Interpretive Report 24-37

2024 Behavioral Health Provider Survey Interpretive Report

Prepared for:

Division of Behavioral Health and Recovery
Washington State Health Care Authority
Olympia, Washington

Submitted by:

Rose Krebill-Prather, PhD
Principal Investigator

Kent Miller. MA
Project Manager

Social & Economic Sciences Research Center
Washington State University

P.O. Box 644014
Washington State University
Pullman, Washington 99164-4014
Telephone: (509) 335-1511
Fax: (509) 335-0116
www.sesrc.wsu.edu

This page left blank for double-sided printing

CONTENTS

This page left blank for double-sided printing

LIST OF TABLES

This page left blank for double-sided printing

List of Figures

This page left blank for double-sided printing

Executive Summary

Background and Purpose

The Division of Behavioral Health and Recovery (DBHR) regularly conducts a survey of agency providers to identify opportunities for improving the quality of behavioral health treatment services in Washington State. In addition, the survey aims to collect information that would allow DBHR to meet federal and state reporting requirements and inform policy at the state and provider level. The DBHR works collaboratively with the Social & Economic Sciences Research Center (SESRC) to administer the survey.

This report presents the results from the 2024 Behavioral Health Provider Survey conducted from March 2024 through August 2024. The questionnaire has three main sections: Agency Characteristics, Quality Improvement, and Behavioral Health Staffing. The Agency Characteristics section asks about the organization type, client population, services provided, funding, cultural competency, and population-specific services. The Quality Improvement part includes questions on quality improvement activities and approaches used to improve client retention and outcome, assess perception of care, and assist clients with educational goals, employment, and housing opportunities. The final section, Behavioral Health Staffing, covers questions related to behavioral health clinical staff.

The web-based survey was open to behavioral health (BH) treatment agencies that provide DBHR-certified, publicly funded, community-based mental health (MH) and substance use disorder (SUD) treatment services. Out of the final 635 behavioral health treatment agencies meeting the inclusion criteria, 287 answered the survey: 249 completes and 38 partial completes. The overall response rate is 45.2%.

Key Findings

Agency Characteristics

- When asked to identify their structure, half of the agencies (50%) considered themselves as a local branch of a multi-site health care organization, 27% as an independent community-based agency and 10% as the main office of a multi-site health care organization.

- Ninety-three percent of agencies serve adults (18 year and over), 57% serve youth (13-17 years old), and 50% serve children (under 13 years old).

- Approximately one-third (34%) of agencies reported providing mental health (MH) treatment services only, with 19% providing substance use disorder (SUD) treatment service only, and 47% providing both MH and SUD treatment services.

- Among agencies that provide both MH and SUD services, 47% have a single or integrated MH and SUD program while 45% have a separate program or staff for MH and SUD services.

- Ninety-five percent of all agencies serving children and youth were accepting new children and youth clients in the last 12 months.

- About one-third (34%) of the agencies in the survey provide co-occurring disorders (COD) treatment services. Of those offering COD treatment services, 46% treat both MH and SUD in their facility, while 25% treat the MH issue and refer clients to another facility for SUD treatment, and 20% treat the SUD only and refer the client to another facility for MH treatment.

Electronic Health Records

- Over ninety percent (94%) of agencies use an electronic health record (EHR) for their client record keeping system while only 7% use a paper record keeping system.

- The five most commonly listed EHR systems are Credible Behavioral Health (20%), Epic (20%), Netsmart/Avatar (14%), Qualifacts (including Carelogic) (10%), and Collective Medical (10%).

- Most agencies create electronic care plans (92%) and use their EHR to record electronic screenings and assessments (92%)

- Behavioral health (91%) is the primary function for which EHRs are used.

- More than two-thirds of agencies (70%) indicated they are very or somewhat satisfied with their EHR system.

- About two-fifths of agencies (40%) indicated they would be very or somewhat willing to accept an offer of a statewide electronic health record (EHR) system with minimal cost-sharing including configuration, implementation support, training, standard workflow, and technical support.

Crisis Stabilization and Response

- Overall, one-third of agencies (33%) indicated they provide crisis stabilization services.

- Crisis outreach and Crisis telephone support are the most common services offered, with over half of agencies indicating that option (56% for each)

- Self-referral (77%) and Designated crisis responders (63%) are the two most common ways clients are referred to the crisis stabilization services.

- Outpatient mental health services (76%) is the most common service provided following an immediate crisis.

Bed Registry

HCA is considering the implementation of a behavioral health bed registry. A behavioral health bed registry will make available information about targeted behavioral health providers (e.g., types of programs offered, populations served) and whether the provider has any available beds.

- The largest percentage of agencies (55%) would use a Bed Registry to identify behavioral health providers with available beds.

- Identifying whether a BH provider could provide services needed by particular clients was selected by nearly half of respondents (47%).

Clinical Integration

In the section of the questionnaire asking about the integration of physical health services with be the agency's behavioral health practice.

- A large majority of agencies use mental health screenings (89%).

- Sixty-nine percent of agencies indicated use of substance use disorder screenings.

- Half of the agencies provide general health risk factor screening (52%).

- The primary way physical health services is integrated with behavioral health practices is through referring to primary care as indicated (83%).

Population Specific Services

Behavioral health agencies offer services designed to meet the needs of specific population groups.

- Approximately one-third of facilities provide population specific services for:
    - Youth (36%)
    - Women (34%)
    - Individuals involved in the criminal legal system (33%)
    - Men (30%)

Quality Improvement

- Chart reviews is the most common quality improvement activity for all three types of agencies (95% for MH treatment services only, 98% SUD treatment services only, and 93% both MH and SUD treatment services).

- Ninety percent or more of facilities indicated the following strategies are used to improve client retention and outcomes.

    - Engage clinicians in trainings (92%)
    - Integrate client's cultural beliefs, practices, and traditions in treatment planning (92%)
    - Active voice of client/family is present in treatment plans (92%)
    - Provide interpreter services to individuals or families whose primary language is not English (90%)

- Over nine in ten agencies have formal grievance procedures (93%) to assess client's perception of the quality of care received.

Behavioral Health Staffing

- Overall, responding agencies indicated they employed 17,124 behavioral health staff and 13,606 behavioral health clinical staff.

- The average number of paid behavioral health staff at facilities is 66 and behavioral health clinical staff is 52.

- Greater than eight out of ten employees work full-time (81%) – which is defined for this study as 32 hours per week or more. (MH 77%, SUD 72%, and MH-SUD 83% full-time).

- The highest percentage of BH clinical staff (31%) receive an annual base salary in the range of $50,001 to $60,000 per year. (MH 30%, SUD 24%, MH-SUD 32%,).

- Over two-thirds of BH clinical staff are identified as Woman (71%) (MH 72%, SUD 56%, MH-SUD 71%,).

- Over half of BH clinical staff in facilities responding to the survey are categorized as White, non-Hispanic (57%). Asian/Pacific Islander and Black or African American are the next most common categories (9% each). Don't know (7.1%), Hispanic (7%), Multiracial (6%), Prefer not to answer (4%), Native American or Alaska Native (1%) and Other (0.2%) round out the list.

- Of BH clinical staff who speak a language fluently other than English, Spanish is used by over two-thirds of those staff (71%). Chinese (3%), Tagalog (2.6%), Korean (2.4%), Hindi (2.2%), and Russian (2.1%) are the next most indicated languages.

- A Bachelor's degree is reported as the most common of educational degrees (37% overall, 42% MH only agencies, 29% SUD agencies, and 35% MH & SUD).

- The top three categories for Washington State Department of Health Credential types are: Agency Affiliated Counselor Registration (24%), Licensed Mental Health Counselor (4%), and Registered Nurse (4%).

- Over one-third of agencies that provide both treatment services have one or more dually credentialed staff (42%).

Behavioral Health Agencies: A Profile of Agency Characteristics

When asked to identify their structure, half of the agencies (50%) considered themselves as a local branch of a multi-site health care organization, 27% as an independent community-based agency and 10% as the main office of a multi-site health care organization.

- Ninety-four percent of the agencies provide treatment services under a contract with a Behavioral Health Organization (BHO), a Managed Care Organization (MCO), or with an Administrative Services Organization (ASO).
- Ninety-three percent of agencies serve adults (18 year and over), 57% serve youth (13-17 years old), and 50% serve children (under 13 years old).
- Approximately one-third (34%) of agencies reported providing mental health (MH) treatment services only, with 19% providing substance use disorder (SUD) treatment service only, and 47% providing both MH and SUD treatment services.

Table 1. Agency Characteristics by Type of Service

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
An independent, community-based agency	20.4%	33.3%	29.9%	27.2%
A local branch of a multi-site health care organization	60.2%	51.0%	42.5%	50.2%
The main office of a multi-site health care organization	5.1%	5.9%	14.9%	9.9%
Other	14.3%	9.8%	12.7%	12.7%
Contract with a BHO, MCO, or ASO	89.8%	98.1%	94.8%	93.7%
Serving adults (18 years and over)	86.7%	100.0%	94.0%	92.7%
Serving youth (13 - 17 years old)	62.2%	25.9%	64.9%	56.6%
Serving children (under 13 years old)	56.1%	13.0%	59.0%	49.3%
Type of service	34.3%	18.9%	46.9%	

Mental health treatment services offered vary by agencies, but the five most common offerings are:

- Individual treatment services (93%)
- Intake evaluation (85%)
- Group treatment services (75%)
- Therapeutic psychoeducation (63%)
- Medication management (61%)
- Agencies also reported providing family treatment (59%), stabilization services (27%), high intensity treatment (25%), dyadic treatment (24%), wraparound with intensive services (17%), inpatient evaluation and treatment (16%), other (14%), and first episode psychosis navigate (11%).

Table 2. MH treatment services provided

	MH treatment services only	Both MH and SUD treatment services	Overall
Individual treatment services	88.8%	96.3%	93.1%
Intake evaluation	80.6%	88.8%	85.3%
Group treatment services	61.2%	84.3%	74.6%
Therapeutic psychoeducation	57.1%	66.4%	62.5%
Medication management	52.0%	67.2%	60.8%
Family treatment	57.1%	60.4%	59.1%
Stabilization services	22.4%	29.9%	26.7%
High intensity treatment	24.5%	26.1%	25.4%
Dyadic family treatment (parental caregiver along with infant, toddler, or preschooler)	21.4%	26.1%	24.1%
Wraparound with Intensive Services (WISe)	8.2%	23.9%	17.2%
Inpatient evaluation and treatment	14.3%	16.4%	15.5%
Other, specify	16.3%	11.9%	13.8%
First episode psychosis navigate	12.2%	10.4%	11.2%

Of the agencies providing SUD treatment modalities:

- 80% provide outpatient services
- 30% provide Medication Assisted Treatment (MAT)
- 21% provide intensive inpatient
- 10% offer withdrawal management
- 10% provide other services
- 4% provide long-term residential treatment
- 3% provide a recovery house
- 2% provide secure withdrawal management.

Table 3. SUD treatment modalities provided

	SUD treatment services only	Both MH and SUD treatment services	Overall
Outpatient	70.4%	84.3%	80.3%
MAT (Medication Assisted Treatment)	25.9%	32.1%	30.3%
Intensive inpatient	25.9%	20.1%	21.8%
Withdrawal management	16.7%	7.5%	10.1%
Other, specify	3.7%	12.7%	10.1%
Long-term residential	1.9%	4.5%	3.7%
Recovery house	0.0%	4.5%	3.2%
Secure withdrawal management	1.9%	1.5%	1.6%

Integration of MH and SUD Services

Among agencies that provide both MH and SUD services:

- Forty-seven percent indicate they have a single or integrated program for both MH and SUD services.
- Forty-five percent report they have a separate program or staff for MH and SUD services.

Table 4. Program structure in facilities offering both MH and SUD services

	Overall
Have a separate program or staff for MH versus SUD services	45.0%
Have a single or integrated program or staff for both MH and SUD	46.6%
Other (please specify)	8.4%

- Ninety-five percent of all agencies serving children and youth were accepting new children and youth clients in the last 12 months.

Table 5. Agencies accepting new children and youth clients in the last 12 months

	MH treatment services only	Both MH and SUD treatment services	Overall
Yes	95.2%	95.4%	95.3%
No/Don't know	4.8%	4.5%	4.7%

Co-occurring Disorders Treatment Services

About one-third (34%) of the agencies in the survey provide co-occurring disorders (COD) treatment services. Of those offering COD treatment services:

- Forty-six percent treat both MH and SUD in their facility
- Twenty-five percent treat the MH issue only and refer clients to another facility for SUD treatment
- Twenty percent treat the SUD only and refer the client to another facility for MH treatment.

Table 6. Co-occurring disorders treatment services and categories

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Yes	17.0%	19.2%	53.1%	34.4%
Treat the MH only and refer the person to another facility for SUD treatment	71.3%	0.0%	1.5%	24.9%
Treat the SUD only and refer the person to another facility for MH treatment	1.1%	92.5%	2.3%	19.1%
Treat both MH and SUDs in this facility	8.5%	5.7%	90.0%	46.2%
Refer the person to another facility that specializes in co-occurring disorders treatment	5.3%	0.0%	1.5%	2.5%
Other (please specify)	13.8%	1.9%	3.8%	6.9%
Don't know	0.0%	0.0%	0.8%	0.4%

Client Record Keeping System

Agencies were asked about their record keeping systems.

- Approximately 94% of agencies indicated they use an EHR record keeping system.
- About one in fourteen agencies (7%) primarily use a paper record keeping system.

Table 7. Which of the following best describes your client record keeping system?

