community of Health (ACH) since the program's inception. Further data on CHW's found in each ACH, including number of participants per county (as of December 2015), participating agencies, and identified trainee roles, can be found in a report produced by the DOH CHW Training Program: <https://www.doh.wa.gov/Portals/1/Documents/Pubs/349-003-CHW-TrainingProgramRegionalData.pdf>

DOH Community Health Worker Education and Training

TABLE 2. Distribution of Department of Health Core Competency Trained Community Health Workers in Washington by Accountable Community of Health

DOH-Trained Community Health Workers	N	Population	Rate per 100,000
Statewide*	1,473	7,183,700	20.5
By Accountable Community of Health (ACH)†			
Pierce County	161	844,490	19.1
North Sound	175	1,206,900	14.5
King County	250	2,105,100	11.9
Better Health Together	266	587,770	45.3
Cascade Pacific Action Alliance	70	614,750	11.4
Greater Columbia	275	710,850	38.7
Southwest Washington	123	493,780	24.9
Olympic Community of Health	55	367,090	15.0
North Central	98	252,970	38.7

Data source: Community Health Worker Training System Data for Regional Accountable Communities of Health Report (DOH 349-003), October 2017.

* Community Health Workers with Washington State registration city only.

† Counties in multi-county ACH's are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

DOH CHW Core Competency trainings are offered regionally four times per year and administered by the Department of Health's Office of Family and Community Health Improvement (OFCHI) in the Prevention and Community Health Division. There is no charge to the attendees of the course, as the program is currently funded through federal grants and other department funds. Strategies must be identified for sustainable funding beyond 2018. (Washington State Department of Health, "Transformation Talk", 2017)

Washington state implemented the DOH CHW Core Competency training curriculum in 2011. This Core Competency training is 30 hours long and requires two in-

person days (one at the beginning and one at the end of the training) with six weeks of online learning between the in-person days. On completion of the Core training program, an additional twenty-five 3 to 5-hour long Health-Specific Modules (HSMs) are offered online free of charge to acquire more specialty skills. A Behavioral Health module is available.

On the first training day, training covers:

- CHW definition, roles, and boundaries
- Communication
- Cultural competency
- Navigating the online training system

Core competency modules online include skill building in:

- Organization
- Documentation
- Assessment
- Service coordination
- Writing and presenting a case study

On completion of the online training, CHWs regroup in person to evaluate their experience, plan implementation of their skills, demonstrate competency via a case study presentation, share local resource knowledge, and receive their Certificate of Completion.

Seniors in high school are allowed to take the training, and some Washington community colleges (Yakima Valley, Lower Columbia, Highline, and Tacoma) offer CHW training graduates up to five credit hours towards select associate and bachelor level programs.

