

Washington's Behavioral Health Workforce: Barriers and Solutions



Phase II Report and Recommendations

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Executive Summary

As Washington moves forward to achieve integration of its statewide physical and behavioral healthcare systems by 2020, demand for a qualified behavioral health workforce continues to grow. While the state has many highly competent and committed professionals working hard to deliver behavioral health services, barriers to educational attainment, professional recruitment, and long-term retention may prove detrimental to the state's ability to provide sufficient behavioral healthcare—defined in this report as mental health and substance use disorder treatment—to its residents.

The 2019 Washington State Legislature directed the formation of a workgroup, funded by the Health Professions Account,¹ to continue work on select workforce barriers outlined in the Workforce Training and Education Coordinating Board's (Workforce Board) 2017 Washington State Behavioral Health Workforce Assessment. The 2017 assessment described the state's behavioral health workforce landscape and provided recommendations for research and policy proposals to better understand and address workforce barriers faced by the industry. This current project builds upon that work, and charged the Workforce Board to lead a workgroup to develop recommendations on the following five topic areas:

- a) Reimbursement and incentives for supervision of interns and trainees.
- b) Supervision requirements.
- c) Competency-based training.
- d) Licensing reciprocity or the feasibility of an interstate licensing compact, or both.
- e) Background checks, including barriers to work related to an applicant's criminal history or substance use disorder.

The workgroup is led by the Workforce Board in collaboration with the University of Washington Center for Health Workforce Studies (UW CHWS) (hereafter "Project Team"); the two entities previously partnered on the aforementioned 2017 Assessment.

This report provides background and recommendations addressing the five topic areas above. These recommendations were developed across the two phases of the project, and in concert with stakeholders throughout the duration of the project. Phase I began in September 2019 and ended with a report on two of the five topics to Governor Inslee and the Legislature in December 2019. Phase II of the project began in January 2020, and culminates with this report to the Legislature, due December 1, 2020. The stakeholder workgroup, which included health facility leaders, behavioral health providers, educators, organized labor, not-for-profit organizations, state and local government agencies, and many more, shaped the recommendations in this report.

¹ Administered by the Washington State Department of Health.

Key Findings

When asked about the specific topics covered in this report, stakeholders were consistent in mentioning the following challenges:

Reimbursement and Incentives for Supervision

- Stakeholders consistently supported improved reimbursement for supervision and suggested a variety of mechanisms to allow for this reimbursement.
- Stakeholders raised concerns that already over-burdened community behavioral health agencies could have additional administrative burdens under some reimbursement arrangements and encouraged supervision reimbursement be done in a way that assures little additional administrative work.

Supervision Requirements

- Stakeholders desired greater transparency regarding how supervision hours requirements are determined and how these impact the workforce.
- Allowing tele-precepting to satisfy supervision requirements hours is needed, according to stakeholders.
- Stakeholders were interested in seeing more supports for distribution of supervision work between supervisory staff, which would allow for specialization and distributed workload. They noted that these supports are particularly lacking in community-based behavioral health agencies due to resource constraints.

Competency-Based Training

- Stakeholders raised concerns about how a competency-based training regime would work and wanted to know more about the viability of replacing supervision hours with competency-based training or testing.
- Stakeholders expressed strong interest in the use of registered apprenticeships for behavioral health training as a practical and effective way to employ competency-based training and address other concerns impacting the behavioral health workforce pipeline.
- Increased behavioral health training for staff in primary care settings was seen as a need by stakeholders.

Reciprocity and Interstate Agreements

- The current licensing and credentialing processes for behavioral health professionals and paraprofessionals who have already established licensure and practice outside of Washington are causing problems for workers and employers, and perhaps patients.
- Stakeholders want faster and more efficient processes for licensing and credentialing well-qualified veteran behavioral health professionals and

paraprofessionals that are taking up residence in Washington and seeking to work in behavioral healthcare, especially for military spouses/domestic partners.

- Stakeholders viewed interstate variation in clinical practice and licensing requirements for behavioral health professionals and paraprofessionals as a major barrier to licensure reciprocity and wanted clarity on which behavioral health practitioners were suited for reciprocity.
- Interstate compacts for licensure were generally perceived as complex, impractical for addressing immediate workforce needs, and controversial due to their wide-ranging policy impacts.

Background Checks

- Background checks are viewed as necessary for public safety, mandated by federal laws, and required to access certain funding. But stakeholders raised some concerns about their application and the time required for completion.
- Some stakeholders were unclear about what types of background checks were required for various occupations.
- Stakeholders desired greater transparency regarding how background check information is used by boards and employers in licensing, credentialing, and employment, as well as consideration of equity in how background checks are applied.
- Stakeholders generally agreed background check use should be regularly reviewed by appropriate authorities to: assess effects of the background check process on efficient licensing and employment; maintain patient safety; and to ensure equitable application with populations disproportionately affected by substance use disorders and/or inherent biases in the criminal justice system.

Recommendations

For specific details on each topic area, including the action required for each recommendation, please see page 20.

Topic I: Reimbursement & Incentives for Supervision

- *Recommendation 1.1:* Develop and implement a funding mechanism that recognizes and supports community behavioral health agencies for performing a significant training function required for behavioral health workers to obtain their educational degree and their clinical licensure.
- *Recommendation 1.2:* Create a stipend for clinical supervision of students, based on patient encounters lost.
- *Recommendation 1.3:* Strengthen and fund loan repayment programs, including the established Washington Health Corps model, that incentivize direct (clinical) behavioral health service provision.
- *Recommendation 1.4:* Expand geographical reach of, and scale up, programs that promote behavioral health supervision.

Topic II: Supervision Requirements

- *Recommendation 2.1:* Remove barriers to effective tele-precepting for supervision in clinical education and pre-licensure settings.
- *Recommendation 2.2:* Assess the impact of current supervision requirements on size, distribution, and availability of select occupations in the behavioral health workforce. Provide recommendations on ways to reduce or standardize the number of supervised hours required for licensure, while assuring clinical competency.
- *Recommendation 2.3:* Structure funding supports to promote new models of supervision which allow for division of labor and multiple pathways to working as a supervisor.

Topic III: Competency-Based Training

- *Recommendation 3.1:* Support development of a registered apprenticeship model for behavioral health professions.
- *Recommendation 3.2:* Identify viability of adapting certain aspects of Washington's existing education, training, and credentialing evaluation metrics into a competency-based method.
- *Recommendation 3.3:* Promote an increase in acquisition of behavioral health competencies among the broader health workforce, with an emphasis on the primary care workforce.

Topic IV: Licensing Reciprocity & Interstate Agreements

- *Recommendation 4.1:* Continue to support Department of Health's work implementing licensing reciprocity.
- *Recommendation 4.2:* Reduce paperwork requirements for established professionals.
- *Recommendation 4.3:* Develop a crosswalk of licensing portability/reciprocity requirements.
- *Recommendation 4.4:* Engage with and incorporate tribal governments' and tribal providers' perspective regarding licensing reciprocity.

Topic V: Background Checks

- *Recommendation 5.1:* Conduct an evidence-based review of the Department of Social and Health Services Secretary's Disqualifying List of Crimes and Negative Actions as applied to behavioral health facilities/employers of behavioral health providers.
- *Recommendation 5.2:* Anticipate a possible increase in behavioral health workers in emergency services/first responder roles.
- *Recommendation 5.3:* Expand community awareness and engagement with Certificate of Restoration of Opportunity and its potential benefits.
- *Recommendation 5.4:* Convene leadership of state agencies with jurisdiction to reduce barriers to behavioral health employment related to criminal background checks.

Background

The 2016-2017 Washington State Behavioral Health Workforce Assessment determined that “the demand for behavioral healthcare—mental health and substance use disorder treatment—exceeds the availability of services throughout the state.”² The assessment went on to detail specific policy recommendations to increase the number of available behavioral health workforce members to provide Washington residents with more timely access and appropriate behavioral healthcare.³ This 2020 report expands upon work done in the 2017 assessment.

The demand for behavioral healthcare exceeds the availability of services throughout the state.

Project to Improve the Behavioral Health Workforce and Access to Care

As Washington moves forward to achieve integration of its statewide physical and behavioral healthcare systems, demand for a qualified behavioral health workforce continues to grow. While the state has many highly competent and committed professionals working hard to deliver behavioral health services, barriers to educational attainment, professional recruitment, and long-term retention may prove detrimental to the state’s ability to provide sufficient behavioral healthcare—defined in this report as mental health and substance use disorder treatment—to its residents.

The 2019 Washington State Legislature directed the formation of a workgroup, funded by the Health Professions Account, to continue work on select workforce barriers outlined in the Workforce Training and Education Coordinating Board’s (Workforce Board) 2017 Washington State Behavioral Health Workforce Assessment. The Workforce Board has led this project, in collaboration with the University of Washington Center for Health Workforce Studies (UW CHWS); the two entities previously partnered on the aforementioned 2017 Assessment.

The 2017 assessment described the state’s behavioral health workforce landscape and provided recommendations for research and policy proposals to better understand and address workforce barriers faced by the industry. This current project builds upon that work and charged the Workforce Board to lead a workgroup to develop recommendations on the following five topic areas:

- a) Reimbursement and incentives for supervision of interns and trainees.
- b) Supervision requirements.

² Gattman, McCarty, Balassa, & Skillman, 2017, p.1.

³ Gattman et al., 2017.

- c) Competency-based training.
- d) Licensing reciprocity or the feasibility of an interstate licensing compact, or both.
- e) Background checks, including barriers to work related to an applicant's criminal history or substance use disorder.

This report provides background and recommendations addressing the five topic areas above. These recommendations were developed across the two phases of the project and in concert with stakeholders throughout the duration of the project. Phase I began in September 2019 and ended with a report on two of the five topics to Governor Inslee and the Washington Legislature in December 2019. Phase II of the project began in January 2020, and culminates with this report to the Legislature, due December 1, 2020. The project's stakeholder workgroup, which included health facility leaders, behavioral health providers, educators, organized labor, not-for-profit organizations, state and local government agencies, and many more, shaped the recommendations in this report. Over 250 individuals participated in the development of this report through individual interviews, large group meetings, and written input.

