Washington State Behavioral Health Workforce Report & Recommendations

DRAFT EDITION

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Project Team

Julia G. O'Connor, Workforce Training and Education Coordinating Board

Nova E. Gattman, Workforce Training and Education Coordinating Board

Liz Coleman, Workforce Training and Education Coordinating Board

Ben Dunlap, University of Washington Center for Health Workforce Studies

Susan M. Skillman, University of Washington Center for Health Workforce Studies

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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—mental health and substance use disorder treatment—to its residents.

The 2019 Washington Legislature directed the formation of a workgroup, funded by the Health Professions Account (administered by Department of Health), to continue the work around select workforce barriers outlined in the 2017 Washington State Behavioral Health Workforce Assessment. The 2017 assessment identified and described the state's behavioral health workforce and provided recommendations for research and policy proposals to better understand and address barriers faced by the behavioral health workforce. This new project builds upon that work, and charges 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 Training and Education Coordinating Board (Workforce Board), with extensive support by the University of Washington Center for Health Workforce Studies (hereafter "Project Team").

To address barriers facing behavioral health professions in Washington, this report provides an initial in-depth analysis of, and recommendations regarding:

- Licensing reciprocity or the feasibility of an interstate compact, and
- Background checks, including barriers to work related to an applicant's criminal history or substance use disorder.

This draft report represents the first phase of this project. Phase I began September 2019 and ends with this report to the Governor and Legislature on December 1, 2019. Two stakeholder workgroups that included health facility CEOs, educators, organized labor, and state and local government agencies shaped the recommendations in this Phase I report. Nearly 100 individuals participated in the development of this report through interviews, large group meetings, and written input.

It's important to note that this Phase I is an **initial** report on these two topics, and is not meant to be an exhaustive analysis. The Project Team will continue exploring these topics and more in Phase II (more below).

Phase II of the project will begin in January 2020. The early recommendations made in the Phase I report will be finalized in Phase II, and the three remaining barriers named in the proviso above will be explored in detail in a final report to the Legislature by December 1, 2020.

Key Findings

To be included in the final report submitted December 1, 2019.

Recommendations

Topic 1: Increase opportunities for behavioral health professionals relocating to Washington to more easily transfer out-of-state professional credentials through expanded licensing reciprocity.

1) Expand lists of states with substantial equivalency in licensing requirements to include all credentialed behavioral health professions, in addition to the existing lists for psychologists and substance use disorder professionals (SUDPs).
2) Identify states with successful behavioral health profession interstate compacts, and which behavioral health occupations are addressed through the compacts.
3) Increase understanding of behavioral health professionals who move to Washington through military service and their ability to gain licensure.

Items requiring further inquiry are detailed in the report.

Topic 2: Review and adapt existing background check policies and practices to increase behavioral health workforce entry and retention, while upholding patient protection and safety measures.

4) Standardize background check use in clinical hiring and education/training admission decisions.
5) Evaluate existing scope of background checks for professional licensing and credentialing, as well as employment to identify aspects which disproportionately impact certain provider populations and demographics.
6) Reduce difference in conduct and interpretation of background checks between state-credentialed agencies by exploring the creation of a central background check unit.

Items requiring further inquiry are detailed in the report.

Background

The 2017 Washington State Behavioral Health Workforce Assessment determined "the demand for behavioral health care—mental health and substance use disorder treatment—exceeds the availability of services throughout the state." 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 (Gattman et al., 2017). This report expands upon the work done in the 2017 Assessment.

The behavioral health workforce can be found in a multitude of professional settings including, but not limited to: in-patient and out-patient treatment facilities; physical/medical care delivery locations; educational institutions; community-based behavioral health agencies; and in private practice. Many occupations involved in providing substance use disorder and mental health treatment are recognizable by name and are profiled in the preceding 2017 Assessment, including: psychiatrists, clinical/counseling psychologists, psychiatric advanced registered nurse practitioners, social workers, mental health counselors, marriage and family therapists, substance use disorder professionals, certified peer counselors, and community health workers. In conjunction with their primary medical care roles, many physical medical providers may also provide behavioral health services.