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Primarily use paper record keeping	12.8%	5.7%	2.3%	6.5%
Primarily use an EHR system	87.2%	94.3%	97.7%	93.5%

Cost and maintenance of an EHR system is the most cited barrier to adoption (47%).

Table 8. Barriers to adopting an EHR system?

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Cost of purchasing and maintaining an EHR system	50.0%	66.7%	25.0%	47.4%
Finding an EHR system that meets your facility's needs	25.0%	66.7%	25.0%	31.6%
Other: please specify	25.0%	0.0%	25.0%	21.1%
Limited or lack of IT staff to support EHR adoption	8.3%	66.7%	0.0%	15.8%
Privacy or security concerns	0.0%	0.0%	25.0%	5.3%
Inadequate/lack of internet connection	0.0%	0.0%	25.0%	5.3%
Loss of productivity during the transition to an EHR system	0.0%	0.0%	0.0%	0.0%
Staff resistance to use EHR	0.0%	0.0%	0.0%	0.0%

- The five most commonly listed EHR systems are Credible Behavioral Health (20%), Epic (20%), Netsmart/Avatar (14%), Qualifacts (including Carelogic) (10%), and Collective Medical (10%).

- Over one-third of respondents indicated they use an EHR not listed in the survey (36%)

Table 9. Name of EHR system

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Credible Behavioral Health	20.7%	8.0%	24.4%	20.1%
Epic	30.5%	14.0%	15.0%	19.7%
Netsmart/Avatar	15.9%	4.0%	15.7%	13.5%
Qualifacts (including CareLogic)	11.0%	2.0%	12.6%	10.0%
Collective Medical	12.2%	2.0%	11.0%	9.7%
CareLogic	2.4%	0.0%	10.2%	5.8%
UniteUS	8.5%	0.0%	5.5%	5.4%
Netsmart	0.0%	2.0%	1.6%	1.2%
Care Everywhere/CareQuality	1.2%	0.0%	0.8%	0.8%
Cerner	0.0%	0.0%	0.0%	0.0%
findhelp (formerly known as Aunt Bertha)	0.0%	0.0%	0.0%	0.0%
NowPow	0.0%	0.0%	0.0%	0.0%
Bamboo Health OpenBeds (formerly known as Appriss Health)	0.0%	0.0%	0.0%	0.0%
Other	24.4%	74.0%	29.1%	36.3%

Table 10. Partial list of other EHRs used

	Number
InSync	11
ReliaTrax	8
Raintree	6
Sigmund/Aura	6
Simple Practice	5
Kipu	4
Methasoft	4
Athena, converting to EPIC next year	3
SMART	3

- Most agencies create electronic care plans (92%) and use their EHR to record electronic screenings and assessments (92%)

Table 11. Activities for which the EHR is used

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Create electronic care plans	95.1%	88.0%	92.1%	92.2%
Record electronic screenings and assessments	92.7%	92.0%	91.3%	91.9%
Send electronic discharge plans	43.9%	36.0%	41.3%	41.1%
Receive electronic referrals	37.8%	18.0%	32.5%	31.4%
Send electronic referrals	34.1%	14.0%	31.7%	29.1%
Other activities, specify:	15.9%	22.0%	11.1%	14.7%

- Behavioral health (91%) is the primary function for which EHRs are used.

- Reporting and analytics (74%). Payer and revenue management (69%), and Managing patient check-in activities (69%) are functions used by over two-thirds of respondents to the survey.

Table 12. Functions for which the EHR is used

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Behavioral health	93.9%	72.0%	96.8%	91.1%
Reporting and analytics	76.8%	64.0%	76.2%	74.0%
Payer and revenue management	68.3%	68.0%	70.6%	69.4%
Manage patient check-in activities	63.4%	74.0%	70.6%	69.0%
Obtain electronic consent to share information	50.0%	62.0%	61.9%	58.1%
Telehealth services	51.2%	30.0%	48.4%	45.7%
Manage social determinants of health (SDOH) information	45.1%	30.0%	47.6%	43.4%
Continuing Care	26.8%	24.0%	37.3%	31.4%
Pharmacy services	34.1%	16.0%	29.4%	28.3%
Manage inpatient services	17.1%	24.0%	27.0%	23.3%
Specialty services	14.6%	14.0%	11.1%	12.8%
Dental services	9.8%	0.0%	5.6%	5.8%
Other functions, specify	6.1%	4.0%	4.0%	4.7%

- More than two-thirds of agencies (70%) indicated they are very or somewhat satisfied with their EHR system.

- One out of six agencies (14%) reported they are somewhat or very dissatisfied with the EHR system.

Table 13. Satisfaction with EHR system

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Very satisfied	32.9%	22.4%	30.2%	29.6%
Somewhat satisfied	39.0%	44.9%	39.7%	40.5%
Neither satisfied nor dissatisfied	18.3%	12.2%	15.1%	15.6%
Somewhat dissatisfied	7.3%	14.3%	10.3%	10.1%
Very dissatisfied	2.4%	6.1%	4.8%	4.3%

Contingent on continued funding, the Washington State Health Care Authority (HCA) will provide access to a state-managed certified electronic health record (EHR) system to be used statewide by behavioral health (BH) agencies, Indian healthcare providers, long-term care (LTC), and rural health agencies. HCA intends to make the EHR system available to these targeted providers with minimal cost-sharing. This would include configuration, implementation support, training, standard workflow configuration, and technical support.

- About two-fifths of agencies (40%) indicated they would be very or somewhat willing to accept this offer.

- Approximately one-fifth (18%) are somewhat unwilling or not willing at all to accept the offer.

Table 14. Willingness to implement an HCA-sponsored EHR

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Very willing	9.8%	16.3%	17.5%	14.8%
Somewhat willing	20.7%	26.5%	27.0%	24.9%
Neutral	41.5%	42.9%	42.1%	42.0%
Somewhat unwilling	9.8%	10.2%	2.4%	6.2%
Not willing at all	18.3%	4.1%	11.1%	12.1%

Crisis Stabilization and Response

A series of questions asked whether the agency provides crisis stabilization services and/or services to individuals who had been experiencing a crisis but are no longer at imminent danger..

- Overall, one-third of agencies (33%) indicated they provide crisis stabilization services.
- Nearly half of MH agencies (45%) provide these service and slightly more than one-third of MH/SUD agencies (37%) do so.
- A small percentage of SUD agencies (2%) offer crisis stabilization.

Table 15. Does your agency provide crisis stabilization services

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Does your agency provide crisis stabilization services	44.7%	1.9%	36.7%	32.8%

- Crisis outreach and Crisis telephone support are the most common services offered, with over half of agencies indicating that option (56% for each)
- Half of agencies offer crisis peer support (50%).

Table 16. Crisis stabilization services provided by the agency

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Crisis outreach	47.6%	100.0%	62.5%	56.0%
Crisis telephone support	47.6%	100.0%	62.5%	56.0%
Crisis peer support	35.7%	100.0%	60.4%	49.5%
Emergency involuntary detention	16.7%	0.0%	37.5%	27.5%
Crisis stabilization unit	14.3%	0.0%	35.4%	25.3%
Other, please specify:	23.8%	0.0%	16.7%	19.8%
23-hour crisis facilities	4.8%	0.0%	6.3%	5.5%
Crisis stabilization living-room model	2.4%	0.0%	6.3%	4.4%

- Self-referral (77%) and Designated crisis responders (63%) are the two most common ways clients are referred to the crisis stabilization services.

- Acute care hospitals/emergency departments (61%), Client's family/friends (61%) and Law enforcement (59%) round out the top five ways clients are referred.

Table 17. Ways clients are referred to your crisis stabilization services

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Self-referral	59.5%	100.0%	72.3%	66.7%
Designated crisis responders	47.6%	0.0%	78.7%	63.3%
Acute care hospitals/emergency departments	52.4%	0.0%	70.2%	61.1%
Client's family/friends	45.2%	100.0%	74.5%	61.1%
Law enforcement	45.2%	0.0%	72.3%	58.9%
Mobile crisis response units	40.5%	0.0%	70.2%	55.6%
Other behavioral health agencies/providers	42.9%	100.0%	48.9%	46.7%
Emergency medical service (EMS) providers	28.6%	0.0%	48.9%	38.9%
Local city, county, tribal jail facilities	16.7%	0.0%	57.4%	37.8%
Physician	28.6%	0.0%	46.8%	37.8%
Schools	19.0%	0.0%	44.7%	32.2%
Other, please specify:	16.7%	0.0%	12.8%	14.4%

- Outpatient mental health services (76%) is the most common service provided following an immediate crisis.
- Over one-half of agencies have crisis telephone support (57%).
- Slightly more than fifty percent of agencies indicated they have crisis outreach (54%), have Same day walk-in BH services (53%), and Refer patient to SUD residential program (53%).

Table 18. Types of crisis response services provided following an immediate crisis

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Outpatient mental health services	76.2%	0.0%	76.6%	75.6%
Crisis telephone support	42.9%	100.0%	68.1%	56.7%
Crisis outreach	45.2%	100.0%	61.7%	54.4%
Same day walk-in behavioral health services	42.9%	0.0%	63.8%	53.3%
Refer patient to SUD residential program	35.7%	100.0%	68.1%	53.3%
Mental Health Peer Service	33.3%	0.0%	63.8%	48.9%
SUD intensive outpatient program	21.4%	100.0%	59.6%	42.2%
Mobile crisis response follow-up	33.3%	0.0%	48.9%	41.1%
Refer patient to inpatient mental health services	31.0%	0.0%	48.9%	40.0%
SUD Peer Services	4.8%	100.0%	21.3%	14.4%
Other, specify:	19.0%	0.0%	8.5%	13.3%
Acute detox	0.0%	0.0%	6.4%	3.3%
Peer-run respite centers	0.0%	0.0%	4.3%	2.2%
Sub-acute detox	2.4%	0.0%	0.0%	1.1%
Sobering unit	0.0%	0.0%	2.1%	1.1%

Bed Registry

HCA is considering the implementation of a behavioral health bed registry. A behavioral health bed registry will make available information about targeted behavioral health providers (e.g., types of programs offered, populations served) and whether the provider has any available beds.

- The largest percentage of agencies (55%) would use a Bed Registry to identify behavioral health providers with available beds.

- Identifying whether a BH provider could provide services needed by particular clients was selected by nearly half of respondents (47%).

Table 19. How would your agency use a behavioral health bed registry

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Identify behavioral health providers with available beds	37.2%	73.1%	60.2%	54.7%
Identify whether a behavioral health provider could provide services needed by particular clients	31.9%	67.3%	49.2%	46.7%
Support electronic referrals	18.1%	42.3%	31.3%	28.8%
Support closed loop referrals	9.6%	30.8%	21.9%	19.3%
Other, specify	7.4%	3.8%	3.1%	4.7%

- The majority of agencies would update information automatically (53%).

Table 20. Updating information in the bed registry

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
1 Manual update (e.g., comma separated value, or CSV, file update)	27.3%	45.0%	20.5%	28.1%
2 Automatic electronic update (e.g., push from agency EHR to portal)	50.0%	45.0%	59.0%	53.3%
3 Other, specify:	22.7%	10.0%	20.5%	18.6%

Clinical Integration

A section of the questionnaire gathered information about the integration of physical health services with be the agency's behavioral health practice.

- A large majority of agencies use mental health screenings (89%).
- Sixty-nine percent of agencies indicated use of substance use disorder screenings.
- Half of the agencies provide general health risk factor screening (52%).

Table 21. Integration of physical health services with behavioral health practices

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Mental health screenings	91.4%	69.2%	94.4%	88.6%
Substance use disorder screenings	41.9%	88.5%	81.7%	69.4%
General health risk factor screenings	51.6%	46.2%	55.6%	52.4%
Assessment to identify health-related social needs (HRSNs) such as housing and food insecurity	48.4%	48.1%	50.8%	49.4%
Targeted physical health risk factor screenings	29.0%	40.4%	39.7%	36.2%

- The primary way physical health services is integrated with behavioral health practices is through referring to primary care as indicated (83%).
- Three-fourths of responding agencies (76%) say they consult with the primary care provider.

Table 22. Integration of physical health services with behavioral health practices

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Refer to primary care as indicated	83.9%	84.6%	81.7%	83.0%
Consult with primary care provider	80.6%	59.6%	78.6%	75.6%
Shared-care planning	38.7%	34.6%	35.7%	36.5%
Other, specify:	9.7%	7.7%	7.9%	8.5%

Population Specific Services

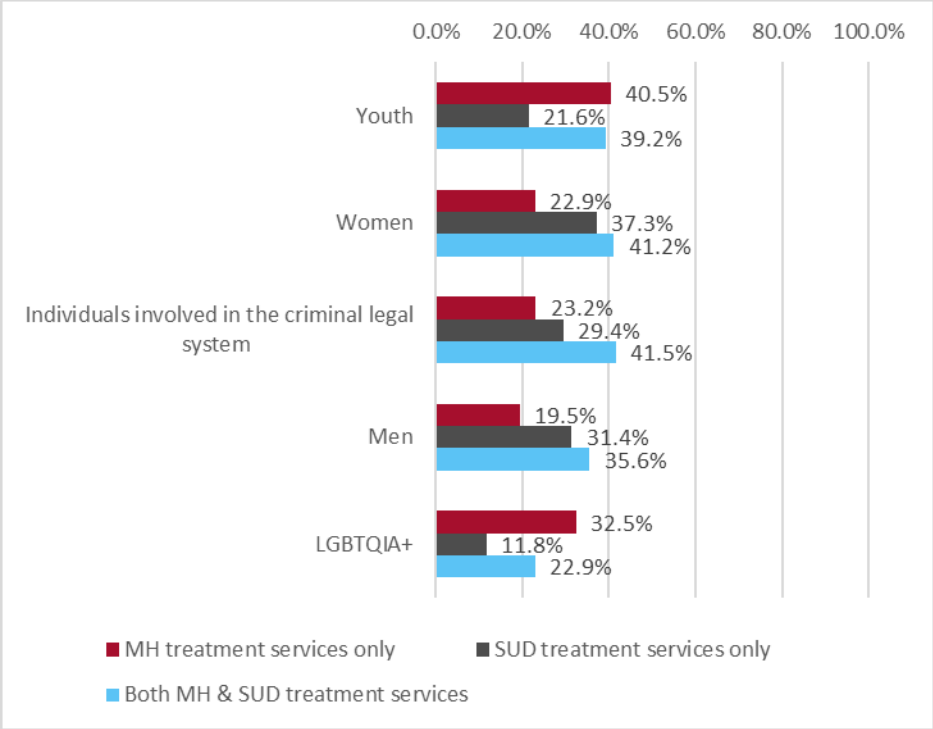
Behavioral health agencies offer services designed to meet the needs of specific population groups.