The Burden of Disease and Barriers to Care

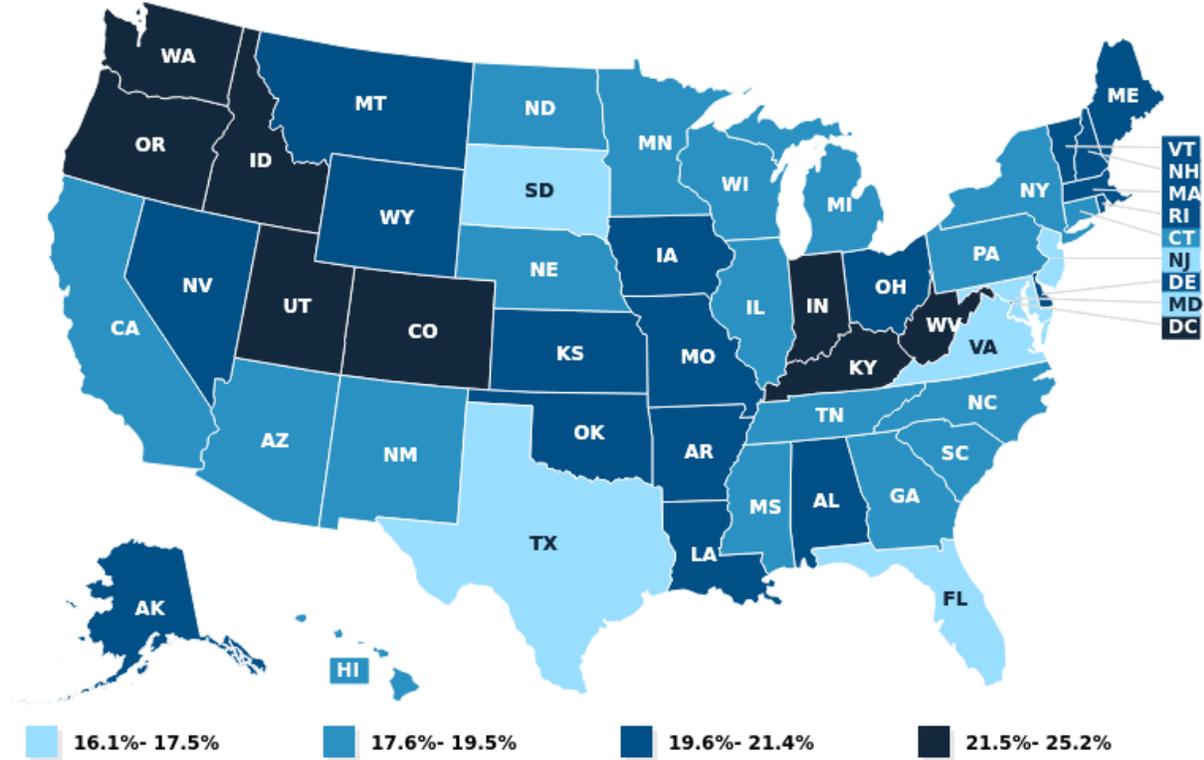
Washington residents continue to experience significant disease burden from mental illness and substance use disorders, and difficulty accessing treatment and maintaining recovery. In 2016 and 2017, an estimated 18.8 percent of Washington adults received treatment for mental illness in the preceding year. However, an estimated 7.1 percent (approximately 398,000 Washingtonians) faced an unmet need in their mental health treatment within the past year (2016-2017) and among them, many did not know where to seek treatment (20.6 percent), or thought they could "handle" the challenges without treatment (30.1 percent). In the same span, an estimated 6.2 percent of Washingtonians experienced substance use disorder within the same year, and 8.4 percent reported receiving substance use disorder treatment in their lifetime.⁴

In 2018, more than 22 percent of Washingtonian adults reported having any mental illness in the past year, higher than the national average of 19 percent (Figure 1), and more than 5 percent reported having a serious mental health issue.⁵

⁴ Substance Abuse and Mental Health Data Archive, 2019.

⁵ Kaiser Family Foundation, 2020.

Figure 1. Adults Reporting Mental Illness in the Past Year, 2017-2018



Source: Kaiser Family Foundation, 2020.

Statewide, pregnant or parenting individuals, as well as those who have had involvement with the criminal justice system, face particularly glaring gaps in behavioral health treatment.⁶ Sufficient availability of appropriately-trained workers to identify, assess, treat, and monitor these patients is a necessary component to providing high-quality behavioral healthcare and reducing disparities in access to appropriate care.

47.6 million
U.S. adults lived with a
diagnosed mental
illness in 2018.

Washington is not unique in facing the complex challenge of addressing access to appropriate behavioral health services; the problem is equally challenging at the national level. In 2018 the burden of mental illness and substance use disorders and access to treatments in the U.S. was considerable:

- An estimated 19.1 percent (47.6 million people) of U.S. adults aged 18 years or older lived with a diagnosed mental illness, and 4.6 percent (11.4 million)

⁶ McGill, 2019.

experienced significant mental illness. Of the 11.5 million U.S. adults severely impaired by a major depressive episode, 31.4 percent did not receive treatment, a statistically significant reduction in access to treatment compared with the preceding seven years.⁷

- 7.8 percent of U.S. adults (19.3 million people) experienced at least one substance use disorder. Within this population, 75.4 percent faced alcohol use disorder, 38.3 percent experienced prescription or other drug use disorder, and 12.9 percent experienced co-occurring alcohol and drug use disorders. In the same year, substance use disorder treatment was provided to 15.3 percent of individuals 18- to 25-years old, 7.0 percent of those 26 years or older, and 3.8 percent of 12-17 year olds.⁸
- Among the estimated 9.2 million individuals experiencing co-occurring substance use disorder and mental illness, 48.6 percent did not receive care for either, a statistic unchanged since 2015.⁹

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use disorder in 2018.

When compared with other U.S. states and the District of Columbia, in 2017-2018, Washington ranked 31st out of 51 on an index of mental illness and access to care, as shown in Figure 2.¹⁰ This was an improvement on the state's 2016-2017 ranking, which was 45th out of 51.¹¹

⁷ SAMHSA, 2019.

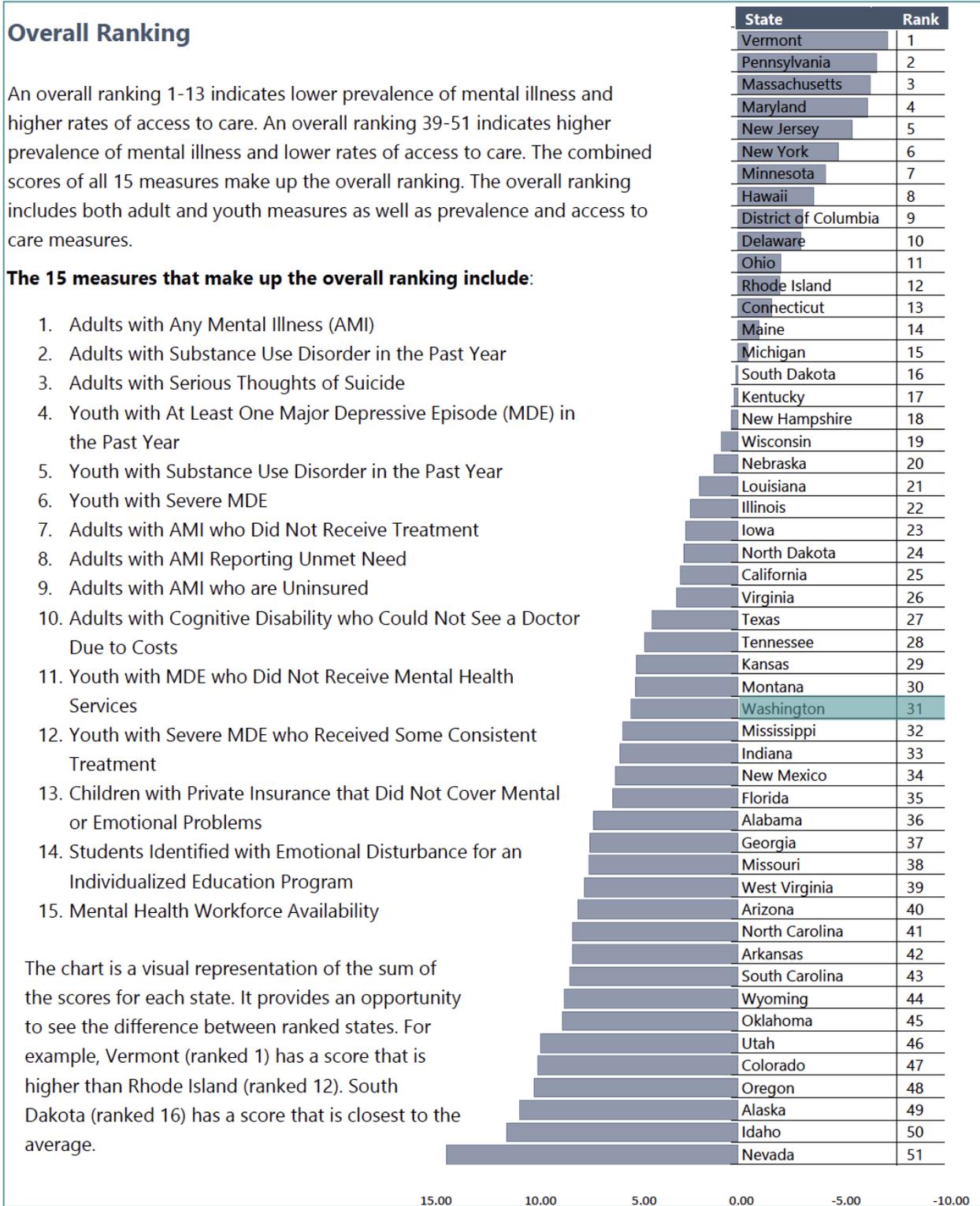
⁸ SAMHSA, 2019.

⁹ SAMHSA, 2019.

¹⁰ Reinert, Nguyen, & Fritze, 2020.

¹¹ Reinert, Nguyen, & Fritze, 2019.

