The Behavioral Healthcare Workforce In Colorado: A Status Report

Photo by Belinda Maltz

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Executive Summary

Introduction

Understanding the current status of the behavioral healthcare workforce[1] in Colorado, and across the nation, is complex. There are many different degrees leading to a job in the behavioral health field. This is complicated by the fact that the different behavioral health professionals are governed by different licensing and credentialing bodies, leading to confusion in the public about what a given degree or license means in terms of what services or roles a given professional is competent to provide or serve. Even though we may know what types of professionals are being trained in Colorado's educational institutions, it is difficult to determine, primarily because the data is not routinely reported and analyzed, if those professionals work in Colorado upon degree completion, if they are meeting the needs of the provider community and ultimately, the needs of persons seeking treatment. Behavioral healthcare workforce data is sparse and generally collected at the institutional or organizational level, if at all.

Colorado: Population and Need

Over 120,000 low income Coloradan's needed but did not receive behavioral health services in 2007. Colorado's population is primarily located in eleven of sixty-four counties, and twenty-seven of the sixty-four have under ten thousand people. Colorado's behavioral healthcare providers are primarily located in a similar distribution: Psychiatrists are primarily located in nine counties, counseling providers in ten counties, and addictions counselors in nine counties, although the ratio of provider to population varies significantly even among these counties. Forty Colorado counties do not have a single psychiatrist; seven counties do not have a single clinical behavioral healthcare provider; and nine counties do not have a single certified or licensed addictions counselor. While Coloradans are familiar with the problems of availability of rural health care, large numbers of underserved individuals were living in metropolitan areas as well.

The Behavioral Healthcare Workforce in Colorado: Issues Identified

Colorado lacks a behavioral healthcare workforce development plan. Almost nothing is known about the state's behavioral healthcare workforce including workers employed in the state's safety net system. While an individual agency director may know a great deal about his or her own workforce, there are currently no statewide efforts to collect, aggregate, and report on uniform data about the safety net behavioral healthcare workforce. Safety net providers are unable to articulate their collective workforce needs and demonstrate those needs with data.

When asked to describe Colorado's current behavioral healthcare workforce, professionals in the field described it as "patchy," "disjointed," and "woefully inadequate" to meet Coloradan's behavioral health needs, especially the needs of those who access the Safety Net system, live in rural/frontier areas, live in urban uninsured or underinsured areas, or need services in a language other than English.

Language/Classification

The landscape of Colorado's behavioral health care workforce is complicated by the fact that there is significant overlap in the scope of practice of the various clinical disciplines. "[We] do not classify staff by their degree. They are classified by their job description... When they [clients] go to a mental health center – they go to a case manager… they don't necessarily know or understand the degree." An "overarching structure" that ameliorates the fact that type of degree or licensure often matters most when an agency or provider is seeking reimbursement and little to not at all when a client is being served.

Education and Training

Over thirteen hundred graduate level clinicians are being trained each year by over a dozen Colorado universities, but these individuals are either not finding their way to underserved urban and rural communities in large enough numbers, or they are not staying in those communities. There are some exciting educational innovations, e.g. University of Denver's Four Corners Master of Social Work (MSW) Degree Program and Metropolitan State College of Denver Master of Social Work Program beginning Fall 2011 that will focus on diverse population, that have the potential to ameliorate this problem. However, there is a noted lack of discussion about rural and underserved internship placements and integrating behavioral health and primary care in the

[1] For the purposes of this report, behavioral health workforce includes providers, administrators, and researchers in both the mental health and substance abuse arenas.

education and training community. Outside of addiction counselor training programs being conducted by academic institutions, the Colorado Division of Behavioral Health (DBH) oversees the Certified Addiction Counseling (CAC) training program. However, at the writing of this report, there was a dearth of publicly available information about addictions counseling training programs.

The type of training opportunity (internship, practicum), for whom (social worker, psychologist), what type of organization (prison setting, community mental health center), and where it is located geographically is generally understood within each training institution or professional discipline but not across institutions or disciplines. Complicating this is the fact that a person with a different degree may be eligible for the same training or employment opportunity (e.g., a Licensed Clinical Social Worker [LCSW], a Licensed Marriage and Family Therapist [LMFT], and a Licensed Professional Counselor [LPC] may each be eligible for a clinical placement and then employment in a given agency). Additionally, clinical staff can be trained to provide addictions counseling, but most lack the intensive training necessary to work with individuals with significant or complex addictions issues.