- Approximately one-third of facilities provide population specific services for:
  - Youth (36%)
  - Women (34%)
  - Individuals involved in the criminal legal system (33%)
  - Men (30%)
- Fewer agencies reported providing services designed for:
  - Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, +; (LGBQIA+) (24%)
  - Individuals who are experiencing homelessness (24%)
  - PPW (Pregnant or parenting women) (22%)
  - Hispanics (21%)
  - Older adults (18%)
  - American Indian, Alaskan Native, Indigenous Persons (17%)
  - African American (13%)
  - Individuals with developmental disabilities (13%)
  - Asian/Pacific Islander (12%)
  - Individuals who are deaf or hard of hearing (10%)
  - Other, please specify (8%)
  - Individuals who are blind or visually impaired (7%)

Table 23. Population specific services

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Youth	40.5%	21.6%	39.2%	36.1%
Women	22.9%	37.3%	41.2%	34.4%
Individuals involved in the criminal legal system	23.2%	29.4%	41.5%	33.1%
Men	19.5%	31.4%	35.6%	29.5%
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, + (LGBTQIA+)	32.5%	11.8%	22.9%	23.8%
Individuals who are experiencing homelessness	15.7%	19.6%	31.4%	23.8%
PPW (Pregnant or parenting women)	13.4%	33.3%	23.9%	22.4%
Hispanics	19.5%	17.6%	23.3%	20.9%
Older adults	20.5%	13.7%	18.1%	18.0%
American Indian, Alaska Native, Indigenous Persons	14.6%	13.7%	19.1%	16.5%
African American	15.7%	13.7%	11.3%	13.3%
Individuals with developmental disabilities	14.6%	7.8%	14.5%	13.2%
Asian/Pacific Islander	12.2%	11.8%	11.3%	11.7%
Individuals who are deaf or hard of hearing	9.8%	7.8%	10.4%	9.7%
Other, please specify:	11.8%	1.9%	8.0%	8.1%
Individuals who are blind or visually impaired	8.5%	3.9%	7.8%	7.3%

Figure 1. Top 5 population-specific services



Quality Improvement

Assuring Quality Care

When asked about quality improvement activities at the facility beyond those specified by accreditation requirements:

- Most agencies (96%) report using chart reviews.
- Periodic quality management meetings (84%) was indicated by a high percentage of agencies.
- Over four out of five agencies use performance measurement (83%).
- Over three-fourths use satisfaction surveys (77%) and Performance measures (80%)
- Reviewing counselor-specific reports (74%) and walkthroughs (64%) are also common quality improvement activities.

Table 24. Quality improvement activities beyond those specified by accreditation requirements

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Chart reviews	94.5%	98.1%	95.2%	95.5%
Periodic quality management meetings	81.3%	82.7%	86.3%	83.9%
Performance measurement	81.3%	80.8%	85.5%	83.1%
Satisfaction surveys	76.9%	75.0%	78.2%	77.2%
Review counselor-specific reports	63.7%	73.1%	81.5%	73.8%
Walkthroughs	64.8%	63.5%	64.5%	64.4%
Other activities: please specify	7.7%	5.8%	6.5%	6.7%

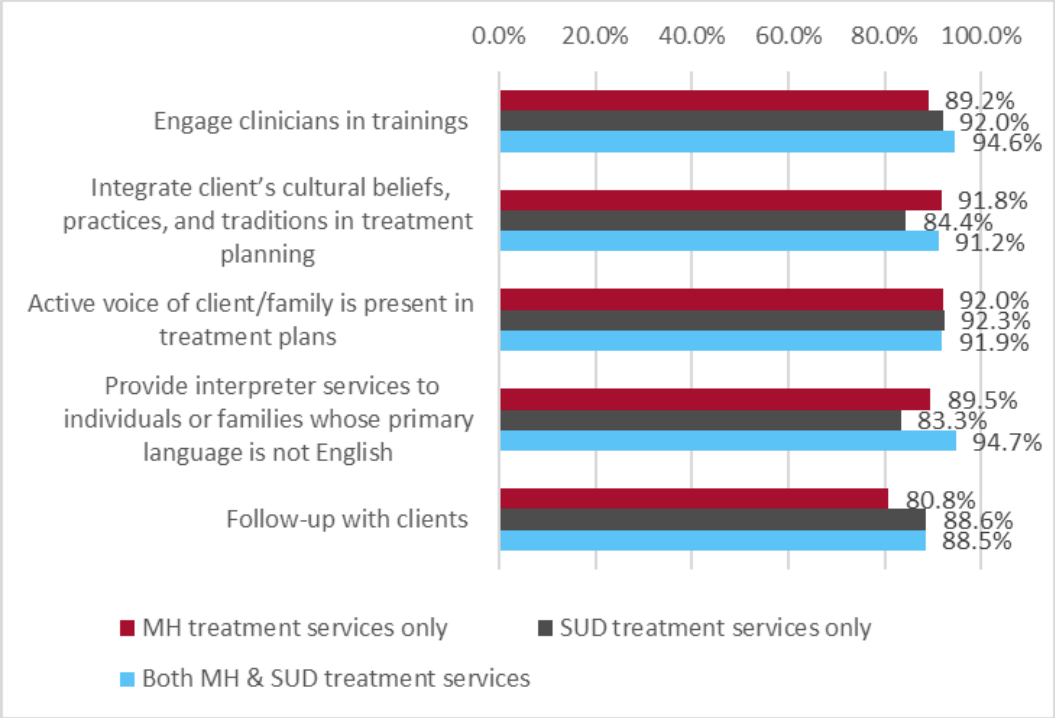
Improving Client Retention and Outcomes

- Ninety percent or more of facilities indicated the following strategies are used to improve client retention and outcomes
    - Engage clinicians in trainings (92%)
    - Integrate client's cultural beliefs, practices, and traditions in treatment planning (92%)
    - Active voice of client/family is present in treatment plans (92%)
    - Provide interpreter services to individuals or families whose primary language is not English (90%)
- Over eighty percent of facilities responding to the survey used the following strategies to improve client retention and ourcomes
    - Follow-up with clients (89%)
    - Meetings or other contact with family members to provide education/support around recovery (87%)
    - Provide case management/care coordination services (86%)
    - Providing interpreter services to individuals or families who are deaf and hard of hearing (83%)
    - Flexible scheduling (83%)

Table 25. Strategies used to improve client retention and outcomes

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Engage clinicians in trainings	89.2%	92.0%	94.7%	92.3%
Integrate client's cultural beliefs, practices, and traditions in treatment planning	91.8%	84.4%	94.6%	91.7%
Active voice of client/family is present in treatment plans	92.0%	92.3%	91.2%	91.7%
Provide interpreter services to individuals or families whose primary language is not English	89.5%	83.3%	91.9%	89.5%
Follow-up with clients	80.8%	88.6%	94.7%	89.0%
Meetings or other contact with family members to provide education/support around recovery	88.3%	82.4%	88.5%	87.4%
Provide case management/care coordination services	78.8%	85.7%	91.7%	86.2%
Provide interpreter services to individuals or families who are deaf and hard of hearing	76.2%	81.6%	89.3%	83.1%
Flexible scheduling	67.2%	97.2%	87.9%	82.7%
Monitor client outcomes	66.7%	72.5%	82.2%	75.0%
Provide transportation or transportation vouchers	58.0%	74.3%	79.8%	71.6%
Accept walk-in appointments	51.6%	82.2%	78.9%	71.1%
Assist clients with housing needs	59.3%	75.0%	77.6%	70.9%
Monitor clinical outcomes for targeted subgroups of patients	60.6%	60.7%	74.7%	67.2%
Assess housing needs of youth and young adult clients at discharge	37.7%	60.0%	69.2%	57.1%
Assist clients experiencing food insecurity	51.6%	67.3%	56.0%	56.7%
Assist clients with employment needs	47.3%	65.4%	57.6%	55.6%
Provide peer support recovery groups	22.0%	36.5%	41.6%	34.0%
Other strategies, specify:	11.0%	3.8%	6.4%	7.5%

Figure 2. Top five strategies for improving client retention and outcomes



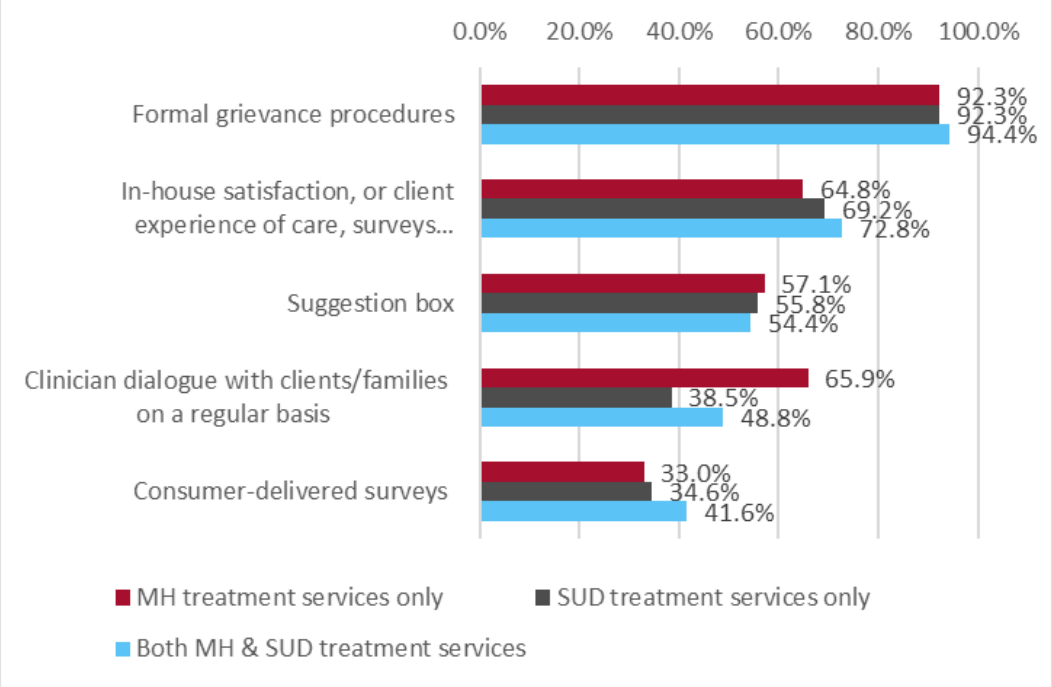
Assessing Client's Perception of the Quality of Care Received

- Over nine in ten agencies have formal grievance procedures (93%) to assess client's perception of the quality of care received.
- Over two-thirds of agencies (69%) conduct in-house satisfaction, or client experience of care, surveys administered during treatment or at discharge.

Table 26. Approaches to assess client's perception of the quality of care received

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Formal grievance procedures	92.3%	92.3%	94.4%	93.3%
In-house satisfaction, or client experience of care, surveys administered during treatment or at discharge	64.8%	69.2%	72.8%	69.4%
Suggestion box	57.1%	55.8%	54.4%	55.6%
Clinician dialogue with clients/families on a regular basis	65.9%	38.5%	48.8%	52.6%
Consumer-delivered surveys	33.0%	34.6%	41.6%	37.3%
Other: please specify	7.7%		7.2%	6.0%

Figure 3. Top 5 approaches for assessing quality of care received



STAFFING

Number of Behavioral Health and Behavioral Health Clinical Staff

Section 3 of the questionnaire asks about the behavioral health clinical staff working at the facility. *Behavioral health clinical staff refers to professionals who provide direct services such as assessment, diagnosis, and treatment to mental health and/or substance use disorder clients.*

- Overall, responding agencies indicated they employed 17,124 behavioral health staff and 13,606 behavioral health clinical staff.