Figure 2. Washington’s Overall Ranking in Behavioral Health and Access to Care



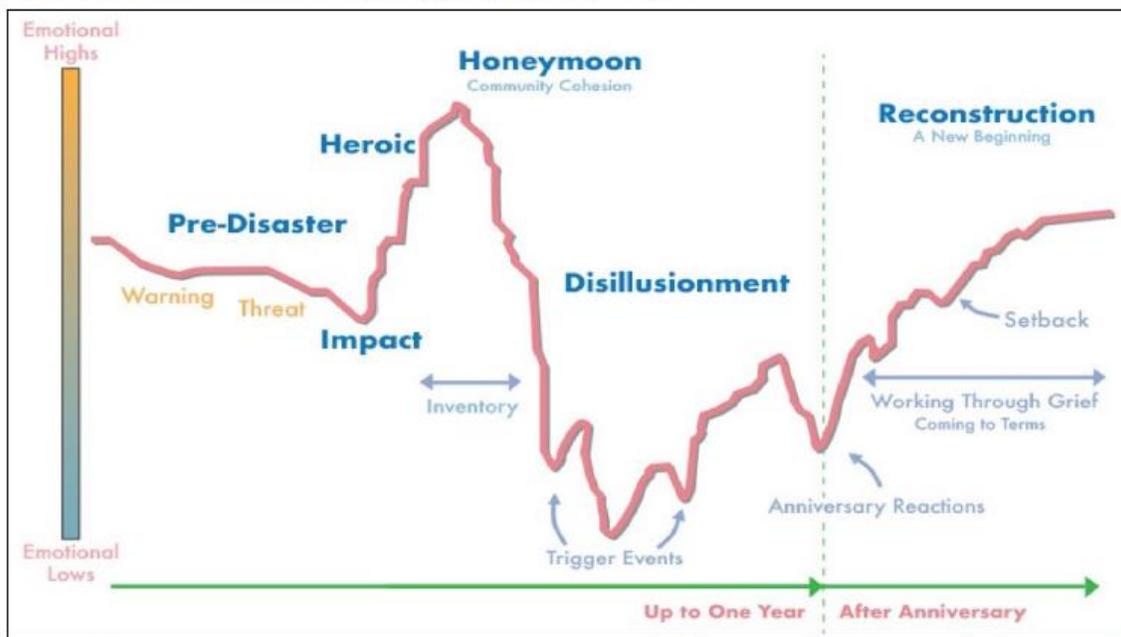
Source: Reinert, Nguyen, & Fritze, 2020.

Behavioral Health During the COVID-19 Pandemic

Behavioral health needs have only increased nationally and in Washington since the COVID-19 pandemic began in early 2020, and this need is expected to increase as the pandemic's cases, and attendant economic and social hardships, continue to rise. Figure 3 illustrates the phases of reactions and behavioral health symptoms before, during, and after a disaster, such as a pandemic, illustrating that behavioral health problems in the U.S. and in Washington are projected to get worse as the pandemic continues. Using available research on behavioral health outcomes following disasters, Washington's Department of Health (DOH) suggested that 30-60 percent of the population may exhibit clinically significant depressive symptoms by year's end.¹²

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symptoms by year's end.

Figure 3. Reactions and Behavioral Symptoms in Disasters



Source: WA DOH; adapted from SAMHSA.

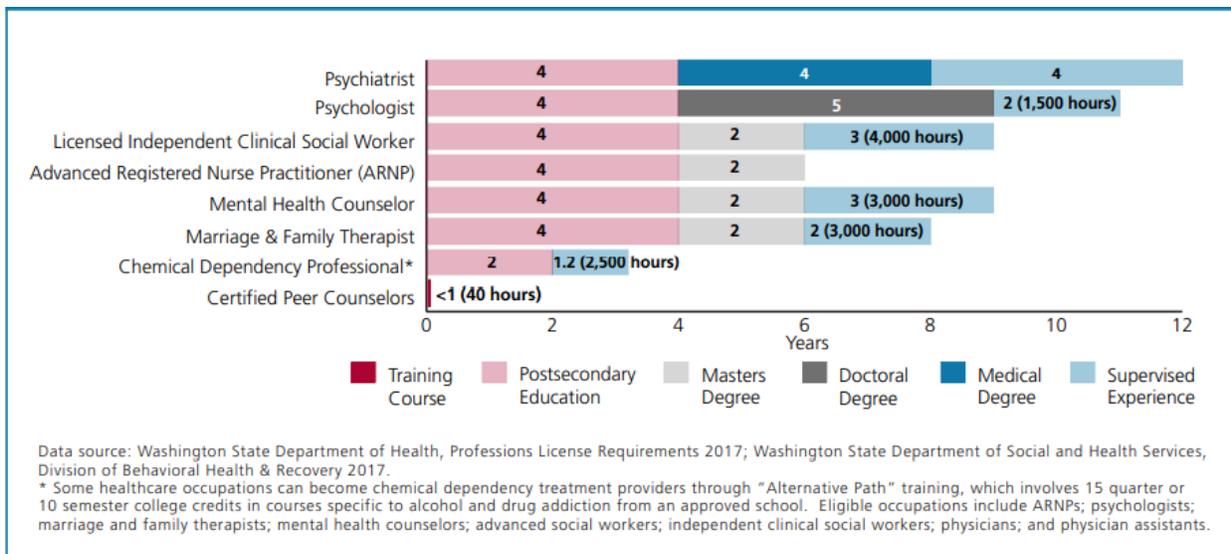
¹² DOH, 2020a.

In October 2020, DOH reported that 5 percent more people are reporting anxiety and 10 percent more people are reporting depression when compared with April 2020.¹³ They found that “just under 1.8 million Washington adults reported experiencing symptoms of anxiety on at least most days and just under 1.2 million reported experiencing symptoms of depression on at least most days.”¹⁴ DOH also found considerable disparities in symptoms by race, reporting that “African American and Multiracial (non-Hispanic) individuals have the highest symptom reporting for both depression and anxiety” during the pandemic.¹⁵

Although the need for behavioral health services has increased during the COVID-19 pandemic, there remain difficulties in recruiting and retaining professionals adequately trained to meet these needs.

Two overarching barriers to workforce development which relate to each of the topics in the proviso charging the Workforce Board with this project, and which were highlighted in the workgroup’s 2016-2017 report, are the many years of training required to join or advance in the behavioral health workforce, as illustrated in Figure 4, combined with the low pay earned by even well-trained clinicians in behavioral health services as illustrated in Figure 5.

Figure 4. Minimum Years of Typical Education and Supervised Experience Required for Select Behavioral Health Occupations in Washington State

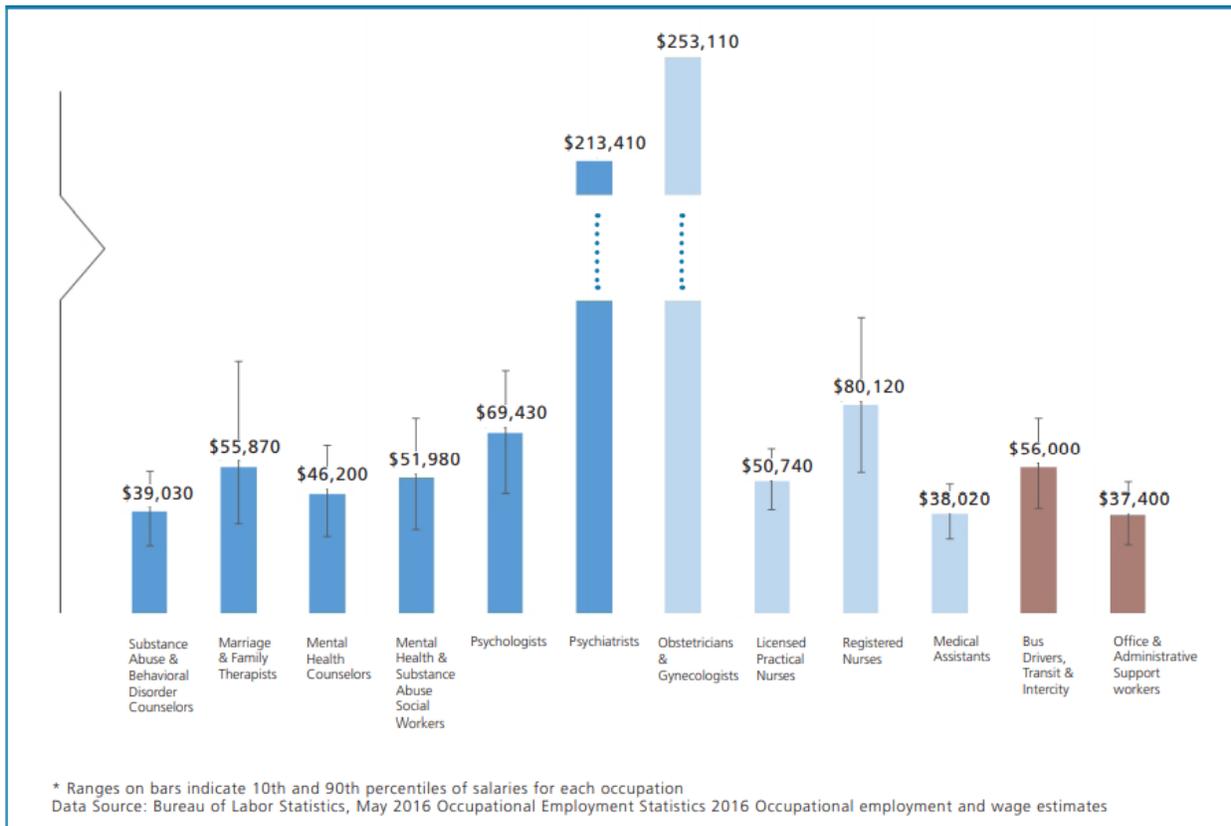


¹³ DOH, 2020b.

¹⁴ DOH, 2020b.

¹⁵ DOH, 2020b.

Figure 5. Full Time Salaries of the Behavioral Health Occupations & Comparison Occupations in Washington State in 2016



There is often significant variation in the geographic distribution of behavioral health providers, complicating access to care, and creating significant disparities in care for those living in rural counties in Washington and other underserved areas. The behavioral health workforce shortage in community settings is expected to worsen as experienced behavioral health professionals and paraprofessionals exit for private practice or hospital-based settings with better pay and lighter caseloads, or retire altogether. New entrants to the field, often graduating with large student loan debt, tend to begin their career in a community-based setting. With severe funding limitations because of the large percentage of Medicaid-funded services, these facilities typically have fewer workers per patient and lower pay scales than hospital-based facilities or others with a higher proportion of private-pay patients. Community-based workers are assigned large caseloads and field increasing demand for services from the community, adding additional stress to their over-burdened workload.¹⁶

¹⁶ Thompson, Flaum, & Pollack, 2017.