Local and National Burden of Disease and Barriers to Care

Washington residents continue to experience significant mental illness, substance use disorder, significant disease burden from mental illness, and experience 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, and among them, many did not know where to seek treatment (20.6 percent), or thought they could "handle" the problems 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 (SAMHSA, 2019).

Statewide, pregnant or parenting individuals, as well as those who are justice-involved, face particularly glaring gaps in behavioral health treatment (McGill, 2019). 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.

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, an estimated 19.1 percent (47.6 million) adults aged 18 years or older lived with a diagnosed mental illness, and 4.6 percent (11.4 million) experienced significant mental illness. Of the 11.5 million 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 (SAMHSA, 2019).

In 2018, 7.8 percent of U.S. adults (19.3 million) experienced 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, 15.3 percent of 18- to 25-year olds received substance use disorder treatment, as did 7.0 percent of those 26 or older; 3.8 percent of 12- to 17-year-olds received substance use disorder treatment. In 2018, 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 (SAMSHA, 2019).

There is significant variation in the geographic distribution of behavioral health providers, complicating access to care, and creating significant disparities in care for those living in non-metropolitan counties in Washington and throughout the U.S. (Andrilla et al., 2018). The behavioral health workforce shortage in community settings is expected to worsen as experienced behavioral health professionals and paraprofessionals exit for better pay with lighter caseloads, or retire altogether. New workers are met with high caseloads, and increasing demand for services (Thompson, Flaum, and Pollack, 2017).

Project to Improve Behavioral Health Workforce and Access to Care

As part of efforts to address these persistent challenges, the Washington State Legislature directed through proviso, the Workforce Board to convene a workgroup to develop policy recommendations on five issue areas (noted below). The barriers and recommendations outlined in the 2017 Washington State Behavioral Health Workforce Assessment provided the starting point for the workgroup.

The workgroup is charged with addressing the following policy topics:

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 work involved is divided into two phases. Phase I took place from September through December 2019 and involved researching and gathering stakeholder feedback for early recommendations to policymakers. Phase II begins January 2020 and will involve more in-depth research and stakeholder engagement to further collect input and collaboratively develop policy recommendations on all five barriers to the behavioral health workforce listed above by December 2020.

In Phase I, the Project Team began study activities (detailed in Approach) addressing two of the topics specified in the proviso:

1) Licensing reciprocity or the feasibility of an interstate compact, and
2) Background checks, including barriers to work related to an applicant's criminal history or substance use disorder.

This Phase I report details the workgroup findings from research by the Project Team, including stakeholder input, and specific recommendations for addressing these challenges to find actionable solutions.

Approach

The Project Team conducted stakeholder meetings and interviews to build and report an understanding of the problems, barriers, potential solutions, and recommendations for topic areas to be covered in Phase I. Stakeholder interaction was supplemented with: background research of relevant published findings; reports and guidance by federal and local government agencies; industry reports; and advocate reports, among other sources. Formal group stakeholder meetings were conducted in person in Renton, Washington September 24, 2019 and through an online webinar October 7, 2019. Meeting participants included a wide range of stakeholders interested in the topics to be covered in Phase I, ensuring input from a broad range of organizations, employers, practitioners, and agencies from across the state.

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. (See page 20 for the full list of Phase I participants.) Background research on federal and other states' policies helped identify important interstate initiatives and relevant federal regulations for each topic, and inform policy recommendations.

Topic I: Reciprocity and Interstate Agreements

Purpose and Definitions

To increase 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 licensure in one state, wishes to practice in another state.

License reciprocity is a policy that allows a professional who is licensed to practice in a given 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 (Understanding Interstate Licensure, 2003).

National Overview of Reciprocity and Interstate Compacts for Behavioral Health Licensure

There are many different standards of practice (SOPs) for behavioral health professionals across states. This variation will need to be addressed for licensing reciprocity or interstate agreements to work in a predictable way for these professions. Psychologists and licensed clinical social workers typically have less variation in standards of practice and licensing standards among states when compared with specialized behavioral health professions and paraprofessionals such as peer counselors (Page et al., 2017).