Table 27. Number of behavioral health and behavioral health clinical staff

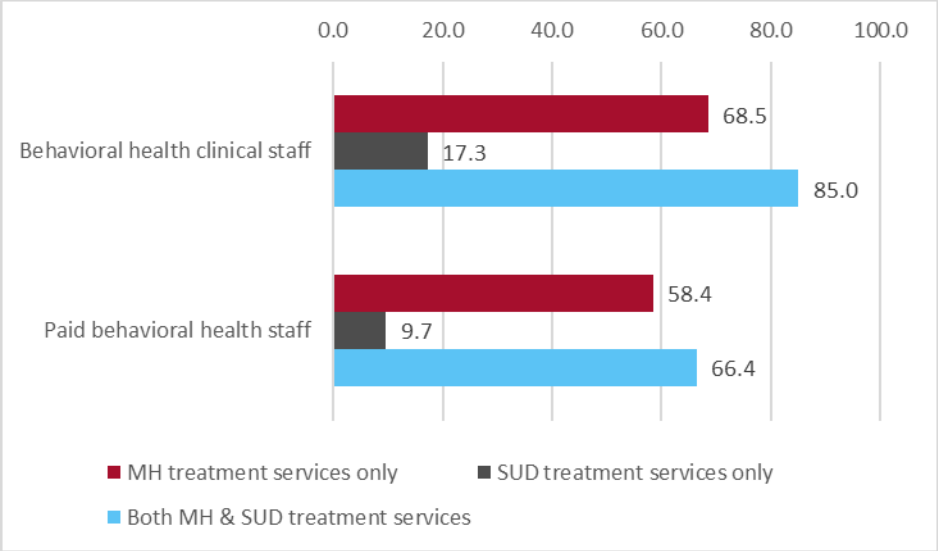
	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Total number of behavioral health staff	6,029	897	10,198	17,124
Total number of behavioral health clinical staff	5,142	502	7,962	13,606

- The average number of paid behavioral health staff at facilities is 66 and behavioral health clinical staff is 52.
- The mean of BH clinical staff at agencies that only provide MH Treatment Services is 58 employees.
- For SUD only agencies, the mean of BH clinical staff is 10 employees
- Facilities that provide both MH and SUD treatment services have a mean of 52 BH clinical staff.

Table 28. Mean of paid behavioral health and behavioral health clinical staff

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Paid behavioral health staff	69	17	85	66
Behavioral health clinical staff	58	10	66	52

Figure 4. Mean of paid BH staff and BH clinical staff



Positions and Employment

Many different titles or positions are used at BH agencies. The most common are:

- Other titles or positions not listed (35.2%)
- Counselor Interns/Practicum (6.5%)
- Case Manager (6.1%)
- Peer Counselor (5.7%)
- Registered Nurse (5.2%)
- Clinical Supervisor (4.8%)
- Mental Health Counselor (4.4%)

Table 29. BH clinical staff that have the following titles or positions

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Administrator	0.6%	1.6%	0.9%	0.8%
Admissions Specialist	0.2%	0.8%	0.4%	0.3%
Advanced Registered Nurse Practitioner (ARNP)	2.6%	2.7%	2.5%	2.6%
Behavioral Health Technician/Assistant	3.3%	0.0%	2.0%	2.4%
Care Coordinator	4.8%	0.4%	3.3%	3.8%
Case Manager	5.8%	1.3%	6.6%	6.1%
Certified Nursing Assistant (CNA)	1.4%	2.3%	0.3%	0.8%
Clinical Director	1.5%	1.3%	1.5%	1.5%
Clinical Manager	1.4%	1.2%	1.7%	1.6%
Clinical Supervisor	5.0%	5.5%	4.6%	4.8%
Community-based Outreach and Referral Navigator/Coordinator	0.1%	1.0%	0.4%	0.3%
Co-occurring Disorder Specialist	0.0%	1.0%	0.4%	0.3%
Counselor	1.6%	1.5%	1.1%	1.3%
Counselor Interns/Practicum	7.9%	0.2%	6.1%	6.5%
Counselor Trainee	0.1%	1.3%	0.1%	0.2%
Director	0.4%	1.1%	0.5%	0.5%
Executive Director	0.3%	1.9%	0.4%	0.4%
Homeless Outreach Specialist	0.0%	0.6%	0.2%	0.1%
Intake Specialist	1.8%	0.8%	1.5%	1.6%
Lead Counselor	0.0%	0.4%	0.9%	0.6%
Medical Doctor	0.2%	2.3%	0.3%	0.3%
Mental Health Counselor	2.7%	0.0%	5.6%	4.4%
Mental Health Professional	3.7%	0.2%	3.9%	3.7%
Nurse	2.3%	4.2%	1.6%	2.0%
Peer Counselor	5.2%	3.5%	6.1%	5.7%
Physician Assistant	0.8%	1.0%	0.7%	0.8%
Program Manager	1.5%	0.6%	1.9%	1.7%
Psychiatrist	1.0%	0.0%	0.8%	0.8%
Psychologist	0.3%	0.0%	0.2%	0.3%
Quality Management Director	0.2%	0.0%	0.1%	0.2%
Registered Nurse	7.2%	4.9%	4.0%	5.2%
Residential Specialist	0.6%	5.0%	1.0%	1.0%
Social Worker	0.7%	0.0%	0.8%	0.7%
Substance Use Disorder Counselor	0.0%	7.5%	0.6%	0.7%
Substance Use Disorder Professional (SUDP)	0.1%	22.0%	2.7%	2.6%
Substance Use Disorder Professional Trainee (SUDPT)	0.0%	16.4%	1.8%	1.8%
Supervisor	0.9%	0.4%	1.3%	1.1%
Supported Employment Specialist	0.3%	0.0%	0.8%	0.6%
Supportive Housing Specialist	0.0%	0.0%	0.8%	0.5%
Therapist	5.7%	0.0%	3.1%	3.9%
Other titles or positions not listed, specify:	27.5%	5.4%	26.1%	25.8%

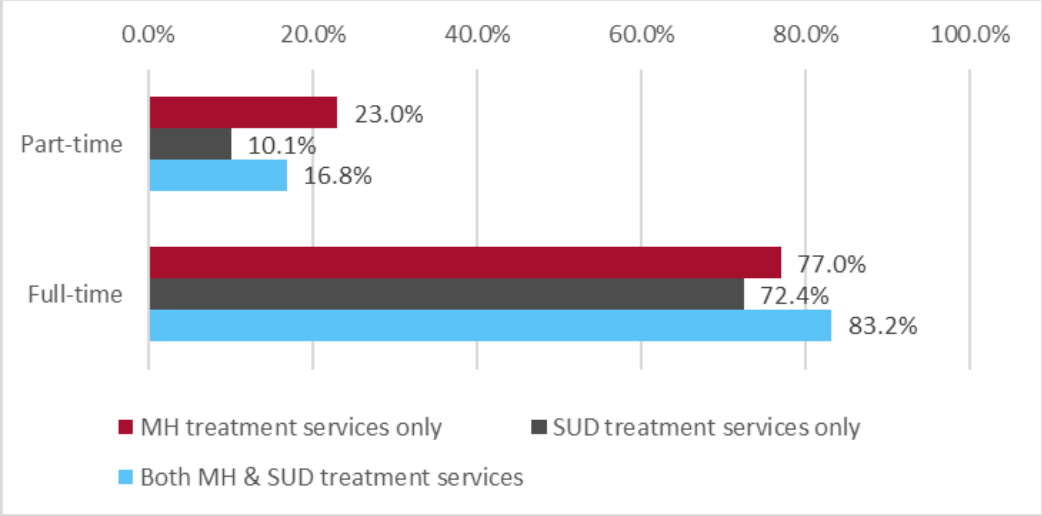
When asked about BH clinical staff work hours:

- Greater than eight out of ten employees work full-time (81%). For this study, full-time employment is defined as 32 hours per week or more.

Table 30. BH clinical staff working part-time or full-time

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Part-time	23.0%	10.1%	16.8%	19.0%
Full-time	77.0%	72.4%	83.2%	81.0%

Figure 5. Percent of your BH clinical staff working part-time or full-time



Income

- The highest percentage of BH clinical staff (31%) receive an annual base salary in the range of $50,001 to $60,000 per year.
- One-sixth receive a base salary of $60,001 to $70,000 (14%).
- Slightly more than ten percent of BH clinical staff receive a salary that is more than $100,000 per year (12%) and $70,001 - $80,000 (11%).

Table 31. BH clinical staff receiving the following annual base salary

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
$20,000 per year or less	8.7%	1.8%	7.1%	7.5%
$20,001 - $30,000 per year	1.8%	0.5%	0.6%	1.0%
$30,001 - $40,000 per year	3.0%	7.4%	2.1%	2.6%
$40,001 - $50,000 per year	10.1%	18.6%	10.6%	10.6%
$50,001 - $60,000 per year	30.3%	24.3%	32.4%	31.4%
$60,001 - $70,000 per year	14.6%	18.8%	13.4%	14.0%
$70,001 - $80,000 per year	11.0%	14.7%	11.2%	11.2%
$80,001 - $90,000 per year	6.0%	4.1%	6.6%	6.3%
$90,001 - $100,000 per year	3.2%	1.6%	4.0%	3.6%
More than $100,000 per year	11.4%	8.4%	12.1%	11.7%

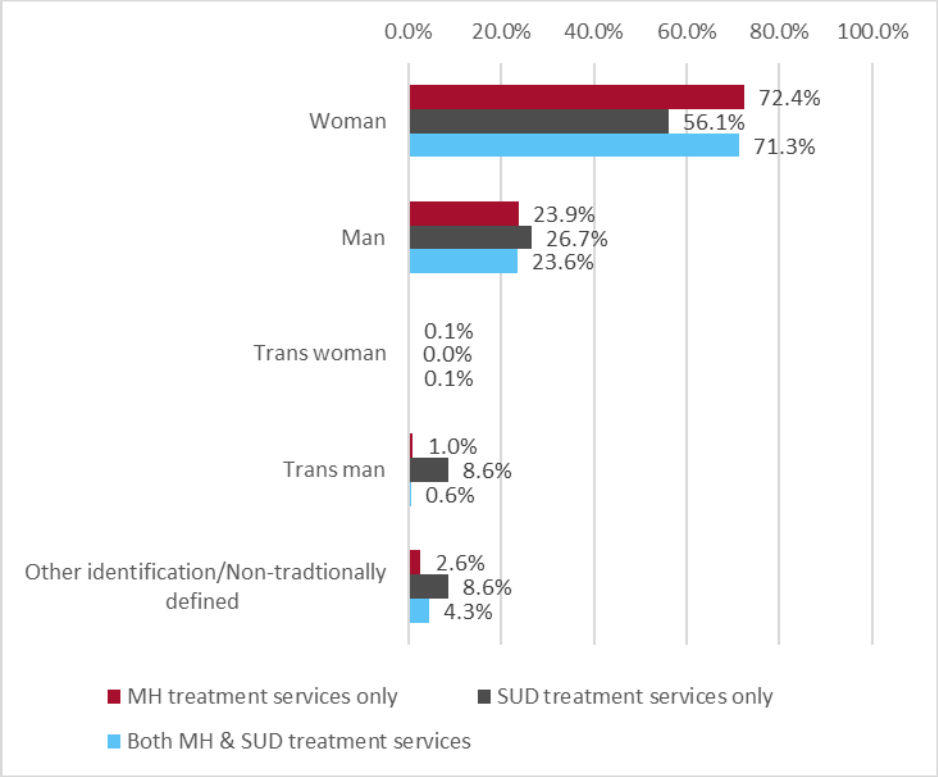
Gender, Race/Ethnicity, Language Spoken, and Education

- Over two-thirds of BH clinical staff are identified as Woman (71%) and one-fourth are Man (24%). Six percent of BH clinical staff are identified as Trans woman (0.1%), Trans man (1%) or other identification/non-traditionally defined (4%).

Table 32. BH clinical staff who fit into each of the gender categories

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Woman	72.4%	56.1%	71.3%	70.9%
Man	23.9%	26.7%	23.6%	23.7%
Trans woman	0.1%	0.0%	0.1%	0.1%
Trans man	1.0%	8.6%	0.6%	1.0%
Other identification/Non-traditionally defined	2.6%	8.6%	4.3%	4.4%

Figure 6. Percent of your BH clinical staff who fit into each of the gender categories



- Over half of BH clinical staff in facilities responding to the survey are categorized as White, non-Hispanic (57%).
- Asian/Pacific Islander and Black or African American are the next most common categories (9% each).

Table 33. BH clinical staff in the following race and/or ethnicity categories

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
White, Non-Hispanic	58.0%	54.7%	55.6%	56.7%
Asian/Pacific Islander	10.6%	1.5%	8.6%	9.0%
Black or African American	10.2%	5.6%	8.5%	9.0%
Don't know	2.2%	13.6%	9.7%	7.1%
Hispanic	6.1%	7.8%	6.9%	6.7%
Multiracial	7.2%	8.0%	5.9%	6.4%
Prefer not to answer	5.0%	5.9%	3.6%	4.2%
Native American or Alaska Native	0.4%	2.8%	1.0%	0.9%
Other	0.3%	0.2%	0.1%	0.2%

- Facilities reported almost six BH clinical staff (5.6) who are bilingual or multilingual and able to provide BH services in a non-English language.

Table 34. Number of bilingual BH clinical staff able to provide BH services in a non-English language (mean reported)

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Mean number of staff	6.4	0.9	7.1	5.6

- Of BH clinical staff who speak a language fluently other than English, Spanish is used by over two-thirds of those staff (71%). Chinese (3%), Tagalog (2.6%), Korean (2.4%), Hindi (2.2%), and Russian (2.1%) are the next most indicated languages.