Measuring Workforce Demand through Washington’s Health Workforce Sentinel Network

Measuring health workforce demand involves gathering a wide range of information, such as the number of available jobs, employed hours, specific needed skills, and changes to 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 skills and roles required to meet employers’ needs, and the reasons for gaps between workforce supply and demand.

Washington’s Health Workforce Sentinel Network,¹⁷ an initiative of the Washington Health Workforce Council,¹⁸ in collaboration with UW CHWS and the Workforce Board, provides qualitative information about health workforce demand in Washington. Through the Sentinel Network, the UW CHWS and the Workforce Board are tracking changes in health workforce demand across the state. The Sentinel Network employs a voluntary short survey of Washington’s healthcare employers (“Sentinels”) which collects data that signal changes in occupations, skills, and roles needed by healthcare employers and employers’ descriptions of the reasons for those needs.

Since its inception in 2016, the Sentinel Network has consistently prompted a relatively high number of responses from behavioral/mental health settings, community health centers, medical clinics, and other settings employing occupations that provide behavioral health services. At every reporting opportunity since 2016, mental health counselors (MHCs) and substance use disorder professionals (formerly called chemical dependency professionals) were identified as the top two positions with “exceptionally long vacancies” as reported by behavioral health facilities. Social workers were consistently named among the top four positions with exceptionally long vacancies in these settings since 2016.

Peer counselor positions and nurse practitioners have frequently appeared among the top occupations identified with exceptionally long vacancies in behavioral health settings. These responses further validate that Washington has a persistent problem accessing the necessary workforce to meet the behavioral healthcare needs of residents. Detailed responses from employers to Washington’s Health Workforce Sentinel Network can be examined online. Figure 6 shows a full list of the top occupations referenced by Sentinels as being difficult to recruit to work at behavioral health facilities.

¹⁷ <http://wa.sentinelnetwork.org/>

¹⁸ <https://www.wtb.wa.gov/planning-programs/health-workforce-council/>

Figure 6. Occupations Difficult to Recruit in Washington’s Behavioral Health Facilities

Behavioral Health Facilities: Top occupations cited as having exceptionally long vacancies by date of reporting								
Rank	Summer 2016**	Spring 2017	Fall 2017	Summer 2018	Spring 2019	Fall 2019	Spring 2020	Fall 2020
1	Mental health counselors	Mental health counselor	Chemical dependency professional	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor
2	Chemical dependency professional	Chemical dependency professional	Mental health counselor	Chemical dependency professional	Chemical dependency professional	Chemical dependency professional	Chemical dependency professional	Chemical dependency professional (SUDP)***
				Peer counselor				
3	Social worker	Social worker	Social worker	Nurse practitioner	Social worker	Peer counselor	Social worker	Social worker (Mental Health/SUDP)
			Nurse practitioner					
4	Nurse practitioner	Nurse practitioner	Peer counselor	Social worker	Marriage & family therapist	Marriage & family therapist	Peer counselor	Registered nurse
				Psychiatrist				
5	Psychiatrist	Registered nurse	Registered nurse	Marriage & family therapist	Peer counselor	Social worker	Multiple occupations cited at same frequency	Marriage & family therapist
					Psychiatrist			Peer counselor
					Psychiatrist			

↑ Most cited

*Behavioral health/mental health, substance use disorder clinics and residential treatment facilities.

**Winter 2016 findings not shown due to space constraints.

***Occupation title changed to Substance Use Disorder Professional (SUDP) in 2019.

Project Approach

During Phase I, the Project Team conducted stakeholder engagement meetings and interviews to identify and report on the problems, barriers, potential solutions, and recommendations for topic areas to be covered in Phase I. Stakeholder input was supplemented with: background research on relevant published findings; reports and guidance by federal and local government agencies; and industry and advocacy reports, among other sources. Formal group stakeholder meetings were conducted in person in September, 2019 and through an online webinar in October, 2019. Meeting participants included a wide range of stakeholders interested in the topics to be covered in Phase I, providing input from a broad range of organizations, facilities, practitioners, and agencies from across the state.

This work was supplemented with interviews with content specialists and key informants. Interviews conducted during Phase I helped provide additional detailed stakeholder input on the topics involved and build stakeholder engagement for Phase II of the work.¹⁹ Stakeholder participation was solicited statewide.

To start work in Phase II, the Project Team held a kickoff meeting in January 2020, which included an orientation and overview of the work ahead, and a review of written input received from stakeholders in January. The Project Team followed up with stakeholders through an online written feedback form which gathered stakeholder input on suggested recommendations for each topic, including a review of those “Items for Further Inquiry” noted in the Phase I report. This written feedback helped lay the foundation for Phase II, by focusing the workgroup’s subsequent efforts as well as gathering additional stakeholder recommendations.

Subsequent topic-specific stakeholder meetings, initially planned as in-person meetings across Washington but later adapted to take place online due to COVID-19 restrictions, were held in April and May, with each of the five proviso topics covered in-depth in a separate meeting. Following this, Project Team members met individually with stakeholders to fine-tune recommendations and participated in the Children and Youth Behavioral Health Workgroup, other relevant committees and meetings, and presented to the Health Workforce Council.

The Project Team developed stakeholder feedback, as well as proposed ideas and concerns, into straw proposals containing a policy action and rationale, and sent these out to stakeholders for an additional round of comments and suggestions. The Project Team followed up with additional topic-specific stakeholder meetings in August and September, and then small group meetings with stakeholders in October 2020. All group stakeholder meetings were open invitation and participation was solicited from a

¹⁹ A full list of participants is provided at the end of this report.

list of nearly 300 individuals representing stakeholders in the behavioral health workforce.

To inform policy recommendations, the Project Team conducted background research for each topic that included federal and other states' policies, important interstate initiatives, and relevant state and federal practices and regulations for each topic.

Topic I: Reimbursement and Incentives for Supervision²⁰

As highlighted in the workgroup's 2016-2017 report, community mental health agencies, substance use disorder (SUD) treatment agencies, and federally qualified health centers (FQHCs) often serve as training sites for professionals seeking supervision hours to meet licensure requirements, but stakeholders consistently reported that the true costs incurred in this arrangement are not fully reimbursed, and may be a net drain on these already lean community organizations. These sites also frequently serve the most complex and chronically ill behavioral health clients, which can be a challenging population for new entrants to the workforce. At times, providers leave for better-paid opportunities with lower acuity patients after completing their facility-sponsored supervision requirements. As a stark example of this problem, one stakeholder from a community agency in a rural setting mentioned that they have "25 open positions" that they have not been able to fill, a gap that is likely negatively impacting patient access to timely and appropriate care.

The lack of compensation for serving as a training site and staff turnover adversely impact the ability of these sites to meet the needs of their behavioral health clients. Recognizing and compensating these sites for this function may help community-based settings provide more training opportunities, and may also retain workers at these sites. Providing compensation for this role 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 training.

The Burden of Supervision in Community-Based Settings

As shown in Figure 1,²¹ a credentialed individual who is seeking one of the more common behavioral health related licenses in Washington must complete anywhere from 1,500 to 4,000 hours of supervised practice, in addition to meeting other requirements, before they can apply for their license. Adding to the challenge of completing these supervision hours over years of work, individuals seeking licensure must first find an appropriately credentialed and licensed professional who is willing to act as their supervisor over this period of time, or find several individuals who can collectively provide supervision.

²⁰ While we acknowledge that medicine includes specific definitions for interns and trainees, for the purposes of this report, we define interns as students completing field work for academic credit, and trainees as graduated professionals seeking hours of supervised clinical practice required for independent clinical licensure.

²¹ Figure 1 is on page 10 of this report.

While pro-bono supervision does exist, supervision is not typically a charitable effort as it requires years of work and an investment of time, energy, and resources on the part of the supervisor to assure the license-seeker is supported and develops professionally through the supervision experience. Acting as a supervisor may also include legal and financial risks to the supervisor or supervisor's employer, such as in the event of malpractice by the supervisee. Short of finding the rare pro-bono supervisor, the typical license-seeking individual will either need to pay out-of-pocket for an appropriately credentialed and licensed professional to provide supervision, or work at a community behavioral health agency, SUD treatment facility, or FQHC which offer supervision hours as an inducement to work at these agencies. As noted previously, these organizations often see high caseloads of higher-acuity patients with few if any social or financial supports, and an overall challenging work environment.

Meeting supervision hour requirements can be particularly challenging when seeking a discipline's upper-tier license because supervisors typically must already hold the license being sought and there are simply fewer potential supervisors in these upper-tiers with flexibility to offer supervision. For example, stakeholders report that obtaining supervision hours for the licensed independent clinical social worker (LICSW) credential is more difficult than obtaining supervision hours for non-independent social worker clinician licenses. This may be due to the fact that professionals seeking the LICSW license in Washington often cannot find a willing and appropriate supervisor outside of the state's larger cities and large hospital systems, further exacerbating inequities in licensing opportunities between rural and urban residents in Washington.

Stakeholders encouraged several possible funding mechanisms to better support and expand supervision of behavioral health professionals seeking licensure in the behavioral health professions. Stakeholders also expressed the need for any changes in policy to also address the administrative burdens of the proposed changes on already over-burdened behavioral health agency staff.

Providing financial support for supervision in community behavioral health agencies, which often provide supervised training opportunities for individuals seeking licensure, was seen as an important step by stakeholders for alleviating the pressures on overburdened agencies, as well as on individuals seeking licensure. For settings in which degree-seeking students are required to have supervised practice hours to obtain their degree, stakeholders supported payment methods based on a calculation of lost patient encounters, as they reported these hours are already tracked, and such tracking would not create a new administrative burden on agencies. Lastly, a model implemented by the Greater Columbia Accountable Community of Health (GCACH) created a way for funds to be disbursed to sites providing supervision to behavioral health license seekers while at the same time supporting new programs within agencies to address unmet local community behavioral health needs.

