

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

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KEY FINDINGS

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

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

Education and training priorities include:

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

CONTENTS

Key Findings.....	1
Background.....	3
Methods.....	3
Findings.....	4
References.....	13
Authors.....	14
Funding.....	14
Acknowledgments.....	14
Suggested Citation.....	14



KEY FINDINGS *continued*

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

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

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BACKGROUND

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

Objectives of this examination include:

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

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

METHODS

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

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

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

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

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

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

FINDINGS

BEHAVIORAL HEALTH WORKFORCE COMPOSITION AND HIRING CHALLENGES

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

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

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

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

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

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

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

■ Substance use disorder (SUD) treatment organizations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADEQUACY OF EDUCATION AND SKILLS PREPARATION

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

The following themes surfaced from our interviews with key informants:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AREAS FOR FURTHER INVESTIGATION

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

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

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

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

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

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

REFERENCES

1. Gattman NE, McCarty RL, Balassa A, Skillman SM. Washington State Behavioral Health Workforce Assessment. Washington Workforce Training and Education Coordinating Board, Dec 2017. Accessed October 22, 2022. http://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2018/01/wa_bh_workforce_fr_dec_2017.pdf
2. O’Connor JG, Dunlap B, Gattman NE, Skillman SM. Washington’s Behavioral Health Workforce: Barriers and Solutions. Phase II Report and Recommendations. Washington Workforce Board and Center for Health Workforce Studies, University of Washington, Dec 2020. Accessed October 22, 2022. <http://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2020/11/Behavioral-Health-Workforce-Assessment-2020.pdf>
3. Washington Health Workforce Sentinel Network. Accessed October 22, 2022. <https://wa.sentinelnetwork.org/> Washington
4. Health Care Authority. 2022. Accessed October 22, 2022. <https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/wraparound-intensive-services-wise>
5. Washington State Legislature. Accessed October 22, 2022. <https://app.leg.wa.gov/wac/default.aspx?cite=246-809-134>

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