Table 35. Most common languages spoken fluently by your BH clinical staff

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Spanish	61.4%	89.4%	74.7%	70.9%
Chinese	4.0%	0.0%	2.6%	3.0%
Tagalog	2.1%	4.3%	2.8%	2.6%
Korean	1.4%	2.1%	3.1%	2.4%
Hindi	2.4%	0.0%	2.4%	2.2%
Russian	4.0%	0.0%	1.1%	2.1%
Other	1.5%	0.0%	2.2%	1.8%
Swahili	3.8%	0.0%	0.5%	1.7%
American Sign Language	3.1%	0.0%	0.9%	1.6%
French	1.0%	0.0%	1.8%	1.4%
Vietnamese	1.7%	0.0%	1.3%	1.4%
Japanese	1.0%	2.1%	1.3%	1.3%
Ukrainian	2.1%	0.0%	0.5%	1.0%
Somali	2.2%	0.0%	0.2%	0.9%
Arabic	1.1%	2.1%	0.7%	0.9%
German	0.7%	0.0%	0.7%	0.6%
Persian (Farsi)	1.4%	0.0%	0.2%	0.6%
Portuguese	1.1%	0.0%	0.2%	0.5%
Urdu	0.4%	0.0%	0.7%	0.5%
Polish	0.7%	0.0%	0.2%	0.4%
Indonesian	0.0%	0.0%	0.7%	0.4%
Italian	0.4%	0.0%	0.2%	0.3%
Khmer	0.4%	0.0%	0.2%	0.3%
Thai	0.0%	0.0%	0.5%	0.3%
Hungarian	0.4%	0.0%	0.0%	0.1%
Greek	0.4%	0.0%	0.0%	0.1%
Laotian	0.4%	0.0%	0.0%	0.1%
Malay	0.4%	0.0%	0.0%	0.1%
Romanian	0.4%	0.0%	0.0%	0.1%
Hebrew	0.4%	0.0%	0.0%	0.1%
Tongan	0.0%	0.0%	0.2%	0.1%

Languages listed in the "Other" category include:

Amharic, Bambara, Croatian, ESL, Igbo, Mandarin, Mandinka, Mongolian, Oromo, Punjabi, Shona, Trgrinya, Wolof, and Yoruba

The following languages were listed in the survey but were not marked as being spoken by any employees: Bengali, Czech, Danish, Dutch, Estonian, Finnish, Ilocano, Lithuanian, Mien, Native American (e.g., Cowlitz, Makah, Ojibwe, Quileute), Norwegian, Serbian, Slovak, Slovenian, Swedish, and Turkish,

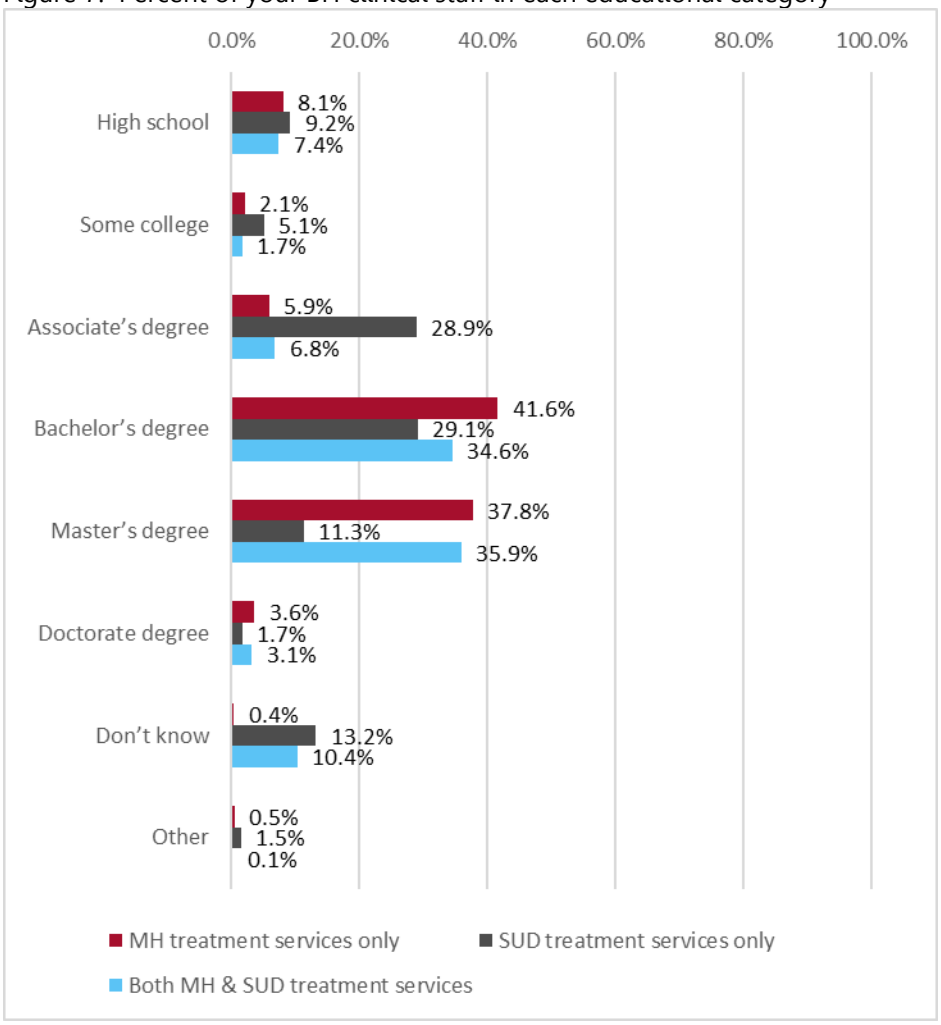
Overall, the most common educational categories are:

- A Bachelor's degree is reported as the most common of educational degrees (37% overall, 42% MH only agencies, 29% SUD agencies, and 35% MH & SUD).
- A Bachelor's degree is most common for MH (42%) and SUD (35%).
- For MH & SUD the most selected option is a Master's degree (36%).

Table 36. BH clinical staff in each educational category

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
High school	8.1%	9.2%	7.4%	7.7%
Some college	2.1%	5.1%	1.7%	2.0%
Associate's degree	5.9%	28.9%	6.8%	7.3%
Bachelor's degree	41.6%	29.1%	34.6%	36.8%
Master's degree	37.8%	11.3%	35.9%	35.7%
Doctorate degree	3.6%	1.7%	3.1%	3.2%
Don't know	0.4%	13.2%	10.4%	6.9%
Other	0.5%	1.5%	0.1%	0.3%

Figure 7. Percent of your BH clinical staff in each educational category



Staff Credentials

The top categories for Washington State Department of Health Credential Type are:

- Agency Affiliated Counselor Registration (24%)
- Licensed mental health counselor (4%)
- Registered nurse (4%)

Table 37. BH clinical staff with the following Washington State Department of Health Credential Type

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Advanced registered nurse practitioner (ARNP)	2.6%	2.3%	1.4%	1.5%
Agency affiliated counselor	42.7%	7.8%	22.4%	24.1%
Certified behavior technician	2.1%	0.0%	0.1%	0.5%
Certified counselor	0.0%	0.0%	0.1%	0.1%
Co-occurring disorder specialist	0.0%	0.0%	0.1%	0.0%
Licensed assistant behavior analyst	0.2%	0.0%	0.0%	0.0%
Licensed behavior analyst	0.5%	0.0%	0.0%	0.1%
Licensed advanced social worker (LASW)	0.2%	0.0%	0.3%	0.2%
Licensed independent clinical social worker (LICSW)	2.9%	0.8%	1.9%	1.9%
Licensed independent clinical social worker associate (LICSWA)	5.0%	0.3%	2.1%	2.4%
Licensed social worker associate advanced (LSWAA)	0.6%	0.0%	0.3%	0.3%
Licensed marriage and family therapist (LMFT)	1.1%	0.0%	0.6%	0.6%
Licensed marriage and family therapist associate (LMFTA)	1.0%	0.0%	0.4%	0.5%
Licensed mental health counselor (LMHC)	7.0%	0.5%	3.5%	3.8%
Licensed mental health counselor associate (LMHCA)	5.9%	0.8%	2.6%	2.9%
Licensed practical nurse (LPN)	2.0%	1.7%	0.9%	1.0%
Medical assistant	0.3%	2.0%	0.3%	0.3%
Nursing assistant	2.8%	0.0%	0.9%	1.2%
Registered nurse	6.9%	5.6%	3.0%	3.6%
Occupational therapist (OT)	0.1%	0.0%	0.0%	0.0%
Certified occupational therapy assistants (COTA)	0.0%	0.0%	0.0%	0.0%
Physician	1.1%	1.5%	0.6%	0.7%
Physician assistant	0.8%	0.3%	0.4%	0.4%
Psychologist	0.4%	0.0%	0.2%	0.2%
Substance use disorder professional (SUDP)	2.2%	33.9%	2.7%	3.1%
Substance use disorder professional trainee (SUDPT)	1.2%	16.2%	1.5%	1.7%
Don't know	1.1%	5.4%	2.8%	2.2%
Other, specify:	9.6%	20.7%	51.0%	46.5%

When asked about the number of BH clinical staff who are dually credentialed to provide both MH and SUD treatment services, it is unsurprising that agencies that provide both treatment services have the higher percentage of dually credentialed staff.

- Agencies that are both offer both MH and SUD treatment services have a mean of 2.4 dually credentialed clinical staff. This calculates to 434 BH clinical staff.
- Three-fourths of MH only agencies (75%) do not have any dually credentialed staff.
- Three-fourths of SUD only agencies (77%) do not have any dually credentialed staff.
- Over one-third of agencies that provide both treatment services have one or more dually credentialed staff (42%).

Table 38. Number of BH clinical staff dually credentialed to provide both MH and SUD treatment service

	MH treatment services only	SUD treatment services only	Both MH and SUD treatment services	Overall
Mean	2.6	0.4	3.2	2.4
None	75.0%	76.5%	36.4%	57.7%
One	10.0%	13.7%	27.3%	18.7%
Two	2.5%	5.9%	13.6%	8.3%
Three or more	12.5%	3.9%	22.7%	15.4%

Appendix A. Survey Information

Study Population

The Division of Behavioral Health and Recovery (DBHR) licenses agencies to provide behavioral health treatment services in Washington State. DBHR keeps licensing information in a database known as the Agency Licensing and Certification System (ALCS). The database accrues additional or new information when agencies apply, and are approved, for a license, when services are added, suspended, canceled, or revoked, or when providers notify DBHR about agency changes that have bearing on their license. However, agency or service information is not generally updated as a matter of routine. Despite this limitation, ALCS offers the best information available on certified behavioral health treatment agencies in Washington State.

A list of agencies meeting the following eligibility criteria was generated from the ALCS in October 2023. To be included in the survey, an agency should offer a mental health (MH) and/or substance use disorder (SUD) treatment service that: (1) has an active or current DBHR certification as of the date when the list was created from ALCS; (2) receives any federal, state, county, Tribal, Behavioral Health Administrative Service Organization (BH-ASO) or Managed Care Organization (MCO) funding; and (3) is community-based. Services for SUD agencies were limited to outpatient, recovery house, intensive inpatient, long-term residential, opiate substitution, and withdrawal management. Services for MH agencies were restricted to outpatient programs and inpatient evaluation and treatment (E&T). SUD treatment programs administered by the Department of Corrections (DOC) and the Juvenile Justice Rehabilitation Administration (JJRA) were not included.

A roll of 759 agencies met the population criteria of DBHR-certified, publicly funded, community-based behavioral health (BH) treatment agencies in Washington State as of October 2023. The population consists of agencies with a single site as well as agencies that are branch sites of a corporate provider. For the purpose of the survey, a branch agency is considered a distinct entity. The number of agencies in this population, however, can change as new information regarding previously unknown facility closure or suspension, change in funding sources, and unreported existence of other branch sites is received during the course of data collection. The number can also change should an agency choose to consolidate its branch sites under one corporate entity or program, an option that was made available to multi-site agencies in order to make survey participation less burdensome.

The provider mailing list generated from the ALCS contained information such as administrator's name, title, and email address, including physical and

mailing addresses. Issues were identified in the process of developing the mailing list. At least 20% of the agencies did not have administrator email address, a critical piece of information required for sending follow-up email invitations and reminder communication. Other pieces of contact information such as administrator name, physical and mailing address, and telephone number were either missing or incomplete for a number of agencies, although the exact tally of how many agencies lacked which information was not determined. These issues were resolved through a combination of time-intensive strategies that included utilizing other DBHR archival databases such as mailing lists from recent surveys and email distribution lists, checking agency web sites, and making phone calls to agencies. An updated mailing list of eligible agencies with complete contact information was sent to SESRC in November 2023. From the time that the pre-invitation and invitation letters were sent to eligible agencies, SESRC updated the mailing list information as required based on data from returned email and regular mail, and communication received from agency staff.

Data Collection

The web survey was launched on March 8, 2024. SESRC used a variety of modes to contact agencies. Initially, MCO/BHO/Regional administrators were sent an email notification from HCA letting them know that this survey was starting. Agencies were mailed a letter announcing the survey. Following that, agencies were sent email reminders then a reminder postal letter. Table A1 shows a complete list of data collection dates.

Table A1. Data Collection Dates

Contact	Date
Invitation Letter	3/8/2024
Email Reminder 1	3/13/2024
Email Reminder 2	3/27/2024
Email Reminder 3	4/22/2024
Email Reminder 4	5/3/2024
Email Reminder 5	6/10/2024
Reminder letter	6/21/204
Email Reminder 6	7/29/2024
Data collection end date	8/26/2024

The data collection period was closed on August 26, 2024.

Response Rate

The following table displays the response rate calculations for all completed and partially completed questionnaires following the guidelines for AAPOR (American Association of Public Opinion Research). The overall **response rate is 45.2%.**

The original sample size was 759 agencies. In our contacts with agencies, we said "If your agency has multiple facilities, each has received a separate invitation. For the purpose of this survey, each site is considered as a distinct facility. Please answer only for the site listed here: [physical address of site listed]. If you believe that there is a good reason to consolidate any of your sites into a single survey, please contact me, Kent Miller, to have a new PIN assigned to you."