The recommendations below are directly reflective of stakeholder sentiment and were developed and finalized with extensive stakeholder feedback over the course of this project.

Recommendation 1.1: Develop and implement a funding mechanism that recognizes and supports community behavioral health agencies for performing a significant training function required for behavioral health workers to obtain their educational degree and their clinical licensure.

Community behavioral health agencies are important sources of supervised training for students completing credential degree requirements, and for post-graduate professionals seeking clinical licensure. Supervision of these students and trainees is expensive, and significant cost burden is placed upon the community behavioral health agencies providing this training. Stakeholders recommended the creation of a teaching clinic enhancement rate, similar to the rate provided to the forthcoming behavioral health teaching hospital, which would allow supervising agencies to improve capacity, while avoiding the administrative burdens of a more complex time-tracking system. A teaching clinic enhancement rate for qualifying behavioral health agencies (BHAs) would also allow both the state and community BHAs to avoid expenses associated with more complex funding structures.

Policy Action: The Health Care Authority (HCA) shall collaborate with Department of Health, the Workforce Board, the Washington Council for Behavioral Health, licensed and certified BHAs, and higher education to develop a recommended teaching clinic enhancement rate for BHAs training and supervising students and those seeking their certification or license. This work should include: developing standards for classifying a BHA as a teaching clinic; a cost methodology to determine a teaching clinic enhancement rate; and a timeline for implementation.

Recommendation 1.2: Create a stipend for clinical supervision of students, based on patient encounters lost.

Educational institutions face challenges in finding sites to host students for clinical internships, in part due to the burden supervision of students/interns places on the host site, which is not eligible for billable reimbursement. A stipend for clinical supervision of students would incentivize potential or existing sites to provide supervision and, if structured correctly, could allow for tracking of payments used for supervision, through tracking of submitted claims. Per the Centers for Medicare & Medicaid Services, “patient encounters” refers to any encounter where clinical treatment is provided; in this case, it includes time dedicated to supervision/precepting of student interns (non-billable) that is not spent providing clinical treatment to a patient, and thus costs the

internship/precepting site potential billable time. Unlike Proposal 1.1, this proposal is *limited to students*, because tracking of student supervision is already required of clinical training sites by education programs and building on this existing structure would not create a new administrative burden for supervisors and supervising agencies.

Policy Action: Compensate clinical training sites providing supervision/precepting of behavioral health students for the decreased number of patient encounters that result from supervision/precepting activities. Compensation should occur at a rate equivalent to direct service reimbursement.

Recommendation 1.3: Strengthen and fund loan repayment programs, including the established Washington Health Corps model, that incentivize direct (clinical) behavioral health service provision.

At present, direct service (clinical) behavioral health positions in community-based settings tend to receive lower annual salaries than for the same behavioral health occupations when serving in administrative roles at state agencies/managed care organizations, which discourages experienced behavioral health professionals from remaining in community-based clinical positions. Support for concentrated loan repayment programs in direct service could help alleviate this barrier to long-term retention in the community practice setting. Careful consideration should be made regarding the unique circumstances of rural behavioral health settings, where direct care providers are more likely to have additional administrative duties, compared with their counterparts in more densely populated areas.

In addition to increased funding, adjustments to the eligibility criteria of established loan repayment programs may broaden the scope of behavioral health professionals who are able to participate in such programs. In conversations with stakeholders, they recommended increasing the number of participants eligible per profession per site from two to three, as well as other administrative changes to expand participation in the program. The Washington Student Achievement Council (WSAC), which administers the Washington Health Corps Behavioral Health Program (BHP), can make such adjustments without legislation or a formal rulemaking process.

Policy Action I: Increase funds allocated to the Washington Health Corps BHP to expand the number of behavioral health workers in Washington who receive loan repayment support through BHP. Additional funding sources should be explored,

including funding from private philanthropy and the private sector, and a dedicated funding source should be established.²²

Policy Action II: WSAC should make changes to the existing Washington Health Corps BHP model to increase access for eligibility and participation in the program. This should include: increasing the number of workers per profession types, per site, from two to at least three; permitting the participation of individuals licensed at the associate level; and increasing the percentage of FTE allotted to administrative work to 30 percent to increase the ability of individuals providing clinical supervision to participate in program.²³

Recommendation 1.4: Expand geographical reach of, and scale up, programs that promote behavioral health supervision.

Incentivized supervision programs, like the GCACH Internship & Training Fund,²⁴ co-create and fund programs that support quality supervision and training experiences for behavioral health professionals, in partnership with regional behavioral health service providers. This funding would support supervision of baccalaureate, masters-level, and post-doctoral behavioral health trainees. Co-creation of similar programs with direct service organizations ensures that funding is directed towards needs and potential solutions identified by the beneficiary organizations, which often have more detailed understanding of specific community needs, and efficient solutions to address those needs.

Policy Action: Through increased funding, support evaluation and scaling of quality incentivized supervision programs, in cooperation with direct service organizations.

²² RCW 28B.115.030 currently permits the Washington Student Achievement Council to “solicit and accept grants and donations from public and private sources for the programs.”

²³ It should be noted that making such adjustments, without adequate financial support for the programs, could have the unintended consequence of limiting the number of awards of fully licensed professionals unless some prioritization of profession types is considered.

²⁴ https://gcach.org/apps/website_event

[Documents/record/b0700953d9087333bd1ce3b9b72978d4/gcachbehavioralhealthinternshipandtrainingfundpolicy.pdf](https://www.wa.gov/documents/record/b0700953d9087333bd1ce3b9b72978d4/gcachbehavioralhealthinternshipandtrainingfundpolicy.pdf)

Topic II: Supervision Requirements

As detailed in the 2016-2017 report, and again mentioned by stakeholders throughout the 2019-2020 project, obtaining the supervised practice hours required for licensure in many behavioral health professions remains a barrier to the development of this workforce in Washington. Assuring high-quality supervision, and training for supervisors, were frequently mentioned stakeholder concerns.

Current requirements to act as a supervisor for behavioral health professions in Washington varies by education, but typically include licensure which is: in good standing for a period of time (varies by occupation); in the discipline being supervised; and must be at the level of or higher than the supervisee.

Stakeholders expressed interest in finding ways to reduce the hours required for licensure while maintaining quality of care and shared their confusion regarding the different professions with similar scopes of work requiring different numbers of supervision hours. Stakeholders expressed frustration at the apparent arbitrary number of supervision hours required for licensure, particularly because of their urgent need for a qualified workforce.

The use of tele-precepting, mentioned by stakeholders early in this project's process, became a popular topic, particularly with the onset of the pandemic, and stakeholders reported significant increases in use of tele-medicine and tele-supervision. Stakeholders were unanimous in supporting ways to make tele-supervision hours count towards a greater share of the supervision hours required of both students and candidates for professional license.

Stakeholders also expressed interest in finding ways to support a distributed supervisory workload. For example, some stakeholders found that allowing supervisors to specialize made supervision work better and improved the quality of supervision. While this approach was supported in theory, concerns were raised that this is not financially viable everywhere, particularly in the community behavioral health settings where having potentially overlapping roles²⁵ is not seen as a wise management approach, given the typically thin reimbursement rates for many clients being served in these settings.

The recommendations that follow are directly reflective of stakeholder comments and were developed with extensive stakeholder feedback.

²⁵ "Overlapping roles" in this instance refers to supervision roles within an organization which may have overlapping responsibilities, such as organizational vs. clinical supervision.

Recommendation 2.1: Remove barriers to effective tele-precepting for supervision in clinical education and pre-licensure settings.

As with provision of behavioral health services via phone- and video-based telehealth, provision of clinical supervision via telephonic or video interaction since the onset of COVID-19 has become necessary, widespread, and is reported to be beneficial to clinicians and supervisors alike. Current laws limit the number of tele-supervision hours which can apply towards clinical education requirements and licensure hours.

Policy Action: Support the increased use of tele-precepting for clinical supervision, including but not limited to: amending relevant laws and policies, or making permanent provisional changes, to allow increased tele-supervision hours required for clinical education requirements, and for licensure requirements.

Recommendation 2.2: Assess the impact of current supervision requirements on size, distribution, and availability of select occupations in the behavioral health workforce. Provide recommendations on ways to reduce or standardize the number of supervised hours required for licensure, while assuring clinical competency.

Due to the complexity of this topic, changes to supervision requirements should involve behavioral health, legal, quality assurance, and credentialing experts to determine and develop consensus around recommendations for improving supervision requirements. A dedicated taskforce could ensure the necessary expertise is included for each of the occupations named above. Considerations for this work could include:

- Why must different supervision requirements be completed for different behavioral health occupations to gain licensure?
- Why are there significant limitations to which professional credentials are eligible to provide supervision for licensure hours? Both clinical and administrative skills are important for training pre-licensure clinicians, yet not all are equally valued.
- Whether there are issues for some occupations which prevent experienced behavioral health workers from providing clinical supervision to trainees.²⁶
- Why some professions have stricter requirements than others (e.g., years in practice, occupation of supervisor). What is the rationale/basis for this, and could these requirements be made more rational and consistent between professions that are providing similar services?²⁷

²⁶ E.g. mental health professionals (MHPs) may not be able to ascend the credential ladder, and are not eligible to provide clinical supervision for licensure, despite their significant experience in the field.

²⁷ Stakeholders noted this point with particular emphasis on LICSWs, licensed marriage and family therapists (LMFTs), and LMHCs.

- Consider standardization of terms related to supervision in behavioral health. For example, alignment of language, including language that translates beyond behavioral healthcare settings, such as the term “trainees” (post-graduate, pre-licensure) would be referred to as “residents” or “fellows” in other healthcare settings.
- The workgroup recommended focusing on the following occupations: SUDPs, LMFTs, LMHCs, LICSWs.

Policy Action: Form a specialized taskforce to investigate the extent to which and reasons why supervision requirements vary by behavioral health occupation and make formal recommendations on where a reduction in hours, or alignment between occupations, would be appropriate. Taskforce membership should include, at a minimum: experts in related legal/judicial issues, behavioral health quality assurance, and behavioral health credentialing; the respective professional associations/societies; and current behavioral health employers.