Even in areas of educational preparation where Colorado is considered to be performing reasonably well, the racial and ethnic minority pipeline is already very constricted by high school graduation, and is extremely small at the baccalaureate degree level and almost non- existent at the graduate degree level.

Recruitment and Retention

Current recruitment techniques being utilized focus on loan repayment that stipulates a two to three year service commitment to work in a facility or community with federal designation. While this is a short-term strategy that has been used for over fifty years in this country to attract professionals to rural and underserved settings, it is not a long-term solution as many of these professionals complete their loan repayment tenure and then return to urban areas. For recruitment efforts, it is critical to identify people who have a desire to live and work in rural and underserved settings. Perhaps even more important is to identify people currently living and working in rural and underserved settings and provide them opportunities to "train up" into needed behavioral health positions in the community. Additionally, the loan forgiveness and loan repayment programs do not uniformly include all or even some behavioral healthcare professions. For example, addictions professionals, certified and licensed, are not allowed to apply for state and federal incentive programs.

Incentivizing individuals who are committed to living and working in rural and underserved communities is a better way to ensure retention in those communities. Identifying those individuals and providing career pathways by maximizing the use of technology mediated training delivery models can extend educational ladders to people in their own community. In addition, a facility or geographic area must be designated as a workforce shortage area in order for provider organizations to be able to provide the loan repayment incentive option in recruiting professionals. Strategies, such as University of Denver's Four Corners MSW program, that facilitate local professionals entering the behavioral healthcare workforce, that facilitate practioners staying in underserved areas past their loan repayment commitment, and those that actively recruit and retain more senior clinicians are necessary and will require a collaborative effort on the part of training institutions, local agencies, and the state.

Current Workforce Development Activities in Colorado

There are many current programs or activities related to behavioral healthcare workforce development in Colorado. These activities vary in objective and scope with regard to their relevance to behavioral healthcare workforce development. Some of the identified activities in the full body of the report include: The Colorado Health Professions Workforce Policy Collaborative, The Partnership for Mental Health and Substance Abuse Reform, Peer Specialist activities, Mental Health First Aid, Colorado State Loan Repayment Program, National Health Service Corps in Colorado, clinical internship opportunities, Behavioral Health Transformation Council, and Metro Crisis Services.

There is a growing trend toward integrating behavioral health and primary care services in Colorado and at the national level. Colorado has been called a "hotbed" of activity in integrated care and is poised to be a leader in the movement toward integration. A summary of current happenings and leadership in the integrated care arena in Colorado can be found in the full report.

Lack of Data Leads to Many Unknowns

Many unknowns about the behavioral healthcare workforce in Colorado became apparent through the process of compiling this report. These issues bubbled to

the surface either because there is not adequate data to understand the whole picture of a given area, or because there is no one entity to assemble and analyze the information that does exist to sufficiently demonstrate trends from which to make recommendations. A fuller understanding of the issues identified including gaps in data, training and education, competence and scopes of practice, and career progression would be instrumental in guiding behavioral healthcare workforce development planning efforts.

Possible Solutions

The possible solutions identified to improve behavioral healthcare workforce development in Colorado were extrapolated from the key informant interviews conducted to inform this report and from examining the status and trends of the behavioral healthcare workforce in Colorado. Some of the solutions identified below could be considered "low hanging fruit" and a place to potentially make an impact to improve the behavioral healthcare workforce in Colorado within a relatively short time frame. While some of these ideas may take significant planning to implement, they are included in the short-term solutions section because there exists some infrastructure or model from which to expand. Possible solutions are noted below.

Planning and Collaboration

- Create a Colorado Behavioral Healthcare Workforce Development Strategic Plan.
- Create a statewide Behavioral Health Training and Provider Planning Group.