Overall, 18 agencies contacted SESRC and asked to have their multiple facilities combined into one survey. These 18 agencies represented 124 separate locations. Of these 124 locations, 18 were kept in the sample as the lead, or main, location. Thus, 106 locations were designated as secondary locations and removed from the response rate calculations.

The final sample size for calculating response rate is 635 agencies. This number is determined by taking the starting sample size (759), and then subtracting the 106 secondary different sites represented by those 19 agencies, and the 18 ineligibles (closed, not yet operating locations, or license expired).

759 – 106 – 18 = 635.

Table A2. Number of Agencies in the Survey Population

Total starting population	759
Closed agencies or not yet operating	(18)
Number of consolidated agencies	(106)
Final population size	635

Table A3 shows the final disposition of the 635 agencies in the survey population. The response rate calculation includes completed and partially completed surveys and follows the guidelines of the American Association of Public Opinion Research (AAPOR). The overall response rate is 45.2%.

Table A3. Final Disposition of Agencies in the Survey Population

Interview (Category 1)	
Web completes (I)	249
Web partial completes (P)	38
Eligible, non-interview (Category 2)	
Refusal and breakoff (R)	1
Non-completed (NC)	333
Undeliverable (NC)	14
No eligible respondent – out of business/no BH services (IE)	18
Total sample used	635
I=Complete Interviews	248
P=Partial Interviews	39
R=Refusal and break off	1
NC=Not Completed	347
IE=Ineligible (out of business/no BH services)	18
Response Rate	
(I+P)/(I+P+R+NC) (249+38) / (249+38+1+347)	**45.2**

Other – agencies consolidated in single surveys	**106**

APPENDIX B. QUESTIONNAIRE

2024 BEHAVIORAL HEALTH PROVIDER SURVEY

Before beginning the survey, please provide your name and contact information in case we need to contact you with any questions.

Contact information	
First name	_____
Last name	_____
Position/Title	_____
Phone (with area code and extension)	_____
Email	_____

AGENCY CHARACTERISTICS

First, we would like to get some basic information about the specific location listed below.

For agencies with branch sites or multiple locations, please report only for the facility with the physical address and Washington State Department of Health License Number appearing below.

{*Insert facility name, physical address, and DOH License Number here*}.

Q1. **Which of the following best describes this facility?** *(Select one response.)*

1. An independent, community-based agency
2. A local branch of a multi-site health care organization
3. The main office of a multi-site health care organization
4. Other, please specify: _____

If needed, you can exit the survey and return at a later time. Your answers are saved as you move from screen to screen in the survey. When you return to the survey and enter your PIN on the introduction screen, you are skipped to the last question you answered. From there you can continue answering the questions or review your previous responses.

Q2. **Does this facility provide treatment services for Apple Health (Medicaid) clients under a contract with a Managed Care Organization (MCO) or Behavioral Health Administrative Services Organization (BH-ASO)?**

1. Yes
2. No → **Skip to Q5**
3. Don't know → **Skip to Q5**

Q3. **Which of the following Managed Care Organizations (MCOs) contract for services with this facility?** *(Check all that apply.)*

☐ Community Health Plan of Washington (CHPW)
☐ Coordinated Care of Washington (CCW)
☐ Molina Healthcare of Washington (MHW)
☐ UnitedHealthcare Community Plan (UHC)
☐ Wellpoint (formerly Amerigroup Washington)

☐ None

Q4. **Which of the following Behavioral Health Administrative Services Organizations (BH-ASOs) contract for service with this facility?** *(Check all that apply)*

- ☐ Carelon Behavioral Health (formerly Beacon Health Options) – Pierce
- ☐ Carelon Behavioral Health (formerly Beacon Health Options) – North Central
- ☐ Carelon Behavioral Health (formerly Beacon Health Options) – Southwest
- ☐ Great Rivers
- ☐ Greater Columbia
- ☐ King
- ☐ North Sound
- ☐ Thurston Mason
- ☐ Salish
- ☐ Spokane

- ☐ None

Q5. **In terms of age, which of these client populations do you serve at this facility?** *(Check all that apply.)*

- ☐ Adults (18 years and over)
- ☐ Youth (13 – 17 years old)
- ☐ Children (under 13 years old)

Q5a. (Answer if Adults and/or Youth is checked in Q5) **Does this facility serve transition age youth (16-24)?**

1. Yes
2. No
3. Don't know

Q5b. (Answer if Children is checked in Q5) **Which of the following age groups of children does this facility serve?** *(Check all that apply.)*

- ☐ School-aged children (6 – 14 years)
- ☐ Preschoolers (3 – 5 years)
- ☐ Infants/Toddlers (birth – 2 years old)

Q6. **Which of following best describes the services provided at this facility?** *(Select one response.)*

1. Mental health (MH) treatment services *only* → **Skip to Q7**
2. Substance use disorder (SUD) treatment services *only* → **Skip to Q8**
3. Both mental health and substance use disorder treatment services → **Skip to Q7**

Q7. (MH & MH/SUD only) **Which of the following mental health treatment services do you provide at this facility?** *(Check all that apply.)*

- ☐ Group treatment services
- ☐ Individual treatment services
- ☐ Family treatment
- ☐ Dyadic family treatment (parental caregiver along with infant, toddler, or preschooler)
- ☐ Intake evaluation
- ☐ Inpatient evaluation and treatment
- ☐ Stabilization services
- ☐ High intensity treatment
- ☐ Medication management
- ☐ Therapeutic psychoeducation
- ☐ Wraparound with Intensive Services (WISe)
- ☐ First episode psychosis navigate
- ☐ Other, specify: _____

Branching instruction for after Q7:
If MH only in Q6, skip to Q10. All others continue with Q8.

Q8. (SUD & MH/SUD only) **Which of the following substance use disorder treatment modalities do you provide at this facility?** *(Check all that apply.)*

- ☐ Outpatient
- ☐ Recovery house
- ☐ Intensive inpatient
- ☐ Long-term residential
- ☐ MAT (Medication Assisted Treatment)
- ☐ Secure withdrawal management
- ☐ Withdrawal management
- ☐ Other, specify: _____

Branching instruction for after Q8:
If MH only in Q6, skip to Q10. All others continue with Q9.

Q9. (SUD & MH/SUD only) **Does this facility offer any primary substance use disorder prevention services?**

Primary prevention services are strategies directed at individuals prior to the onset of a diagnosis and not identified to be in need of treatment. Programs and strategies must target both the general population and subgroups that are at risk for substance use disorders. Primary prevention approaches focus on helping people develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors.

1. Yes → **Continue with Q9a**
2. No → **Skip to Q9b**

Q9a. (SUD & MH/SUD only) **What primary substance use disorder prevention services do you offer at this facility?** *(Check all that apply)*

- ☐ Media campaign(s)/public education
- ☐ Health fairs/health promotion
- ☐ Youth mentoring programs
- ☐ Youth education and skill building
- ☐ School based curriculum
- ☐ Parenting and family education classes
- ☐ Groups for children with a family history of substance use disorder
- ☐ Employee assistance programs
- ☐ DUI education programs
- ☐ Drug take back programs
- ☐ Evidence based prevention programs: please specify: _____
- ☐ Other primary substance use disorder prevention services: please specify: _____

After answering Q9a, skip to Q10.

Q9b. (SUD & MH/SUD only) **What are the reasons you do not provide substance use disorder prevention services?** *(Check all that apply)*

- ☐ Lack of funding.
- ☐ Lack of staff capacity.
- ☐ Not within scope of the agency.
- ☐ Unfamiliar with these strategies.
- ☐ Other, specify: _____

Q10. (MH, SUD & MH/SUD) **Does this facility offer any suicide prevention, intervention and/or postvention services?**

Suicide prevention services are activities implemented prior to the onset of an adverse health outcome (e.g., dying by suicide) and designed to reduce the potential that the adverse health outcome will take place. Prevention programs and strategies can target both the general population and subgroups that are at risk for suicidal ideation. Suicide intervention services are activities designed to decrease risk factors or increase protective factors in individuals who exhibit symptoms or have been identified by screening or assessment as being at risk for suicidal behavior. Suicide Postvention services are activities following a suicide to help alleviate the suffering and emotional distress of the survivors, and prevent additional trauma and contagion. All approaches focus on helping people develop the knowledge, attitudes, and skills to reduce the risk for suicide.

1. Yes → **continue with Q10a**
2. No → **Skip to Q10b**

Q10a. (MH, SUD & MH/SUD) **What suicide prevention, intervention and/or postvention services do you offer at this facility?** *(Check all that apply.)*

- ☐ Media campaign(s)/public education
- ☐ Gatekeeper trainings
- ☐ Screenings
- ☐ Crisis response services
- ☐ Managed care plan for individuals with suicidal ideation
- ☐ Postvention response services
- ☐ Restriction of lethal means
- ☐ Employee assistance programs
- ☐ Evidence based suicide programs: please specify: _____
- ☐ Other suicide prevention services: please specify: _____

After answering Q10a,
•skip to Q11 if MH or MH/SUD
•skip to Q14 if SUD only

Q10b. (MH, SUD & MH/SUD) **What are the reasons you do not provide suicide prevention, intervention and/or postvention services?** *(Check all that apply.)*

- ☐ Lack of funding.
- ☐ Lack of staff capacity.
- ☐ Not within scope of the agency.
- ☐ Unfamiliar with these strategies.
- ☐ Other, specify: _____

Q11. (MH & MH/SUD only) **Does this facility offer any mental health promotion services?**

Mental Health Promotion services are strategies directed at individuals prior to the onset of a diagnosis and not identified to need treatment. Mental Health Promotion consists of strategies and interventions that enable positive emotional adjustment and adaptive behavior. Promotion approaches focus on helping people improve, and increase control over, their health. Promotion programs and strategies target both the general population and those experiencing health disparities.

1. Yes → **continue with Q11a**
2. No → **Skip to Q11b**

Q11a. (MH & MH/SUD only) **What mental health promotion services do you offer at this facility?** *(Check all that apply.)*

- ☐ Media campaign(s)/public education
- ☐ Health fairs/health promotion
- ☐ Youth mentoring programs
- ☐ Wellness programs
- ☐ School-based curriculum
- ☐ Employee assistance programs
- ☐ Parenting and/or play groups
- ☐ Infant-early childhood mental health consultation
- ☐ Infant-early childhood home visiting
- ☐ Other mental health promotion services: please specify _____

After answering Q11a,
•skip to Q12 if MH/SUD
•skip to Q14 if MH only
•skip to Q14 if SUD only

Q11b. (MH & MH/SUD only) **What are the reasons you do not provide mental health promotion services?** *(Check all that apply.)*

- ☐ Lack of funding
- ☐ Lack of staff capacity
- ☐ Not within scope of the agency
- ☐ Unfamiliar with these strategies
- ☐ Other, specify: _____

Q12. (MH/SUD only) **Which of the following categories best describes the staff at this facility?** *(Select one response.)*

1. Have a separate program or staff for MH and SUD services
2. Have a single or integrated program or staff for both MH and SUD
3. Other, specify: (Write text here)

Branching instruction for after Q12:
If Q5=Adult only skip to Q14
If Q5=Youth and/or Children and Q6=MH only, continue to Q13a
If Q5=Youth and/or Children and Q6=SUD only, skip to Q14
If Q5=Youth and/or Children and Q6=MH and SUD, continue with Q13a

Q13a. [If Q5=Youth and/or Children and Q6=MH treatment services only or MH and SUD treatment services] **Was this facility actively accepting new children and youth clients within the last 12 months for BH treatment?** *(That is, clients who started receiving behavioral health treatment from the agency in the last 12 months, not merely being placed on a waitlist.)*

1. Yes
2. No
3. Don't know

Q13b. [If Q5=Youth and Q6=MH treatment services only or MH and SUD treatment services] **Is any of your behavioral health clinical staff qualified to provide any of the following treatment approaches for youth?** *(Check all that apply.)*

- ☐ No, none of our providers is qualified to provide any of these treatment approaches for youth
- ☐ Cognitive Behavioral Therapy for SUD
- ☐ Adolescent Community Reinforcement Approach
- ☐ Contingency Management (CM)
- ☐ Motivational Enhancement Therapy
- ☐ Brief Strategic Family Therapy
- ☐ Family Behavior Therapy
- ☐ Functional Family Therapy
- ☐ Multidimensional Family Therapy
- ☐ Multisystemic Therapy
- ☐ Other, please specify: _____
- ☐ Don't know

Q13c. **How does your agency support recovery for adolescent clients and their families?** *(Check all that apply.)*

- ☐ No, this agency does not provide any of these services
- ☐ Teen only peer support recovery groups
- ☐ Family-based sessions
- ☐ Education advocacy, communication with schools
- ☐ Employment advocacy, communication with job sites
- ☐ Housing advocacy, communication with housing resources
- ☐ Routine monitoring of client progress using standard measures
- ☐ Support families to meet physical and social needs through service referrals
- ☐ Other, please specify: _____
- ☐ Don't know

Q13d. [If Q5b=Infants, Toddlers and/or Preschoolers and Q6=MH treatment services only or MH and SUD treatment services] **Was this facility actively accepting new infant, toddler, and/or preschool clients within the last 12 months?**

1. Yes
2. No
3. Don't know

Infants, young children, and preschoolers have unique developmental needs when it comes to their mental health. The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:05™) is the internationally accepted system for developmentally appropriate assessment of young children's mental health. The DC:05™ uses developmentally specific diagnostic criteria that reflects mental health disorders that are typically diagnosed in infancy and early childhood. To learn more about the DC:05™ and its implementation within the Apple Health system, visit our website listed in Q13e.