Recommendation 2.3: Structure funding supports to promote new models of supervision which allow for division of labor and multiple pathways to working as a supervisor.

Some stakeholders reported using bifurcated supervision roles (separate positions for both clinical and organizational) to help improve both quality and ease of supervision, but at significant (and often unsustainable) financial cost. However, division of supervision responsibilities provides an opportunity for an increase in the quality of supervision provided and other benefits, including:

- To avoid conflicts of interest between organizational supervision (including performance review and traditional workplace management) and clinical supervision (necessary clinical training and practice development).
- To alleviate the caseload burden associated with insufficient supervision staffing.
- To encourage the best workers to become supervisors, by providing multiple career pathways that allow individuals with different professional strengths to achieve the level of supervisor.

Policy Action: With resources allocated, develop a pilot program to allow behavioral health employers to fund a bifurcated supervision model, dividing responsibilities between clinical supervision and organizational supervision. The pilot should place emphasis on access to those employers in rural and underserved regions of the state. The pilot could attach a stipend to supervisors carrying a full load of supervisees, including monthly reporting on the number of supervisees on a caseload and

subsequent stipend qualification. The pilot would need to carefully consider to how these roles are defined and how a “full caseload” is defined.

Topic III: Competency-Based Training

To assess possible ways behavioral health workers might more quickly move into licensed practice while maintaining standards of care, the Workforce Board was charged with examining if competency-based training was a viable option to substitute for some or all of the time-based supervised practice currently required for independent licensed clinical practice. This focus was motivated by a number of factors highlighted in the workgroup's 2016-2017 report, including: (1) stakeholder concerns that supervised hours requirements may lack strong evidence and may be set arbitrarily; and (2) inconsistencies between the years of clinically supervised practice required of the masters-level behavioral health occupations, and the relatively low pay of these professions, which exacerbates recruitment and retention problems in these professions, and contributes to Washingtonians' difficulty accessing behavioral healthcare.²⁸

Limited Use of Competency-Based Approaches

Stakeholders highlighted the significant technical, administrative and political barriers that make substitution of competency-based for time-based supervision a challenging proposition. In addition, the Project Team found no examples of states using competence assessments in place of supervised clinical hours for licensing of behavioral health occupations. Existing competency-based training and assessment efforts within the behavioral health professions are framed in the context of healthcare quality-improvement, and so are defined as something that is done in addition to, not a replacement for, supervised practice hours. Many clinical professions have moved towards a competency-based approach to skills assessment.^{29,30} This effort within the professions was motivated in part by concerns that existing structures which used hours-based supervision were not sufficient for assuring high-quality care.³¹

In educational settings, the role of practice-based learning and assessment for future clinicians is often specified in accreditation standards set by accreditation bodies. For example, the Council on Social Work Education (CSWE), which adopted a competency based framework in 2008 to focus on student skill outcomes (rather than content taught), requires that students in accredited bachelors and masters level social work programs meet nine broad competencies. In addition, for each of these competencies CSWE standards require at least two assessment measures per competency and specify

²⁸Gattman et al., 2017.

²⁹Campbell, Hendry, Delva, Danilovich, & Kitto, 2020.

³⁰Falender & Shafranske, 2017.

³¹Falender & Shafranske, 2017.

that “one of the assessment measures is based on demonstration of the competency in real or simulated practice situations.”³²

Some states have also worked to further specify the competencies required to practice in a profession by requiring a certain number of course hours in various topics. For example, while the majority of U.S. states do not specify course hour requirements in specific topics when seeking licensure as an MHC, California’s requirements are very specific in this regard.³³

Opportunities for Changes in Assessment of Competency

Stakeholders asked whether some behavioral health providers could “test-out” of the supervised hours of practice. While this might be technically possible given significant investments in the effort, to our knowledge there are no U.S. states which currently use this model. For example, among mental health counselors, every U.S. state and territory requires supervision hours, and competencies to be achieved through these hours are set by professional bodies and/or state policy. To our knowledge there is only one state, Alabama, which allows for a limited number of hours of post-master’s coursework to be substituted for supervised practice hours when seeking licensure as a mental health counselor, for example.³⁴

The assessment of clinical competency in behavioral health is a challenging and technical topic that is beyond the scope of this report. Fundamentally, any assessment or test of competency needs to assure that it can provide a consistent and accurate measure when instituted, and also maintain an acceptable level of accuracy and consistency over time as standards of practice will change over time. This is a challenging task, particularly in behavioral health, as standards may differ between the diversity of professions involved, and the skills required to successfully interact with and effectively treat different patient populations may vary widely between practice settings.

Due to the complexity of this topic, the workgroup did not arrive at a firm endorsement of broad adoption of competency-based training, but it identified some best practices for competency-based training and evaluation, such as registered apprenticeships, and proposed a pilot to conduct a proof-of-concept in a single behavioral health occupation to test the viability of moving to a more competency-based model.

The recommendations below are directly reflective of stakeholder comments and were developed with extensive stakeholder feedback.

³² “Educational Policy and Accreditation Standards,” 2015.

³³ Hodges, 2019.

³⁴ Hodges, 2019.

Recommendation 3.1: Support development of a registered apprenticeship model for behavioral health professions.

Registered apprenticeships promote an “earn-while-you-learn” model, which reduces direct costs and student loan debt risk to workers and may reduce cost barriers to education required for a career in behavioral health. These features promote increased access to behavioral health professional training for marginalized and under-represented groups, help promote diversity of the workforce, and potentially increase availability of patient-provider background-concordant care. In comparison with loan repayment, apprenticeship does not require the same degree of up-front financial commitment and debt assumption at the onset of a clinical career. This poses a particular opportunity to expand access to the field to lower income individuals, and reduce inequity among the provider population.

Policy Action: Continue to work with and support the existing efforts of SEIU Healthcare 1199NW Multi-Employer Training Fund, SEIU Healthcare 1199NW, the Behavioral Health Institute, and relevant stakeholders to develop and implement behavioral health registered apprenticeship models, with state support.

Recommendation 3.2: Identify viability of adapting certain aspects of Washington’s existing education, training, and credentialing evaluation metrics into a competency-based method.

Rather than relying on a set number of hours to graduate or qualify for independent licensure, should supervision measure actual competency and clinical skills? Equity between different credentials might also be useful, including a focus on clarifying discrepancies between hourly requirements across behavioral health professions, and understanding why such variation exists. Transition into competency-based evaluation is a complex issue that will require evidence-based assessment before formal rulemaking and legislation can occur. One significant barrier to universal competency-based metrics is the variety of professions included in the behavioral health workforce, which have unique educational and supervision requirements; though overlap in employment is common, specific qualifying standards are not.

Likewise, the decision to shift to a competency-based evaluation model is likely to occur by individual profession, rather than the behavioral health workforce as a whole, due to the presence of different accreditation bodies and professional societies. Rather than evaluating the entirety of the behavioral health workforce, a focus on a single credentialed profession within the broader workforce provides a foundation for academic inquiry. According to Sentinel Network findings, MHCs continue to be cited as positions with the longest vacancies, indicating a significant need for more MHCs within

Washington, and an occupation which could benefit from such a pilot evaluation. The workgroup also agreed with MHCs as a starting place for this evaluation.

The Project Team recognizes there are substantial challenges facing the state's budget this year and, where possible, any proposal in this space should identify areas to supplement any potential state investment with private philanthropy.

Policy Action: The Legislature should identify an academic institution or similar organization to administer a study on competency-based education, training, and evaluation of MHCs, or another behavioral health occupation(s) in high-demand in the state. The study should examine the viability of adapting certain existing education, training, and credentialing metrics into competency-based assessment and should identify challenges to adapting those existing structures into competency-based ones.

Recommendation 3.3: Promote an increase in acquisition of behavioral health competencies among the broader health workforce, with an emphasis on the primary care workforce.

Following the state's bidirectional integration of its behavioral and physical healthcare systems, the provision of behavioral health care outside traditional (solely) behavioral health settings has increased, particularly among primary care settings. Indeed, many patients with mental health and/or substance use symptoms receive initial behavioral health services outside exclusively behavioral health settings. While many physical healthcare providers receive a degree of behavioral health training, stakeholders reported that this training is not necessarily sufficient to achieve a degree of confidence in providing behavioral health services. Resources currently exist to provide training in behavioral health competencies (including continuing education) but identifying and accessing adequate resources can be a barrier. Developing a clearinghouse of these resources, as well as conducting outreach to provider organizations that could utilize these resources, would help to streamline access issues.

Policy Action: With resources allocated, the Allied Health Center of Excellence, which "serves as a resource to all 34 community and technical colleges, K-12 Health Science, business/industry partners, plus identified government entities to ensure a continuous pipeline of new healthcare professionals,"³⁵ should develop a clearinghouse of behavioral health continuing education opportunities, and work with the relevant provider organizations to educate their workforce about available courses.

³⁵ Washington Allied Health Center of Excellence, 2020.

Topic IV: Licensing Reciprocity and Interstate Agreements

License reciprocity is a policy that allows a professional who is licensed to practice in one state to gain licensure in another state through recognition of their prior licensure and practice experience. In contrast, a professional licensing interstate agreement or interstate compact allows a professional, who is already licensed to practice in a given state, to practice in other states which are members of the compact, without requiring the professional to apply for and secure an additional license in the other states.³⁶

To increase the availability of behavioral healthcare workers, some states have passed licensing reciprocity agreements and/or interstate compacts into law, with the intention of reducing barriers to licensure or certification when a behavioral health professional—who already holds a license in one state—wishes to practice in another state.

National Overview of Reciprocity and Interstate Compacts for Behavioral Health Licensure

Scope of practice for each behavioral health occupation varies by state, as do licensing standards. The level of education, training, testing, supervision, and practice experience needed to meet the requirements for licensure are typically set by each profession's state board or commission. This variation in licensing standards would need to be considered for licensing reciprocity or interstate agreements to work in a predictable way for these professions. Some occupations are further along than others; psychologists and licensed clinical social workers typically have less variation in licensing standards among states when compared with specialized behavioral health professions and paraprofessionals such as peer counselors.³⁷

Reflecting a need for consistency in behavioral health professional scope of practice, several national professional and certification organizations have developed standardized certifications for specialized licensed professionals treating substance use disorders. The Association for Addiction Professionals (NAADAC) has developed standardized exams used in most states, including Washington, to establish qualifications to practice for some types of substance use disorder professionals.³⁸ The International Certification & Reciprocity Consortium (IC&RC) has developed certification standards used by many state licensing agencies—including those in Washington—responsible for oversight of various types of substance use disorder professionals.³⁹

³⁶ Understanding Interstate Licensure, 2003.