Reflecting a need for uniformity of behavioral health professional standards of practice, several established organizations have developed standardized certification of 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 substance use disorder professionals (NAADAC, 2019). The international Certification & Reciprocity Consortium (IC&RC) has developed certification standards used by many state licensing agencies responsible for oversight of various substance use disorder professionals (IC&RC, 2019).

Mental health professionals also have resources and examples of existing interstate licensing agreements to draw upon. The Psychology Interjurisdictional Compact 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 in any member state to practice using face-to-face in-person interactions, in addition to telepsychology, with patients for a limited 30-day period (without requiring an additional license) in any other member state (ASPPB, 2019).

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, including psychiatric nurses, to practice in 36 member states (NLC, 2019). Similarly the Interstate Medical Licensure Compact (IMLC) allows medical and osteopathic doctors, including psychiatrists, a process allowing them to practice in one of the 29 member states (IMLC Commission, 2019).

Arizona's 2019 deregulation of all occupational licensing represented a radical step, 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 (HB 2569 P, 2019).

Other historic compacts focused on mental health treatment provision. Between 1967 and 1980, eight states[1] enacted the Interstate Compact on Mentally Disordered Offenders, through which member states sought to promote, "*research and training of personnel on a cooperative basis, in order to improve the quality or quantity of personnel available for the proper staffing of programs, services, and facilities*" (Interstate Compact on Mentally Disordered Offenders, 2019).

Washington's Participation in Compacts Related to Behavioral Healthcare

Washington enacted the Compact on Mental Health in 1965, joining 44 other states and the District of Columbia to provide mental healthcare for patients "*in need of institutionalization by reason of mental illness or mental deficiency*," with the understanding that "*community safety and humanitarianism require that facilities and services be made available for all who are in need of them*" (RCW 72.27.01, Article I; Article III (a)).

Although the Compact does not contain specific language for staffing, it does grant powers to make rules and regulations to meet the needs of the Compact (Article X). Furthermore, the Compact as chaptered in Washington law authorizes party states' administrative authorities to collaborate and take action to improve care collaboratively (Article XI).

The Washington State Department of Health (DOH) maintains a list of other states with "substantially equivalent" licensing requirements for psychologists and substance use disorder professionals. For substance use disorder professionals, "*all applicants credentialed in another state can be certified without taking the required exam if the other state's credential standards are equivalent to those of Washington*" (WAC 246-811-060). Applicant substance use disorder professionals are still required to demonstrate they meet education and experience requirements for certification (DOH, 2019).

For psychologists, "*Washington State may issue credentials to applicants with credentials in another state based upon the other state's qualifications. The other state's credentialing standards must be equivalent to Washington State's qualifications*" (DOH, 2019).

In 2019, Washington took action to expand reciprocity for other behavioral health professions. The Legislature enacted Senate Bill 5054, which requires DOH to: "*(1) Establish a reciprocity program for applicants for licensure or certification as a chemical dependency professional, mental health counselor, social worker, or marriage and family therapist in the state*" (SB 5054, 2019). In 2017, Washington passed House Bill 1337, "creating the interstate medical licensure compact." The Project Team is closely monitoring and participating in this work to avoid duplication of its efforts.

Given the national shortage of behavioral healthcare workers, it appears reasonable to assume reciprocity agreements alone are unlikely to lead to a sharp increase in behavioral healthcare workers in Washington. However, as Washington continues to attract new residents, there may be opportunities for the state to incorporate incoming behavioral health workers more quickly.

[1] Delaware, Illinois, Maine, Missouri, New Hampshire, New Mexico, North Dakota, and West Virginia.

Recommendations

Topic 1: Increase opportunities for behavioral health professionals relocating to Washington to more easily transfer out-of-state professional credentials through expanded licensing reciprocity.