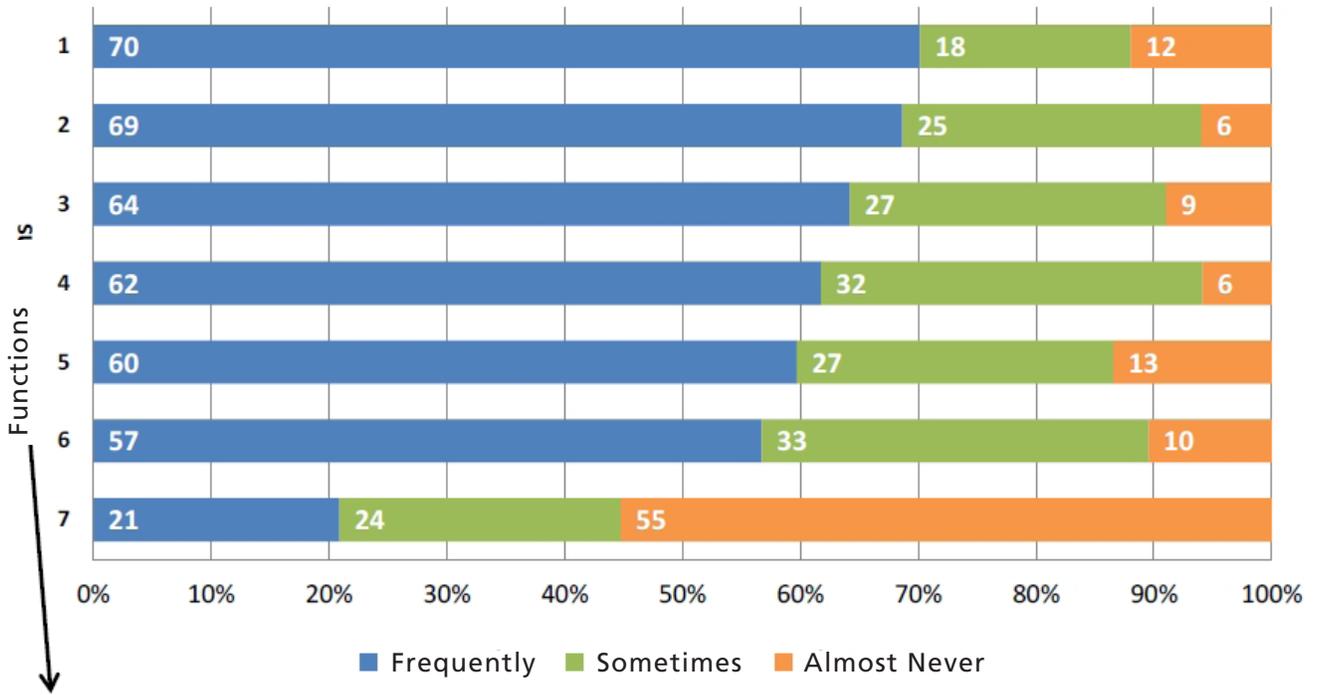
Credentialing

There is currently no certification or other credentialing established for CHWs in Washington state. The DOH CHW Training Program provides a certificate of completion which is not a professional credential.

Practice Characteristics

Evaluative data from the Washington State Department of Health’s Community Health Worker Program summarizes a CHW workforce survey completed in 2015. (Washington State Department of Health, 2015) About 74.5% of survey respondents who completed the training worked as a CHW in the prior year, 42.6% in paid positions, 5.3% as supervisors of CHWs, and 25.5% as volunteers.

Figure 1: Type of Functions Performed as Community Health Worker



1. Provide culturally appropriate health education and information
2. Advocate for needs and perspectives of community members served
3. Provide cultural link between organizations and communities
4. Provide informal counseling, coaching, or social support to people
5. Make sure people get access to health and social services they need through case study, referral, and follow-up
6. Help community members increase health knowledge and be self-sufficient
7. Provide direct services such as first aid or blood pressure screening

* Replicated and used with permission from Community Health Worker Training Program, Washington Department of Health

TABLE 3. Percentage of Survey Respondents in Work Setting, 2015

Work Setting	Percent
Community-based organization*	40.4
Doctor's office or clinic	26.3
Other	21.1
Hospital	19.3
Migrant or Community Health Center	14.0
Faith-based organization	12.3
Schools or universities	8.8
Local Health Jurisdiction	7.0
Housing Authority	5.3
Adult Family Homes	3.5
Shelters	3.5
Private insurance company	1.8
Tribal Health Center	0.0

* Social service agency, YMCA, etc.

Participants could select more than one setting. Used with permission from the Community Health Worker Training Program Washington Department of Health

Table 3 shows the settings where participants most often worked as a CHW in the 2015 evaluation.

Of those CHWs who responded (N = 94), the most frequently used skills reported were communication (85.1%) and cultural competency (78.7%). Of those respondents who worked as a CHW and completed the Health-Specific module in Behavioral Health (N=46), 76.1% sometimes or frequently used the information and skills taught in that module. About two-thirds of participants had an employer or supervisor who suggested or required that they attend the training. Only 5 out of 57 question respondents received a promotion, pay raise, or better job as a result of participating in the DOH CHW Training Program. (Washington State Department of Health, 2015)

Forty-seven CHW employers also completed the evaluative survey. Ninety-four percent of the employers reported seeing some to substantial improvement in staff core competency skills and knowledge. Over half of the employers required their employees, contractors, or volunteers doing work as a CHW to attend formal external training after being hired. Most (80.9%) allowed their employees to complete the online portions of the

training while at work. The most frequently reported barrier to using CHWs was the limited or lack of funding, the lack of ability to bill insurers for CHW services, and limited understanding of CHW roles and duties. All employers agreed that use of CHWs was in some measure important for eliminating health disparities among vulnerable populations served by their organizations. Further information is provided in the original report.(Washington State Department of Health, 2015)

In 2015, the Community Health Worker Task Force was created to develop policy and system change recommendations to align the community health worker with the Healthier Washington initiative and recommend measures to support CHW integration into the healthcare system.(Community Health Worker Task Force, 2016) The Task Force provided recommendations concerning increasing the scope of training and education for CHWs, investigating sustainable financing options, and means of integrating CHWs into transformation initiatives.