³⁷ Page et al., 2017.

³⁸ NAADAC, 2019.

³⁹ IC&RC, 2019.

Other mental health professionals also have resources and examples of existing interstate licensing agreements to draw upon. The Psychology Interjurisdictional Compact (PSYPACT) was created in 2015 through the Association of State and Provincial Psychology Boards (ASPPB) with the initial goal of addressing telepsychology licensing to improve access to care. The compact was later amended to allow psychologists licensed in any member state to practice using in-person interactions, in addition to telepsychology, with patients in any other member state for a limited 30-day period without requiring an additional license.⁴⁰ Although this compact was discussed in the legislature during the 2019 session, Washington is not currently a member of PSYPACT.

Other Healthcare Licensure Compacts and Agreements

There are also compacts for licensed healthcare professionals who may provide behavioral health treatment in addition to other services, such as primary or specialty care. For example, the Nurse Licensure Compact (NLC) provides a process for licensed nurses (registered and licensed practical/vocational), including psychiatric nurses, to practice in 36 member states.⁴¹ Similarly the Interstate Medical Licensure Compact (IMLC) allows medical and osteopathic doctors, including psychiatrists, to practice in 29 member states, including Washington.⁴²

The State of Arizona's 2019 deregulation of all occupational licensing represented a major policy shift, with some qualifiers written into the law. The new law permits the issuance of an occupational license "in the discipline applied for and at the same practice level as determined by the regulating authority to a person" establishing residence in Arizona. The professional must be currently licensed or certified for a minimum of one year in another state, meeting "minimum education requirements and, if applicable, work experience and clinical supervision requirements." The other state must also verify the applicant met their requirements, passed a licensing/credentialing examination, has no unresolved/uncorrected disciplinary action on the previous license, or had the license revoked. Applicants may also be required to pass a state law-specific exam in Arizona.⁴³

Washington's Participation in Compacts Related to Behavioral Healthcare

In 2019, Washington took action to improve license portability for behavioral health professions by enacting Senate Bill 5054, which requires DOH to: "(1) Establish a reciprocity program for applicants for licensure or certification as a psychologist, chemical dependency professional, mental health counselor, social worker, or marriage

⁴⁰ ASPPB, 2019.

⁴¹ NLC, 2019.

⁴² IMLC Commission, 2019.

⁴³ Arizona HB 2569, 2019.

and family therapist in the state.”⁴⁴ This effort resulted in substantive new rules which allow for greater license portability for a broad array of behavioral health professions, and established a provisional license for experienced behavioral health specialists moving to Washington State.⁴⁵ Prior to the passage of Senate Bill 5054, The Washington State DOH maintained a list of other states with “substantially equivalent” licensing requirements for psychologists and substance use disorder professionals.⁴⁶ Under the auspices of 5054, DOH expanded the list of substantially equivalent states for a variety of behavioral health professions.

Given the need for behavioral healthcare workers in most professions across the United States, it appears reasonable to assume reciprocity agreements alone are unlikely to lead to a sharp increase in the supply of behavioral healthcare workers in Washington. However, by increasing opportunities for license reciprocity, qualified behavioral health professionals who move to Washington or who live and work near state borders may be able to gain licensure more quickly and provide care sooner to Washington residents in need.

Workgroup Position on Compacts

While licensing portability is the goal, and interstate agreements are one possible mechanism to support licensing portability, the stakeholder workgroup is neutral on the feasibility of an interstate licensing compact at this time.

Despite significant discussion throughout the course of this project, clear consensus on membership in behavioral health licensing compacts did not arise. Workgroup members expressed both curiosity and hesitance regarding the potential for Washington to enter into various compacts currently in existence. Per feedback from stakeholders, efforts to initiate Washington’s membership in occupation-specific compacts should be led by professional associations, who can best speak to the specifications of each occupation’s scope of practice and unique professional licensing/practice needs. Individual members of the workgroup may stay engaged in this discussion after the workgroup’s timeline has completed.

The workgroup recommends no specific legislative action at this time. Efforts to enter into compact membership should be championed by the respective professional associations, but not this broad workgroup.

The recommendations that follow are directly reflective of stakeholder comments and were developed with extensive stakeholder feedback.

⁴⁴ Washington SB 5054, 2019.

⁴⁵ DOH, 2020c.

⁴⁶ DOH, 2019.

Recommendation 4.1: Continue to support Department of Health’s work implementing licensing reciprocity.

As noted, SB 5054 (2019) required DOH to expand lists of substantial equivalency to determine eligibility for a provisional license, based on a scope of practice comparison for psychologists, social workers, marriage and family therapists, mental health counselors, and substance use disorder professionals. DOH conducted this work following passage of SB 5054 and has indicated interest in expanding the lists to eventually include all 50 states. The current lists are based on a scope of practice comparison, but having similar lists based on a comparison of licensing requirements will help behavioral health professionals considering relocation to Washington to identify missing licensure requirements; such missing requirements can occur even if the scope of practice in the original state and Washington are equivalent.

Policy Action: As part of the ongoing nature of this work, support expanding lists of substantial equivalency based on both licensing requirements (e.g., hours of supervision, years of practice, etc. required for license) and scope of practice (e.g., what the licensee can legally do in practice). This could include development of, and promoting communication of, the “missing requirements” crosswalk identified in a subsequent recommendation.

Recommendation 4.2: Reduce paperwork requirements for established professionals.

Individuals who have a strong record of providing high-quality behavioral healthcare, and wish to work in Washington, should be encouraged to provide these services to Washingtonians. Stakeholders reported difficulty transferring licensure or hiring employees who require licensure reciprocity due to challenges in documenting initial supervision hours and/or academic requirements. Specific barriers include: difficulty finding and making document requests to previous supervisor(s), and engaging educational institutions from past decades for transcripts.

Stakeholders noted their appreciation for DOH’s recent adoption of a rule providing an exemption in documented supervision hours for those out-of-state clinicians who have been licensed for five consecutive years in good standing, but noted that five years was still a burdensome length of time, and would continue to present hiring challenges; they requested an update of this rule to two or three consecutive years in good standing for eligibility in this exemption.

The workgroup and Project Team determined two potential avenues to improve upon DOH's recent rulemaking, as part of this recommendation:

- The first, a reduction of the consecutive years of good-standing licensure from five to two, will exempt a greater number of workers with significant clinical experience and training from the academic transcript and/or clinical supervision documentation requirements.
- The second, allowing those workers with at least two years of consecutive good-standing licensure, who do not meet the existing five year requirement, to be eligible for a provisional license if employed at a qualifying BHA. This allows the worker a longer window of time to acquire necessary documentation. BHAs are incentivized to assume the responsibility associated with employing workers with provisional licenses, because this provisional license will allow the worker to be credentialed and practice to the maximum limits of their job description, and for the worker's services to be billed at a higher rate than with an associate license. It should be noted that this concept was specifically identified and requested for inclusion by behavioral health employers within the stakeholder group.

Policy Action I: Update DOH's recently-adopted rule providing a behavioral health professional who has been licensed for five consecutive years in good standing (no discipline and no criminal history), to state that a professional who has been licensed for two consecutive years in good standing, is deemed to have met the required post-graduate supervised hours without providing formal documentation, regardless of the base number of supervised hours required in the other state at original licensure.

Policy Action II: Adapt the existing provisional license for behavioral health clinicians relocating to Washington, who have been licensed in good standing in another state for at least two years but less than five, to delay the requirement for submission of academic transcripts and/or clinical supervision documentation until the end of the initial provisional license period, provided they are employed at a certified BHA. The employing BHA shall assume responsibility for the worker, per the specific policies as documented in the worker's provisional license requirements.⁴⁷

⁴⁷ DOH noted that if the Department does not receive a provisional licensee's documentation until the end of their provisional period, it could create unintended gaps in licensure, as the Department would not be able to inform the licensee of what requirements they must meet to obtain a full license until their provisional license is about to expire.

Recommendation 4.3: Develop a crosswalk of licensing portability/reciprocity requirements.

Workers who are entering jobs and relocating to Washington with existing clinical licensure need clarity on what they are permitted to do with which degrees/credentials. For example: LMFTs moving from California to Washington need additional coursework to meet Washington requirements, and a crosswalk would help clarify which missing licensing requirements (course completions, supervision hours, etc.) are required for them to achieve licensure and practice in Washington.

Policy Action: With funds available, Department of Health should develop a crosswalk of reciprocal licensing requirements for licensed behavioral health workers moving to Washington, including education, supervised hours, and specialized training.

Recommendation 4.4: Engage with and incorporate tribal governments' and tribal providers' perspective regarding licensing reciprocity.

Tribal nations have their own laws, regulations, and policies specific to their jurisdictions. As a community, tribes are acutely affected by behavioral health concerns, at disproportionately high rates compared to non-tribal counterparts, and have specific experience working to improve access to behavioral health services, due to its longstanding concern within these communities. Overall, more expertise is needed on this topic. Rather than a workgroup or similar long-term effort (which might require financial support), an initial tribal behavioral health summit could be a starting point. The summit could be held in partnership with the Accountable Communities of Health.

Policy Action: Convene a summit of tribal leaders and behavioral health experts to discuss how these nations address the challenges of licensing and recognition of behavioral health licensing across jurisdictional boundaries, with an eye towards learning approaches to licensing portability that could be tailored to non-tribal jurisdiction(s). The Summit may also include other behavioral health-specific topics, as resources and interest allows.