Workforce-related barrier: *The complexity and variation of behavioral health profession licenses/certification between states makes hiring trained employees relocating to Washington a difficult, slow, and sometimes impossible undertaking.*

Unlike many physical health occupations, behavioral health professionals experience variety in licensing permissions and scope of practice from state-to-state, resulting in a patchwork of educational and supervised practice requirements for licensure. For example, both Massachusetts and Washington offer certification for a Licensed Independent Clinical Social Worker, but while Massachusetts requires 3,500 hours of post-graduate supervised practice, accumulated over a minimum of two years, Washington requires 4,000 hours of post-graduate supervised practice, accumulated over a minimum of three years.

Such variety creates significant barriers to transferring behavioral health licensure between states, including (but not limited to): challenges applying for and receiving licensure in the new state; cost of additional training and/or education to meet new state requirements; and limited employment opportunities, particularly working with marginalized populations, such as Medicaid recipients.

Stakeholders frequently voiced concerns regarding the availability of information related to licensing reciprocity, both for job seekers new to Washington and employers recruiting out-of-state workers to Washington. Practitioners holding current licensure from other states cannot practice in Washington until they have been credentialed by DOH, which oversees licensure and credentialing for all behavioral health professions, with the exception of peer counselors (licensed by the Department of Social and Health Services). Delays in this process can lead to employers assuming the financial burden of sponsoring licensure (and potentially paying employee salary and benefit costs) during a period in which the employee cannot work.

1) **Expand existing lists of states with substantial equivalency to include all credentialed behavioral health professions, in addition to the existing lists for psychologists and substance use disorder professionals (SUDPs).**

At present, the Washington State Department of Health maintains lists of “Substantially Equivalent States/Countries” for both psychologists and SUDPs. The lists identify states determined to have educational and practice training requirements comparable to Washington. The lists note the date of review for individual states (for psychologists only) and if the state has been deemed “equivalent.” For states deemed not equivalent, DOH notes how psychologist applicants for Washington licensure with current licensure in the respective state may meet Washington qualifications; such specifications are not available for substance use disorder professionals.

In stakeholder discussions, many participants noted confusion regarding requirements for licensure application in Washington for those practitioners already holding approved licensure in another state. Employers reported lengthy delays in the licensure application process when hiring out-of-state clinicians, resulting in disruption in client care, significant financial burden, and potential loss of workers, who depart in favor of employment in states with a less-challenging process. When asked which behavioral health professions are impacted, stakeholders reported a broad spectrum with particular emphasis on masters-level clinicians (licensed independent clinical social worker, licensed marriage and family therapist, licensed mental health counselor) and substance use disorder professionals.

Action Required: With resources allocated for this purpose, DOH could expand the existing substantial equivalency lists to include all credentialed/licensed behavioral health professions. Lists could begin by examining and assessing comparability between Washington and the five states with the highest rates of behavioral health professionals locating to Washington, as well as "neighboring states," as defined by DOH, with a long-term goal of capturing information for all 50 states.

2) Identify states with successful behavioral health profession interstate compacts, and which behavioral health occupations have interstate compacts working at present.

The intricate jurisdictional patchwork of state-regulated behavioral health professional licensure creates a challenging foundation to build an interstate compact. Enactment of compacts typically requires passage of legislation by each member state, as well as involvement of a broad spectrum of stakeholders, including professional associations, labor unions, licensing authorities (such as DOH and DSHS), employers, and state agencies.

Each behavioral health profession has unique education, training, and scope of practice standards, and all vary by state. While the ease of movement afforded by an interstate compact membership is appealing, it is important that each profession and its respective workforce are best served by such a policy proposal.

To determine the feasibility of Washington membership in any behavioral health profession compacts, an examination of existing compacts and their member-states would be a necessary first step. From there, successful strategies for legislative development and implementation, challenges faced (and overcome) by member-states to enacting such legislation, regulatory hurdles, and positive or negative impact on populations served by providers within the compact can be identified.

Similarly, an analysis of existing interstate compacts among behavioral health professions, such as those existing for psychiatrists and nurse practitioners (including psychiatric nurse practitioners), can help to identify aspects of clinical practice which can be standardized, evaluated, and regulated among multiple state authorities, as well as those professions better suited for reciprocity measures such as licensure by endorsement or provisional licensure.