Q13e. For the diagnostic assessment of children birth through age five, does your agency offer any guidance on using the DC:05™ (https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/mental-health-assessment-young-children)?

1. No, we do not offer any specific guidance on using the DC:05™.
2. Yes, we recommend that clinicians use the DC:05 for the diagnostic assessment of children birth through age five.
3. Yes, we require that clinicians use the DC:05™ for the diagnostic assessment of children birth through age five.
4. Don't know

Q13f. Are any of your behavioral health clinical staff qualified to provide any of the following treatment approaches for infants, toddlers, or preschoolers? *(Check all that apply.)*

☐ Child-Parent Psychotherapy (CPP)
☐ Attachment & Biobehavioral Catch-up (ABC)
☐ Promoting First Relationships (PFR)
☐ Parent-Child Interaction Therapy (PCIT)
☐ Circle of Security
☐ Incredible Years (IY)
☐ Triple P (Positive Parenting Program)
☐ Other, please specify: _____
☐ Don't know

Q13g. Do you experience barriers to accessing Medicaid reimbursement for IECMH (Infant-Early Childhood Mental Health) assessment, diagnosis, and/or treatment?

1. Yes
2. No → **Skip to Q14**
3. Don't know → **Skip to Q14**

Q13h. Are you willing to be contacted with additional questions about these barriers?

1. Yes
2. No

Q14. Do you provide specifically defined co-occurring disorders treatment services at this facility?

1. Yes
2. No
3. Don't know

Q15. Which of the following categories best describes this facility: *(Select one response.)*

1. Treat the mental health *only* and refer the person to another facility for substance use disorder treatment
2. Treat the substance use disorder *only* and refer the person to another facility for mental health treatment
3. Treat *both* mental health and substance use disorders in this facility
4. Refer the person to another facility that specializes in co-occurring disorders treatment
5. Other, specify: _____
6. Don't know

Healthcare providers are increasingly using computer applications to electronically store clinical and other service information about their clients. Known by different vendor names, or brands, these applications enable providers to create electronic health records (EHRs) of their clients. Your answers to the next questions will allow us to assess how behavioral health treatment providers in Washington State use EHRs in patient care. Your facility data will help inform policies related to the use of information technology in healthcare at the state and provider levels.

Q16. Which of the following best describes your client record keeping system?

1. Primarily use paper record keeping → **skip to Q16a**
2. Primarily use an EHR system (***do not include billing record system***) → **skip to Q17a**

Q16a. Does your agency have plans to transition to an EHR (electronic health record) or are you currently evaluating an EHR system?

1. Have plans to transition to an EHR system
2. Currently evaluating an EHR system
3. No plans to transition to an EHR system → **skip to Q16c**

Q16b. When does your agency plan to transition to an EHR system?

1. Within the next 6 months
2. Within the next year
3. Within the next 2 years
4. Some other timeframe (please describe): _____

Q16c. Which of the following were or are barriers to adopting an EHR system experienced by this agency? *(Check all that apply)*

☐ Finding an EHR system that meets your facility's needs
☐ Limited or lack of IT staff to support EHR adoption
☐ Cost of purchasing and maintaining an EHR system
☐ Loss of productivity during the transition to an EHR system
☐ Staff resistance to EHR use
☐ Privacy or security concerns
☐ Inadequate/lack of internet connection
☐ Other, specify: _____

After answering Q16c, skip to Q18

Q17a. Please indicate the name of this facility's health information technology (HIT) or electronic health record (EHR) system. *(Mark all that apply.)*

- ☐ Credible Behavioral Health
- ☐ Epic
- ☐ Netsmart
- ☐ Netsmart/Avatar
- ☐ Cerner
- ☐ Qualifacts (including CareLogic)
- ☐ CareLogic
- ☐ Collective Medical
- ☐ Care Everywhere/CareQuality
- ☐ UniteUS
- ☐ findhelp (formerly known as Aunt Bertha)
- ☐ NowPow
- ☐ Bamboo Health OpenBeds (formerly known as Appriss Health)
- ☐ Other, specify: _____

Q17b. Do you use your EHR for any of the following activities? *(Check all that apply.)*

- ☐ Send electronic referrals
- ☐ Receive electronic referrals
- ☐ Create electronic care plans
- ☐ Record electronic screenings and assessments
- ☐ Send electronic discharge plans
- ☐ Other activities, specify: _____

Q17c. Do you use your EHR for any of the following functions? *(Check all that apply.)*

- ☐ Manage inpatient services
- ☐ Manage patient check-in activities
- ☐ Pharmacy services
- ☐ Dental services
- ☐ Behavioral health
- ☐ Manage social determinants of health (SDOH) information
- ☐ Payer and revenue management
- ☐ Reporting and analytics
- ☐ Telehealth services
- ☐ Obtain electronic consent to share information (e.g., to enable SUD data exchange consistent with 42 CFR Part 2)
- ☐ Continuing Care (e.g., long-term care, wound care, etc.)
- ☐ Specialty services (e.g., anesthesiology, emergency, lab, etc.), specify:_____
- ☐ Other functions, specify: _____

Q17d. Overall, how satisfied or dissatisfied are you with your EHR system?

1. Very satisfied
2. Somewhat satisfied
3. Neither satisfied nor dissatisfied
4. Somewhat dissatisfied
5. Very dissatisfied

Contingent on continued funding, the Washington State Health Care Authority (HCA) will provide access to a state-managed certified electronic health record (EHR) system to be used statewide by behavioral health (BH) agencies, Indian healthcare providers, long-term care (LTC), and rural health agencies. HCA intends to make the EHR system available to these targeted providers with minimal cost-sharing. This would include configuration, implementation support, training, standard workflow configuration, and technical support.

Q17e. How would you rate your willingness to implement an HCA-sponsored EHR?

1. Very willing
2. Somewhat willing
3. Neutral
4. Somewhat unwilling
5. Not willing at all

Q17f. To help us interpret these results, please tell us the reason for this choice.

CRISIS STABILIZATION AND RESPONSE

The following questions seek to gather information about whether you provide crisis stabilization services and/or services to individuals who had been experiencing a crisis but are no longer in imminent danger.

Q18. Does your agency provide crisis stabilization services?

1. Yes
2. No → **skip to Q19**
3. Don't know → **skip to Q19**

Q18a. What types of crisis stabilization services does your agency provide? *(Check all that apply.)*

- ☐ Crisis stabilization unit
- ☐ 23-hour crisis facilities
- ☐ Crisis relief centers
- ☐ Crisis stabilization living-room model
- ☐ Crisis outreach
- ☐ Crisis telephone support
- ☐ Crisis peer support
- ☐ Emergency involuntary detention
- ☐ Other, please specify:_____

Q18b. How are clients referred to your crisis stabilization services? *(Check all that apply.)*

- ☐ Mobile crisis response (MCR) teams
- ☐ Designated crisis responders
- ☐ Law enforcement
- ☐ Local city, county, tribal jail facilities
- ☐ Acute care hospitals/emergency departments
- ☐ Physician
- ☐ Other behavioral health agencies/providers
- ☐ Schools
- ☐ Client's family/friend
- ☐ Self-referral
- ☐ Emergency medical service (EMS) providers
- ☐ Other, please specify: _____

Q18c. Following an immediate crisis (once the imminent danger is resolved), what types of crisis response services does your agency provide?

- ☐ Mobile crisis response follow-up
- ☐ Crisis outreach
- ☐ Crisis telephone support
- ☐ Outpatient mental health services
- ☐ Acute detox
- ☐ Sub-acute detox
- ☐ Sobering unit
- ☐ SUD intensive outpatient program
- ☐ Mental Health Peer Service
- ☐ SUD Peer Services
- ☐ Peer-run respite centers
- ☐ Same day walk-in behavioral health services
- ☐ Refer patient to SUD residential program.
- ☐ Refer patient to inpatient mental health services
- ☐ Other, specify:_____

NEXT DAY APPOINTMENT

A next day appointment (NDA) is a service that may be offered to a person experiencing a crisis. It aims to provide immediate support to help resolve a crisis. We are trying to assess the capacity of behavioral health agencies in the community to offer NDAs regardless of payor types.

Q19. Does this facility offer next day appointments to individuals experiencing a crisis?

1. Yes
2. No → **Skip to Q19b**
3. Don't know → **Skip to Q20a**

Q19a. What is the referral source for individuals in need of next day appointments *(check all that apply):*

- ☐ Individual
- ☐ Medicaid managed care
- ☐ BH-ASO
- ☐ Commercial insurer
- ☐ Other: Specify_____

After answering Q19a, skip to Q20a

Q19b. What are the reasons that you do not provide next day appointments *(check all that apply):*

- ☐ Lack of funding
- ☐ Lack of staff capacity
- ☐ Not within scope of the agency
- ☐ No demand for next day appointments
- ☐ Other, specify: _____

BED REGISTRY

The following questions are intended to gather information in advance of implementation of a behavioral health bed registry and ascertain whether and how your agency could use a behavioral health bed registry. A behavioral
health bed registry will make available information about targeted behavioral health providers (e.g., types of programs offered, populations served) and whether the provider has any available beds.

Q20a. Which of the following describes how your agency would use a behavioral health bed registry? *(Check all that apply.)*

- ☐ Identify behavioral health providers with available beds
- ☐ Identify whether a behavioral health provider could provide services needed by particular clients
- ☐ Support electronic referrals
- ☐ Support closed loop referrals
- ☐ Other, specify: _____

- ☐ Would not use a behavioral health bed registry → **If checked, skip to Q21**

Q20b. If a portal is available for a behavioral health bed registry, which of the following describes how you would update information in the registry (e.g., information about: bed availability, types of beds available, genders/programs served for available beds)? *(Select one.)*

1. Manual update (e.g., comma separated value, or CSV, file update)
2. Automatic electronic update (e.g., push from agency EHR to portal)
3. Other, specify:_____

CLINICAL INTEGRATION

The following questions are intended to gather information about the integration of behavioral and physical health services in your agency.

Q21. Does your agency conduct any of the following behavioral or physical health screenings at intake or follow-up visits? *(Check all that apply.)*

- ☐ No, we do not conduct any behavioral or physical health screenings at intake or follow-up visits

- ☐ General health risk factor screenings (e.g., PCP visit, screenings for depression, alcohol and substance use, blood pressure, HIV, colorectal screening, cervical cancer screening, overweight/obesity, tobacco use)
- ☐ Targeted physical health risk factor screenings (e.g., intimate partner violence, diabetes, cholesterol, immunizations, sexually transmitted infection, hepatitis B, hepatitis C, tuberculosis, mammogram, osteoporosis)
- ☐ Mental health screenings (e.g., PHQ2/9, GAIN SS)
- ☐ Substance use disorder screenings (e.g., AUDT-C, DAST)
- ☐ Assessment to identify health-related social needs (HRSNs) such as housing and food insecurity
- ☐ Other, specify: _____

Q22. Does your agency collaborate with clients' primary care providers in any of the following ways? *(Check all that apply.)*

- ☐ No, we do not collaborate with clients' primary care providers.
- ☐ Refer to primary care as indicated
- ☐ Consult with primary care provider
- ☐ Shared-care planning
- ☐ Other, specify: _____

Q23. Does this facility have a policy that requires staff to complete a cultural competency training?

1. Yes
2. No
3. Don't know

Q24. Do you provide population-specific services for any of the following at this facility? *(Check all that apply.)*

☐ No, we do not provide any population-specific services in this facility

☐ Women
☐ Men
☐ Older adults
☐ Youth
☐ American Indian, Alaska Native, Indigenous Persons
☐ Hispanics
☐ African American
☐ Asian/Pacific Islander
☐ Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, + (LGBTQIA+)
☐ Individuals who are deaf or hard of hearing
☐ Individuals who are blind or visually impaired
☐ Individuals with developmental disabilities
☐ Individuals who are experiencing homelessness
☐ PPW (Pregnant or parenting women)
☐ Individuals involved in the criminal legal system
☐ Other, please specify: _____
☐ Don't know

QUALITY IMPROVEMENT

Now, please let us know what you are doing with respect to quality improvement at this facility.

Q25. Do you conduct any of the following quality improvement activities at this facility beyond those specified by accreditation requirements? *(Check all that apply.)*

☐ No, we do not conduct any quality improvement activity at this facility beyond those specified by accreditation requirements.

☐ Review counselor-specific reports
☐ Performance measurement
☐ Periodic quality management meetings
☐ Walkthroughs
☐ Chart reviews
☐ Satisfaction surveys
☐ Other activities, specify: _____

☐ Don't know

Q26. What strategies do you use at this facility to improve client retention and outcomes? *(Check all that apply.)*

- ☐ No, we do not use any strategy to improve client retention and outcomes

- ☐ Flexible scheduling (e.g., evenings and/or weekends; appointments held off-site)
- ☐ Accept walk-in appointments
- ☐ Meetings or other contact with family members to provide education/support around recovery
- ☐ Active voice of client/family is present in treatment plans
- ☐ Provide transportation or transportation vouchers
- ☐ Follow-up with clients (e.g., reminder postcards/call for upcoming or missed appointments)
- ☐ Engage clinicians in trainings (e.g., cultural competency, principles of recovery, motivational work, recovery support)
- ☐ Provide case management/care coordination services
- ☐ Integrate client's cultural beliefs, practices, and traditions in treatment planning
- ☐ Provide interpreter services to individuals or families whose primary language is not English
- ☐ Provide interpreter services to individuals or families who are deaf and hard of hearing
- ☐ Monitor client outcomes (e.g., homelessness, unemployment rates, incarceration, hospitalization)
- ☐ Assess housing needs of youth and young adult clients at discharge
- ☐ Monitor clinical outcomes for targeted subgroups of patients (e.g., those with depression, or are overweight, or receiving medication for opioid use disorder)
- ☐ Assist clients with housing needs
- ☐ Assist clients with employment needs
- ☐ Assist clients experiencing food insecurity
- ☐ Provide peer support recovery groups
- ☐ Other strategies, specify: _____
- ☐ Don't know

Q27. Do you use any of these approaches to assess clients' perception of the quality of care they receive at this facility? *(Check all that apply.)*

- ☐ No, we do not assess clients' perception of the quality of care they receive at this facility.