Topic V: Background Checks

Background checks are required for licensure in many behavioral health occupations, and often used by employers across all industries, including behavioral health employers. These checks typically examine an applicant's criminal or substance use history, with the goal of preventing risk to vulnerable patient populations, but may also present unnecessary barriers to employment of needed behavioral health professionals. Any changes in policy regarding the use of background checks for behavioral health workers will need to balance patient safety, workforce availability, and equity. Participating stakeholders expressed concern about the availability of appropriate workforce members, some who may have a criminal or substance use history, who can help address behavioral healthcare needs. For example, peer counselors provide a recognized therapeutic function in behavioral health treatment *because of* their prior lived experience, which some patients may identify with and draw support from in their recovery. Peer counselors are also a valued part of community behavioral healthcare teams in agencies across the state: they act as guides and role models for those undergoing behavioral health treatment, and provide hope that recovery is possible. However, this lived experience may also include criminal justice involvement, which can put peer counselors at risk for failure to pass background checks required for employment or credentialing.

When background checks are used to unnecessarily exclude individuals from providing behavioral health services due to a criminal or substance use record, the result may reduce patient access to behavioral healthcare. In 2018, the past president of Oregon's Addiction Counselor Certification Board reported that, "one-in-five behavioral health workers with a criminal history have been denied employment because of that history," despite high demand for such workers.⁴⁸

DOH staff indicated that length of time since an infraction's occurrence and the applicant's self-disclosure of past criminal and/or substance use history is considered when reviewing background check results as part of applications for licensure.

National Overview of Background Checks

In 2012, the Equal Employment and Opportunity Commission (EEOC) issued specific guidance on the use of background checks under Title VII of the Civil Rights Act.⁴⁹ This guidance clarified that "people with arrest or conviction records are protected under Title VII because the use of criminal background checks has a significant 'disparate impact' on people of color," though exceptions are allowed if the applicant's conviction,

⁴⁸ Foden-Vencil, 2018.

⁴⁹ U.S. EEOC, 2012a.

“would compromise the requirements of the job and there are no alternatives to such exclusions.”⁵⁰

In an attempt to lessen disparate impact on communities of color, fair-chance laws, which include ‘ban-the-box’ policies, have proliferated throughout the U.S. As of July 2019, 35 states, including Washington, and 150 cities and counties, had implemented some kind of ‘ban-the-box’ regulation, which prohibits most potential employers from asking applicants about criminal or arrest history prior to evaluating the candidate on qualifications for the position.⁵¹

Certain occupational settings are exempted from these laws, including those working with vulnerable adults, and background checks may still be legally used after making a conditional hiring offer. In some cases, applicants with a criminal record can provide a hiring committee with additional information related to their criminal and/or recovery history, which can be reviewed by the committee. However, the review processes conducted by agencies or employers may be uneven, varied, and potentially subject to implicit or overt bias, as are other hiring processes throughout the U.S.⁵²

Communities of color in Washington continue to experience disproportionate marginalization and disparate impact. This indicates more robust measures may be needed to prevent intentional and unintentional hiring discrimination on the basis of race.

Lack of Clarity of Background Check Applications

Several stakeholders noted confusion resulting from the lack of a centralized “clearinghouse” for all background check-related questions, policies, and processes. Confusion was mentioned specifically regarding which types of checks are conducted (e.g., federal versus Washington versus other states), for which professions or licenses each check is relevant, and what authority is responsible for which check.

Centralization could also contribute to a streamlining of the overall licensure and/or employment application processes, as the administrative timeline followed by the governing body is frequently prolonged by delays related to background check processing. Development of such a policy should include active stakeholder engagement, with particular emphasis on equitable representation of employers (e.g., community behavioral health agencies, hospitals, schools, and treatment facilities).

The recommendations that follow are directly reflective of stakeholder comments, and were developed with extensive stakeholder feedback.

⁵⁰ Williams et al., 2016, p. 60.

⁵¹ Avery, 2019.

⁵² Sherman, 2017.

Recommendation 5.1: Conduct an evidence-based review of the Department of Social and Health Services (DSHS) Secretary’s Disqualifying List of Crimes and Negative Actions as applied to behavioral health facilities/employers of behavioral health providers.

Background checks remain incredibly important to uphold necessary patient protection and safety measures. Despite this, stakeholders reported significant concerns with the utilization of a list containing automatic disqualifiers, such as the DSHS Secretary’s Disqualifying List, particularly given the importance of lived experience in the development of some behavioral health providers. Such lists do not account for the nuance and context of the individual’s lived experience, and often include crimes which are not directly relevant to performing behavioral health services, yet automatically disqualify an individual from employment in the field. An individualized assessment, while not wholly devoid of bias and stigma, provides an opportunity for a consideration of the individual’s more complete history, and could allow for the inclusion and employment of clinically competent workers who have relevant lived experience.

According to the EEOC, individualized assessment is defined as consisting of “notice to the individual that [they] have been screened out because of a criminal conviction; an opportunity for the individual to demonstrate that the exclusion should not be applied due to [their] particular circumstances; and consideration by the employer as to whether the additional information provided by the individual warrants an exception to the exclusion and shows that the policy as applied is not job-related and consistent with business necessity.”⁵³ With individualized assessment, a background check is still performed to adhere to necessary patient protection policies. Following a negative finding, the prospective employee would receive an individual assessment of any adverse findings, rather than an automatic exclusion from consideration due to a negative finding included on the Disqualifying List.

In 2019, following the outcome of *Fields v. DEL*, DSHS underwent an internal review process aimed at proactively addressing unjust barriers to finding work related to the DSHS Secretary’s Disqualifying List; this process indicates the agency’s willingness to engage in such efforts. The agency could build upon this initial effort by conducting a review which brings in two items not considered in the previous review process: apply a behavioral-health specific lens (the 2019 internal review addressed the early learning workforce), and provide serious attention to the role of systemic racism as applied to background checks, a topic repeatedly emphasized as important by stakeholders.

It is important to note that while the behavioral health workforce most explicitly affected by the DSHS Secretary’s List is the workforce of the state’s psychiatric hospitals (Western

⁵³U.S. EEOC, 2012b.

State Hospital and Eastern State Hospital), stakeholders, particularly employers, reported that the DSHS Secretary's List is used as a general reference guide by facilities, government agencies, and others when interpreting background check results and in influencing hiring/admissions decisions. This indicates the DSHS Secretary's List has influence beyond its legal scope, outside of DSHS's intended internal use.

Policy Action: Specific to behavioral health occupations, use an evidence-based risk assessment framework to review and potentially amend the DSHS Secretary's Disqualifying List of Crimes and Negative Actions, with an eye towards: optimizing reduction of risk to patients; reducing opportunities for direct or disparate impact discrimination against legally protected groups; and improving opportunities for lawful work and income among those with a criminal record. The assessment should:

- Consider whether the DSHS Secretary's Disqualifying List is unnecessarily limiting the pool of qualified behavioral health workforce applicants, particularly among peer counselors with lived experience;
- Examine possible negative implications and barriers to employment caused by the DSHS Secretary's Disqualify List, and should consider if DSHS should transition to an individualized assessment policy, similar to that used by DOH, and what barriers such a transition would produce;
- Consider and address the role of stigma of a criminal record, in addition to risk assessment; and
- Follow a framework that acknowledges and addresses the role of systemic racism in assessing an individual's readiness for work.

Recommendation 5.2: Anticipate a possible increase in behavioral health workers in emergency services/first responder roles.

Stakeholders were enthusiastic about the potential to address the need for more positions for qualified peers through an expansion of the peer role, as behavioral health workers may be called upon to meet staffing demands in first responder and/or emergency services roles. It is worth noting that the lived experience which provides the cornerstone of peer expertise could be particularly meaningful in a first responder scenario, particularly given the percentage of first responder calls to address mental health and substance use. Concepts like a state-endorsed training certificate for peer crisis responders could help to continue professionalization of the valuable peer counselor role, while also addressing demand for more behavioral health workers in emergency services settings.

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

Recommendation 5.3: Expand community awareness and engagement with Certificate of Restoration of Opportunity (CROP) and its potential benefits.

Since its implementation in 2017, applications to CROP⁵⁴ have been extremely low when compared with individuals who may be eligible for the program. Stakeholders and experts on CROP have speculated that this may be due to a lack of education and awareness among potentially eligible participants. Direct engagement with soon-to-be released incarcerated individuals could provide an opportunity to expand awareness as individuals prepare to transition to life post-incarceration, and could also provide a unique opportunity to engage potential behavioral health workers with lived experience in both justice system involvement and substance use disorder.

Policy Action: In partnership with the relevant entities, develop an educational pilot program for incarcerated individuals approaching release, which provides information and resources for participating in the CROP process, and potential career opportunities in behavioral health, such as peer counseling. Pilot could focus on participants with non-violent, substance use disorder-related offenses, who are interested in entering the behavioral health workforce. It could partner with community colleges and second chance Pell sites who are already providing educational services in correctional facilities (such as Yakima Valley College and Coyote Ridge Corrections Center).

Recommendation 5.4: Convene leadership of state agencies with jurisdiction to reduce barriers to behavioral health employment related to criminal background checks.

The process for reforming background check policies is complex; the critical health and safety concerns are lengthy, and specialized expertise is necessary to identify and propose changes to legal precedent, particularly given the involvement of the judicial system. While the workgroup and Project Team strongly agree that such reform should occur, the complexities of enacting such change warrant more specific study with legal and professional expertise.

⁵⁴ CROP defined: "Under the legislation, a person can now apply for this certificate in Superior Court. If the certificate is signed by the judge, then a licensing body cannot deny someone's application for an occupational license based on criminal history alone, but the person must be otherwise qualified and suitable for the license." (https://columbialegal.org/policy_reforms/crop/)

In conversations with the legal community and the full stakeholder group, the concept of a specialized taskforce – which would include members equipped with the previously described professional knowledge – surfaced as an effective step forward. Involving a broader spectrum of professionals, including legal/judicial in addition to behavioral health, would allow the taskforce to more precisely identify areas for change to existing background check policies, while the involvement of employers and those with lived experience navigating the criminal justice system should aid in identifying those barriers to employment that are specifically affecting the behavioral health workforce.

Policy Action: Create a taskforce comprised of representatives from the office of the Attorney General, DOH, DSHS, Office of the Governor, Division of Behavioral Health and Recovery within the Health Care Authority, and others (including behavioral health employers and those with lived experience), to examine impacts and changes proposed to the use of criminal background checks in employment in behavioral health settings, with the goal of reducing barriers to developing and retaining a robust behavioral health workforce, while maintaining patient safety measures.

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