Action Required: With resources allocated for this purpose, University of Washington Center for Health Workforce Studies, with consultation from the Workforce Board and Health Workforce Council, could conduct a study to determine which states have successfully enacted interstate behavioral health professional compacts and which occupations have successfully implemented interstate agreements.

3) Increase understanding of behavioral health professionals who move to Washington through military service and their ability to gain licensure.

In both workgroup meetings and key informant interviews, stakeholders noted the additional burdens faced by behavioral health practitioners affiliated with the military, particularly spouses and domestic partners of active duty service members. These providers are more likely to move between states due to change in military assignment, and face a unique set of professional licensure hurdles at every new deployment.

Stakeholders noted that for providers serving within the military community (typically on a base or in a veteran-affiliated capacity), billing permissions are restricted to physicians, nurses, and clinical social workers, limiting employment opportunities for military-affiliated professionals.

Establishing a single point of assistance specifically for military-affiliated professionals to attain employment in Washington and navigate the licensure transition system was identified as a potential solution.

Action Required: With resources allocated for this purpose, the Washington State Employment Security Department (ESD) could be charged with developing and implementing an employment navigator program for all incoming military-affiliated individuals seeking behavioral health professional licensure. This could be complimented by a portal or highlight on WorkSouceWA.com, and potentially in tandem with the existing initiative on this topic of the Washington State Military Transition Council.

Items that require further study for Phase II:

- Explore implementing more behavioral health apprenticeship programs.
- Greater use of certification of behavioral health occupations, which can be a faster process than licensure.
- Identify funding sources, such as grants, for reducing the costs of licensure/credentialing for behavioral health professionals moving into Washington State.
- Work with DOH and Health Care Authority to explore alternative pathways to state licensure, including consideration of a focus on graduates from outside the United States and/or a "5th year" residency option for those seeking licensure. Any related recommendations would need to be feasible for Medicaid reimbursement.
- Investigate strategies to reduce processing time for applications for behavioral health licensure through reciprocity, including exploring the concept of offering provisional license to practice while waiting for administrative processing. (Note: DOH is exploring this through Senate Bill 5054 implementation.)
- Charge Washington Association for Community Health to consider adding a supervised pathway to behavioral health licensure for practitioners from other countries.
- Mapping all 50 states and military programs and their respective licensure/credentialing requirements for specific behavioral health professions, and creating a crosswalk with Washington's requirements, to determine gaps.
    - Partner with educational institutions to map stackable education credential add-ons to meet Washington's requirements, and utilizing Credential Engine's[2] existing crosswalk pilot programing.

[2] www.credentialengine.com

Topic II: Background Checks

Purpose and Definitions

A change in policy regarding the use of background checks for behavioral health workers will need to balance patient safety, workforce availability, and equity.

In this context, the availability of appropriate workforce members is a concern. For example, peer counselors provide a recognized therapeutic function in behavioral health treatment as they have prior lived experience and an experience of recovery, which some patients may identify with and draw support from in their recovery. However, this lived experience can also lead to criminal justice involvement, which creates complex situations when peer counselors are needed for work with vulnerable populations.

There are concerns that potential behavioral health professionals or paraprofessionals, particularly peer counselors, may be excluded unnecessarily from providing services due to a criminal record, and that patients are not able to access behavioral healthcare providers that provide culturally-responsive behavioral healthcare. For example, in Oregon in 2019, the past president of the 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 (Foden-Vencil, 2019).

National Overview of Background Checks

In 2008, a national screening pilot project presented to the U.S. Senate indicated that 9,500 individuals with past convictions for offenses were denied employment in home health settings due to background check results, which used FBI fingerprint data, in addition to other sources (Senate Committee on Aging, 2008). The FBI is authorized (through public law 92-544) to exchange federal criminal history record information with state and local government agencies for licensing and employment purposes, and FBI fingerprint data is now used in many state agencies' background checks throughout the United States.