- ☐ In-house satisfaction, or client experience of care, surveys administered during treatment or at discharge
- ☐ Suggestion box
- ☐ Formal grievance procedures
- ☐ Clinician dialogue with clients/families on a regular basis (month, quarterly) about how services are working and/or what could be improved
- ☐ Consumer-delivered surveys (Quality Review Teams)
- ☐ Other, specify: _____

- ☐ Don't know

BEHAVIORAL HEALTH STAFFING

In this section, we will be asking questions about the *behavioral health clinical staff* working at this facility.

- *Behavioral health clinical staff refers to professionals who provide direct services such as assessment, diagnosis, and treatment to mental health and/or substance use disorder clients.*

Q28. **First, what is the total number of paid behavioral health staff at this facility?** For the total number of paid behavioral health staff, please include clinical and non-clinical staff, whether they work full-time, part-time, or on-call, and paid clinical and non-clinical interns. *Do NOT include volunteers.*

_____ total number of paid behavioral health staff

Q29. **Now, of the total number of paid behavioral health staff at this facility, *how many are considered behavioral health clinical staff, including paid and unpaid clinical interns?***

_____ number of behavioral health clinical staff

Q30. **Please indicate the number of your behavioral health clinical staff that have the following titles or positions.**

Title or Position	Number of staff	Title or Position	Number of staff
Administrator	_____	**Mental Health Counselor**	_____
Admissions Specialist	_____	**Mental Health Professional**	_____
Advanced Registered Nurse Practitioner (ARNP)	_____	**Nurse**	_____
Behavioral Health Technician/Assistant	_____	**Peer Counselor**	_____
Care Coordinator	_____	**Physician Assistant**	_____
Case Manager	_____	**Program Manager**	_____
Certified Nursing Assistant (CNA)	_____	**Psychiatrist**	_____
Clinical Director	_____	**Psychologist**	_____
Clinical Manager	_____	**Quality Management Director**	_____
Clinical Supervisor	_____	**Registered Nurse**	_____
Community-based Outreach and Referral Navigator/Coordinator	_____	**Residential Specialist**	_____
Co-occurring Disorder Specialist	_____	**Social Worker**	_____
Counselor	_____	**Substance Use Disorder Counselor**	_____
Counselor Interns/Practicum	_____	**Substance Use Disorder Professional (SUDP)**	_____
Counselor Trainee	_____	**Substance Use Disorder Professional Trainee (SUDPT)**	_____
Director	_____	**Supervisor**	_____
Executive Director	_____	**Supported Employment Specialist**	_____
Homeless Outreach Specialist	_____	**Supportive Housing Specialist**	_____
Intake Specialist	_____	**Therapist**	_____
Lead Counselor	_____	**Other titles or positions not listed, specify:**	
Medical Doctor	_____	_____	_____

Q30a. (Answer if Question 30 total is greater than Question 29). **Your total number of positions listed in question 30 is greater than the number of employees listed in question 29. Is that because an employee or employees fill multiple positions or some other reason?**

1. An employee or employees fill multiple positions
2. Some other reason (please specify) _____

Q31. **How many of your behavioral health clinical staff work part-time or full-time?** *(Total should equal your total behavioral health staff listed in Q29.)*

Average hours worked per week	Number of staff
Part-time (less than 32 hours per week)	_____
Full-time (32 hours per week or more)	_____
Total number of behavioral health clinical staff	_____

Q32. **How many of your behavioral health clinical staff work on an on-call basis?**

On-call staff	Number of staff
Number of on-call staff who are called *only* when services are needed	_____
Number of on-call staff who are scheduled outside, or in addition to, their regular hours	_____
Total number of on-call behavioral health clinical staff	_____

Q33. **How many of your behavioral health clinical staff receive the following annual base salary? Do not include benefits such as retirement, health insurance, or annual leave, etc.** *(Total should equal your total behavioral health clinical staff listed in Q29.)*

Annual salary	Number of staff
$20,000 per year or less	_____
$20,001 - $30,000 per year	_____
$30,001 - $40,000 per year	_____
$40,001 - $50,000 per year	_____
$50,001 - $60,000 per year	_____
$60,001 - $70,000 per year	_____
$70,001 - $80,000 per year	_____
$80,001 - $90,000 per year	_____
$90,001 - $100,000 per year	_____
More than $100,000 per year	_____
Total number of behavioral health clinical staff	_____

Q34. How many of your behavioral health clinical staff fit into each of the following gender categories? *(Total should equal your total behavioral health clinical staff listed in Q29.)*

Gender	Number of staff
Woman	_____
Man	_____
Trans woman	_____
Trans man	_____
Other identification/Non-traditionally defined	_____
Total number of behavioral health clinical staff	_____

Q35. How many of your behavioral health clinical staff are in each of the following race and/or ethnicity categories? *(Total should equal your total behavioral health clinical staff listed in Q29.)*

Race/ethnicity	Number of staff
White, Non-Hispanic	_____
Black or African American	_____
Hispanic	_____
American Indian or Alaska Native	_____
Asian/Pacific Islander	_____
Multiracial	_____
Don't know	_____
Prefer not to answer	_____
Other, specify: Write text here	_____
Total number of behavioral health clinical staff	_____

Q36a. How many of your behavioral health clinical staff are bilingual or multi-lingual and are able to provide BH services in a non-English language?

_____ number of bilingual or multi-lingual staff **(if zero, skip to Q37)**

Q36b. *(Answer if Q36a is greater than 0).* **How many of your behavioral health clinical staff speak a language other than English?** *(Since a person may speak more than one language, you may count that person more than once for this question.)*

Language	Number of staff	Language	Number of staff
American Sign Language	_____	**Malay**	_____
Arabic	_____	**Mien**	_____
Bengali	_____	**Native American (e.g., Cowlitz, Makah, Ojibwe, Quileute)**	_____
Chinese	_____	**Norwegian**	_____
Czech	_____	**Persian (Farsi)**	_____
Danish	_____	**Polish**	_____
Dutch	_____	**Portuguese**	_____
Estonian	_____	**Romanian**	_____
Finnish	_____	**Russian**	_____
French	_____	**Serbian**	_____
German	_____	**Slovak**	_____
Greek	_____	**Slovenian**	_____
Hebrew	_____	**Somali**	_____
Hindi	_____	**Spanish**	_____
Hungarian	_____	**Swahili**	_____
Ilocano	_____	**Swedish**	_____
Indonesian	_____	**Tagalog**	_____
Italian	_____	**Thai**	_____
Japanese	_____	**Tongan**	_____
Khmer	_____	**Turkish**	_____
Korean	_____	**Ukrainian**	_____
Laotian	_____	**Urdu**	_____
Lithuanian	_____	**Vietnamese**	_____
If not in the above list, please specify:			_____

Q37. **How many of your behavioral health clinical staff are in each of the following educational categories?** *(Total should equal your total behavioral health clinical staff listed in Q29.)*

Educational category	Number of staff
High school	_____
Some college	_____
Associate degree	_____
Bachelor's degree	_____
Master's degree	_____
Doctorate degree	_____
Don't know	_____
Other, specify:	_____
Total number of behavioral health clinical staff	_____

Q38. **How many of your behavioral health clinical staff have the following Washington State Department of Health professional credentials?** *(Total should equal your total behavioral health clinical staff listed in Q29.)*

Washington State Department of Health Credential Type	Number of staff
Advanced registered nurse practitioner (ARNP)	_____
Agency affiliated counselor	_____
Certified behavior technician	_____
Certified counselor	_____
Co-occurring disorder specialist	_____
Licensed assistant behavior analyst	_____
Licensed behavior analyst	_____
Licensed advanced social worker (LASW)	_____
Licensed independent clinical social worker (LICSW)	_____
Licensed independent clinical social worker associate (LICSWA)	_____
Licensed social worker associate advanced (LSWAA)	_____
Licensed marriage and family therapist (LMFT)	_____
Licensed marriage and family therapist associate (LMFTA)	_____
Licensed mental health counselor (LMHC)	_____
Licensed mental health counselor associate (LMHCA)	_____
Licensed practical nurse (LPN)	_____
Medical assistant	_____
Nursing assistant	_____
Registered nurse	_____
Occupational therapist (OT)	_____
Certified occupational therapy assistants (COTA)	_____
Physician	_____
Physician assistant	_____
Psychologist	_____
Substance use disorder professional (SUDP)	_____
Substance use disorder professional trainee (SUDPT)	_____
Don't know	_____
Other, specify:	_____

Q39. (Answer If Agency Affiliated Counselor credential is greater than 0) **How many of your (number from Q39B) Agency Affiliated Counselors are in the following roles?**

Agency Affiliated Counselor roles	Number of staff
Mental Health Professional	_____
Designated Mental Health Professional	_____
Certified Peer Counselor	_____
Mental Health Care Provider	_____

Q40. **How many of your behavioral health clinical staff are dually credentialed to provide both Mental Health and Substance Use Disorder treatment services?**

_____ number of dually credentialed staff

Q41. Thank you for completing our survey. Is there anything else you would like to tell us about your facility?

Thank you very much for completing the survey. We appreciate your help.

If you have any questions about the survey, please feel free to contact:

Behavioral Health Provider Survey
Washington State University
PO Box 641801
Pullman, WA 99164-1801

Appendix C.
Project Profile

Title: 2024 Behavioral Health Provider Survey

Abstract: The Social and Economic Sciences Research Center (SESRC) worked collaboratively with the Division of Behavioral Health and Recovery (DBHR) of the Washington State Health Care Authority (HCA) to conduct the **2024 BHPS Survey** (Behavioral Health Provider Survey). This statewide survey of behavioral health agencies was open to behavioral health (BH) treatment agencies who provide DBHR-certified, publicly funded mental health (MH) and substance use disorder (SUD) treatment services. The aim is to collect current information regarding services and clinical staff to help DBHR identify opportunities for improving the quality of BH treatment services in Washington State, meet federal and state reporting requirements, and inform policy at the provider and state level. With 287 responses (249 completes and 38 partial completes), the overall **response rate is 45.2%.**

Method: For this survey, respondents were initially contact by mail with an invitation letter. Subsequent contacts were primarily by email with one telephone reminder built in. All contacts included information on how to access the web survey or a link they could click to be taken directly to the online survey as well as information on how to contact the project manager.

Timeframe: March 2024 – August 2024

Agreement with:
Felix I Rodriguez, PhD
Division of Behavioral Health and Recovery
Washington State Health Care Authority
PO Box 45330
Olympia, WA 98504-5330
360-791-4125
Felix.rodriguez@hca.wa.gov

SESRC Acronym: BHPS23
Data Report Number: 24-36

Deliverables: Data Report; SPSS Data set; frequency listings; open-ended remarks file.

Credits

Project Team

SESRC is committed to high quality and timely delivery of project results. The following list identifies the SESRC team members responsible for particular elements of this project.

Kent Miller	Project Manager
Rose Krebill-Prather	Principal Investigator

SESRC Staff

All of the work conducted at the Social & Economic Sciences Research Center is the result of a cooperative effort made by a team of dedicated research professionals. The research in this report could not have been conducted without the efforts of interviewers and part-time personnel not listed.

Lena Le, Ph.D.	Director
Rose Krebill-Prather, Ph.D.	Senior Research Fellow
Thom Allen, B.A.	Project Manager II
Ruben Angel Arias Rueda, PhD.	Project Manager
Jack Beck	Fiscal Analyst I
Darren Bystrom, B.A.	Assistant Director of Information Systems and Technology
Timothy Chatburn, Ph.D.	Project Manager
Hui-Chun Chen, Ph.D.	Project Manager
Tara Courtney, B.S.	Survey Supervisor
Tim Haight, M.S.	Information Technology Specialist
Cascade Herriott, BASc	Information Systems Manager, Office of Commercialization
Jair Johnson, M.A.	Survey Supervisor
Sara Keifer, B.A.	Fiscal Specialist II
Colleen Kulesza, M.S. Ed	Data Collection Coordinator
Mick LeClaire, B.A.	Survey Supervisor
Kathryn Mazidi, B.A.	Survey Supervisor
Adam McKee, Ph.D.	Research Assistant Professor, Puget Sound
Kent Miller, M.A.	Assistant Director for Operations, Pullman
Nathan Palmer, M.S.	Project Manager II
Nikolay Ponomarev, Ph.D.	Sr. Programmer
Michael Schiwart, B.S.	Project Manager, Puget Sound
Katrina Shelton, B.S.	Administrative Manager, Office of Research
Dan Vakoch, M.S.	Data Manager

Social & Economic Sciences Research Center
Washington State University
PO Box 644014
Pullman, Washington 99164-4014
Telephone: (509) 335-1511 Fax: (509) 335-0116
http://www.sesrc.wsu.edu
sesrc@wsu.edu