The 2016 mean annual wage¹ for community health workers in Washington was \$39,980.(Bureau of Labor Statistics, "Employment Statistics", 2017) The 10th percentile mean annual wage was \$24,780 and the 90th percentile mean annual wage was \$60,830.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

In the clinical setting, CHWs contribute to the aim of optimizing patient health outcomes. Examples where CHWs may be used is walking patients to internal referrals for a "warm hand-off", referring them to community resources, conducting home visits to assess barriers to meeting medical goals, and providing basic patient education.(Reinschmidt, et al., 2017) For behavioral health care, CHWs provide social support, referral to behavioral health resources, and screening. From the DOH program evaluation survey, 75% of the responding training completers worked as part of a health care team.(Washington State Department of Health, 2015)

Research examining how to support integration of CHWs into clinical healthcare teams recommended that CHWs receive fundamental training on health literacy/terminology, clinical system knowledge, and utilization of clinical information systems and technology in

¹Estimates do not include self-employed workers.

order to effectively communicate in clinical settings.(Chapman, Schindel, & Miller, 2017) The Washington Task Force and Training Program Evaluation report also mentioned these training needs. However, the implementation of these skills may be a differentiated between CHWs that work in community versus integrated clinical settings. Role clarification for the CHW is also critical to a successful holistic care team that includes community supports, as well as team recognition of CHW value in achieving patient-centered care. (Reinschmidt, et al., 2017)

Demand

Demand data for CHWs is lacking, and a model to assess demand for CHW roles in clinical settings is still being developed.(Chapman, Schindel, & Miller, 2017)

State data from the Washington State Employment Security Department (ESD) estimates that the average annual growth rate for CHWs between 2015 – 2020 will be 1.7% and for 2020 – 2025 will be 1.4%.(Washington State Employment Security Department, 2017) This equates to 24 and 22 annual openings due to growth, respectively. ESD estimates, however, are based on average health sector growth trends and do not necessarily take into account state initiatives that may increase demand for behavioral health occupations.

Washington’s 1115 Medicaid Waiver Demonstration Project allows CHWs to be paid as part of a Medicaid value-based payment. (National Academy for State Health Policy, 2017) CHWs can be part of Washington’s Health Homes, which allows them to receive Medicaid funding for each patient served. This may lead to an increased demand in CHWs in Washington.

Several programs in Washington use or plan to use CHWs in their work. The DOH CHW Training Program partnered with the DOH Heart Disease, Diabetes and Stroke Prevention Unit to train more community individuals in monitoring their blood pressure and diabetes.(Washington State Department of Health, 2015) In a “train the trainer” model, they also partnered with the Spokane Regional Public Health District, which has been using the training curriculum locally since 2015.

The CHW Pilot Integration Project is a partnership between Healthy Gen and DOH to integrate a CHW into a primary care team at clinics to address chronic disease prevention and management. The Project works with six clinical settings across the state and is identifying best practices and providing technical assistance for the utilization of CHWs in the clinical environment. While these examples are not specific to CHW roles in BH settings, the need for these skills is high among behavioral health clients.

Working with and receiving input from regional partners, the Better Health Together Accountable Community of Health (BHT ACH) chose a community-based care coordination model called “Pathways Community HUB Model” to deliver standardized and measured means of connecting at-risk individuals to health and social services.(Better Health Together, 2017; Rockville Institute, 2017) To support this effort, the Washington Department of Health is exploring the creation of a CHW Pathways Training System to develop infrastructure for a Pathways Community HUB Certification Program.(Pyle, 2017) A September 2017 Department of Justice grant awarded to Spokane County and City will create a Jail Transitions Pathways Community HUB pilot in collaboration with the BHT ACH whereby CHWs will engage incarcerated participants to link them to health and social community resources at the time of their release.(Palomba, 2017)

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TECHNICAL NOTES

1. Washington State Employment Security Department, SOC code 21-1094 (Community Health Workers).

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