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, which required employers to meet certain criteria before disqualifying a specific candidate for employment. Enforcement actions ensued, stating that:

> *"There are two ways in which an employer's use of criminal history information may be discriminatory. First, the relevant law, Title VII of the Civil Rights Act of 1964, prohibits employers from treating job applicants or employees with the same criminal records differently because of their race, national origin, or other protected characteristic (disparate treatment discrimination). Second, the law also prohibits disparate impact discrimination. This means that, if criminal record exclusions operate to disproportionately exclude people of a particular race or national origin, the employer has to show that the exclusions are 'job related and consistent with business necessity' under Title VII to avoid liability.' [Doing so] is not burdensome. The employer can make this showing if, in screening applicants for criminal conduct, it (1) considers at least the nature of the crime, the time elapsed since the criminal conduct occurred, and the nature of the specific job in question, and (2) gives an applicant who is excluded by the screen the opportunity to show why he[/she] should not be excluded."* (EEOC, 2012).

Similarly, a 2016 report by the National Employment Law Project (NELP) noted 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" (NELP, 2016). Despite this, employers may circumvent such protections if the applicant's conviction "*would compromise the requirements of the job and there are no alternatives to such exclusions*" (NELP, 2016).

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 March 2018, 11 states (including Washington) and 150 cities had implemented some kind of 'ban-the-box' regulation, preventing potential employers from asking applicants about criminal or arrest history prior to evaluating the candidate on qualifications for the position (NELP, 2016).

Certain occupational settings are exempted from these laws, including working with vulnerable adults, and the background check can still be applied after offering the position, creating a conditional hiring situation. In some cases, applicants 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. (Sherman, 2017).

Communities of color in Washington continue to experience disproportionate marginalization and disparate impact, despite the existence of such laws as 'ban-the-box.' This indicates more robust measures may be needed to prevent intentional and unintentional hiring discrimination on the basis of race.

Recommendations

Topic 2: Review and adapt existing background check policies and practices to increase behavioral health workforce entry and retention, while upholding patient protection and safety measures.

Workforce-related barrier: *The broad scope of background check implementation, utilization, and frequency poses significant barriers to both entry into and retention within the behavioral health workforce.*

Background checks function as a mode of consumer protection by identifying individuals with criminal histories that might endanger the physical safety of clients and put employers at financial risk. These checks evaluate authenticity of employment history, education, professional license, driving record, criminal offense history, substance use testing, and fingerprinting, among other items. Considering the potential for frequent contact with vulnerable populations such as children, the elderly, and people with developmental disabilities, behavioral health employers have a responsibility to conduct comprehensive evaluation of a potential employee's history, to ascertain if the prospective employee will pose any risk to the client population served and the organization's liability of service.

Stakeholders identified specific barriers presented by background checks as including: cost of conducting the check(s), particularly to the student/worker; time required, both of employer and worker, to complete the check(s); confusion regarding *who* is conducting the check, and at what level (i.e., federal/FBI, current state of practice, previous state of residence, etc.); and lack of consistency in how background checks are interpreted, particularly in hiring decisions. Also identified was a lack of communication and/or clear practice between agencies and employers in the use of background checks due to variation among professions, different purposes of background checks (e.g., certification vs. for employment), and different levels of risk, among other reasons.

The scope of *who* is requiring the background checks varies, as well. Checks may be required for licensing/credentialing by state agencies; for education program entry by educational institutions; for assignments to clinical training by the clinical training site; at initial employment by the employer; and occasionally at intervals during employment. Despite the frequent opportunity for conducting background checks, stakeholders reported confusion regarding the existence of a standardized process for which checks are conducted, and for which purpose, at various points in the behavioral health career path.

While the entire behavioral health workforce is impacted by barriers related to background checks, certain sub-populations are more vulnerable, including those with criminal offense and substance use histories. Stakeholders noted the particular difficulty faced by previously incarcerated persons to entering behavioral health careers, as employment restrictions and limitations resulting from background check results can prevent eligibility in working with certain populations (children and vulnerable adults). Similarly, several stakeholders identified peer counselors, who draw upon lived experience as a central aspect of their behavioral health practice, as likely to face negative impacts of background check results related to hiring decisions.

Current background check use may limit access to employment for historically marginalized communities, such as Native American, African American, and Latino populations. Such populations are more likely to be justice-involved and face low representation within the behavioral health workforce. Character competency and suitability reviews, utilized when a potential employee's background check results include non-disqualifying conviction(s), pending charge(s), and/or negative charge(s), are a subjective measure used by potential employers. Stakeholders identified these reviews as being inconsistently used, and a related barrier that can lead to bias and potentially exacerbate institutional racism.

4) Standardize background check use in clinical hiring and education/training admission decisions.

Stakeholders frequently named inconsistent use of background check results as a barrier to both entry and long-term retention/career pathway movement within the behavioral health field. While various reasons were named for such inconsistency, consensus identified a lack of training related to background check reading, interpretation, and implementation as most problematic. Despite the frequency of using background checks in hiring and retention decisions, few employers provide related training. Background check use standardization requires developing guidelines, training and educating hiring managers (and others) who frequently utilize background checks in the field. This type of training may be found in education and childcare professions; however, the rapid growth of the behavioral healthcare field has yet to include extensive training in this regard.

Action Required: As part of its Phase II work, the Project Team, with support of the workgroup, will research and evaluate best practices for standardized background check use, with the intent of informing a curriculum and/or training guidelines for the interpretation and use of background checks in hiring processes and education/training program admissions. The curriculum/training guidelines should be developed using an equity lens to address disproportionate impact on marginalized populations, such as communities of color and those with a history of criminal offense and/or substance use disorder.

5) Evaluate existing scope of background checks for professional licensing and credentialing, as well as employment, to identify aspects which disproportionately impact certain provider populations and demographics.

Stakeholder discussions frequently referenced the potential negative impact of background check results which include long-ago incidents and criminal history. While context and severity of past charges and convictions remain important considerations in hiring and/or licensing decisions, the inclusion of some results may contribute to increased stigma and decreased likelihood of employment/licensure, while disregarding the potential for rehabilitative growth (both personal and professional) in the intervening years, particularly for those professions in which lived experience is emphasized.

As mentioned previously, marginalized communities, particularly communities of color, are more likely to have interaction with the justice system, including higher rates of arrest and conviction, and thus are more likely to experience the ramifications of background check results noting long-ago criminal history. The potential for exacerbation of hiring bias and institutionalized racism presents further barriers to building and supporting a culturally and linguistically diverse workforce, one which is able to provide culturally-responsive and equitable care.

It is important to note that 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.

Action Required: With resources allocated for this purpose, the Governor's Interagency Council on Health Disparities could be charged with examining the current role of background checks for professional licensing and employment decisions, and providing recommendations to reduce the potential for negative impact on historically marginalized populations.

6) Reduce difference in conduct and interpretation of background checks between state-credentialed agencies by exploring the creation of a central background check unit.

Several stakeholders noted particular confusion resulting from the lack of a centralized "clearinghouse" for all background check-related questions, policies, and processes. They reported particular confusion regarding which types of checks are conducted (federal versus Washington versus other states), for which professions or licenses each check is relevant, and what authority is responsible for which check. Lack of understanding, reported across the employee-to-employer spectrum, can also further marginalize those providers with previous negative experiences in the background check realm, who may be intimidated by such confusion.

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 unit should include active stakeholder engagement, with particular emphasis on equitable representation of employers (such as community behavioral health agencies, hospitals, schools, and treatment facilities, among others).

Action Required: With resources allocated for this purpose, the Washington State Patrol could be charged with developing a model for a background check central unit and/or process for centralized, integrated behavioral health professional background check screening.

Items that require further study for Phase II:

- Further examination of DSHS Secretary's Disqualifying List of Crimes & Negative Actions to understand its role in employment-related actions (hiring versus not hiring) resulting from background check results, with particular attention to disproportionate impact on underrepresented population groups, including communities of color.
- Research current implementation of Certificate of Restoration of Opportunity to identify potential problems and solutions.

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Participants in Stakeholder Meetings & Key Informant Interviews

Participant	Organization
Amber Leaders	Office of the Governor
Amber Siefer	Department of Commerce
Amelia Davis	Coordinated Care of Washington
Amy Persell	SEIU 775 Benefits Group
Ann Christian	Washington Council for Behavioral Health
Anna Ratzliff	University of Washington, Department of Psychiatry and Behavioral Health
Annabelle Payne	Pend Oreille County Counseling Services
Avanti Bergquist	Washington State Council of Child and Adolescent Psychiatry
Becky Fraynt	SEIU 775 Benefits Group
Ben Dunlap	University of Washington Center for Health Workforce Studies
Brenna Renn	University of Washington, Department of Psychiatry and Behavioral Health
Caitlin Lang-Perez	Washington State Board of Health
Caitlin Martin	SEIU 775 Benefits Group
Carol Moser	Greater Columbia Accountable Community of Health
Carolyn McKinnon	State Board for Community & Technical Colleges
Casey Ruiz	SEIU 1199NW
Chris De Villeneuve	Catholic Charities of Central Washington
Chris Kaasa	Washington Association for Community Health
Christie Spice	Department of Health
Christy Curwick Hoff	Washington State Board of Health
Claudia Shanley	Washington Student Achievement Council
Clifford Thurston	Worldbridgers
Cori Garcia-Hansen	Area Health Education Center for Western Washington
Dan Ferguson	Washington State Allied Health Center of Excellence
Devon Nichols	Office of Financial Management
Eleni Papadakis	Workforce Training and Education Coordinating Board
Greg Attanasio	Washington State Senate

James Chaney	Department of Health
Jean Tang	University of Washington School of Nursing
Jim Vollendroff	Harborview Medical Center
Joe Roszak	Kitsap Mental Health Services
Julia O'Connor	Workforce Training and Education Coordinating Board
Julie Benson	Tacoma Community College
Jürgen Unützer	University of Washington, Department of Psychiatry and Behavioral Health
Kate Di Nitto	Area Health Education Center for Western Washington
Katharine Weiss	Washington State Nurses Association
Katherine Lechner	Washington Association for Community Health
Kellee Gunn	Washington State Senate
Kevin Black	Washington State Senate
Kris Lau	Lake Washington Technical College
Krista Loney	Eastern Washington University Area Health Education Center
Kristin Peterson	Department of Health
Kristin Reichl	Department of Health
Lauri St. Ours	Washington Health Care Association
Laurie Lippold	Partners for Our Children
Leslie Stahlnecker	Educational Service District 123
Linda Grant	Evergreen Recovery Center
Linda Lou Miller-Bever	Catholic Community Services of Western Washington
Lindsey Grad	SEIU 1199NW
Liz Coleman	Workforce Training and Education Coordinating Board
Louisa Erickson	Department of Social and Health Services
Louise Nieto	Health Care Authority
Maddy Thompson	Office of the Governor
Marianna Goheen	Office of Superintendent of Public Instruction
Marissa Ingalls	Coordinated Care of Washington
Martin Pittioni	Department of Health

Mary Clogston	House Democratic Caucus
Melanie Smith	Contract Lobbyist for Various Behavioral Health Organizations
Melodie Pazolt	Health Care Authority
Nancy Lawton	Greenwood Medical Clinic
Nancy Tyson	Department of Health
Nova Gattman	Workforce Training and Education Coordinating Board
Randon Aea	International Community Health Services
Rebecca Hammill	Passages Family Support
Renee Fullerton	Department of Health
Russell Maier	Community Health of Central Washington
Shirley Maike	Passages Family Support
Sofia Aragon	Washington Center for Nursing
Stafford Strong	Washington State Senate
Subharati Ghosh	SEIU 775 Benefits Group
Sue Skillman	University of Washington Center for Health Workforce Studies
Suzanne Swadener	Health Care Authority
Tammy Browning	Catholic Charities of Central Washington
Wei Yen	Office of Financial Management
Wendy Sisk	Peninsula Behavioral Health Services