Program Support and/or Enhancements

- Expand coordinated Mental Health First Aid efforts in Colorado.
- Expand the loan repayment eligibility criteria to include a broader array of behavioral health professionals.
- Expand the capacity of the Colorado Office of Rural Health's program to include behavioral health providers.
- Increase data collection on behavioral health providers.
- Examine the Mental Health Professional Shortage Area (MHPSA) designation process in Colorado.
- Expand the pipeline for students pursuing behavioral health careers.

Training and Education

- Increase integrated care (behavioral health and primary care) training into existing educational and training programs for both behavioral health providers and medical professionals.
- Develop an American Psychological Association (APA) accredited rural psychology internship consortium.
- Replicate the Rural Track model for behavioral health providers.
- Develop a statewide peer specialist certification program.

Technology

- Develop a statewide tele-behavioral health professional network for training, support, and service provision.
- Create a Supervisor Technology Planning Group to increase the use of technology to provide supervision.

The potential solutions are abundant. It will be important to prioritize the solutions based on what is feasible and what can be measured to demonstrate impact. While this may seem daunting, some strategic planning to organize the short- and long-term objectives and desired outcomes will make Colorado a leader and more forward thinking than most states who generally do very little behavioral healthcare workforce planning on a statewide basis.

Summary

Over the past several years, some momentum has formed behind behavioral healthcare workforce development. It is important to capitalize on this momentum, as largely rural states, such as Colorado, have had ongoing difficulties recruiting and retaining an effective behavioral healthcare workforce. A limited workforce translates into critical gaps in the availability and accessibility of services. At present, much of Colorado is designated as a mental health professional shortage area and as a whole has an inadequate amount of licensed professionals. This shortage is especially acute in rural and some urban areas. The shortage can result in those seeking services having to wait longer and/or having inconsistent treatment due to staff changes. As they wait, the severity of their problems often worsens, which can lead to mental health crises.

Also apparent is the disparity between the growing minority population versus that same population obtaining a higher education degree. In conjunction, the state needs to take a hard look at the low numbers of all populations even graduating from high school. The 25 to 64 year-old workforce continues to dwindle as the baby-boomers retire. Workforce development strategies can

take this data into account as they target the future generations of clinicians that will replace a now-aging healthcare workforce.

It is not clear that higher education programs include sufficient training on how to understand, navigate, and respond to a changing health care system (e.g., evidence based practice training in their curricula, training on the public behavioral health system and how it is financed, increased diversification of placing students in community, public, non-profit settings, trainig on alternative job opportunities and settings in the behavioral health field). Higher education institutions need to ensure that training curricula reflects the needs of the populations to be served and brings training opportunities to those who live and will likely stay in rural areas. This is often referred to as a "grow your own" approach, which is an adjunct to incentive-based programs, such as student loan repayment for working in rural areas. Loan repayment programs do provide a reason for many young professionals to live and practice in rural areas, but the period of repayment is limited, and it is unclear to what extent those participating in the program are trained in rural behavioral health. Additionally, loan repayment programs offer only a short-term incentive to experienced professionals to live and work in rural or underserved areas.

With the advent of healthcare reform and the national trend toward the integration of primary care and behavioral health, the time is ripe with opportunity to capitalize on the existing energy and expertise in the state to develop a more coordinated effort to enhance the behavioral healthcare workforce in Colorado.

Behavioral Healthcare Workforce Shortages are a National Issue*

Multiple reports dating from the Eisenhower era Presidential Commission on Mental Health through today indicate that the behavioral healthcare workforce shortage problem is persistent with little improvement.[2] "Of approximately $100 billion spent annually on U.S. mental health care, about 70 percent pays for the labor of mental health professionals. Yet we lack valid and reilable workforce data, and academic research rarely focuses on the mental health workforce. A workforce crisis currently affects…recruitment, retention, training and technical assistance, compensation, career advancement, and geographic distribution."[3]

In a seminal report that identified an action plan for behavioral healthcare workforce, several important factors were noted when describing the workforce crisis in behavioral health. Most critically, there are significant concerns about the capability of the workforce to provide quality care, especially in areas of health promotion, prevention, and integrating resilience- and recovery-oriented practices.

> *It takes well over a decade for proven interventions to make their way into practice, since prevention and treatment services are driven more by tradition than by science. The workforce lacks the racial diversity of the populations it serves... In large sections of rural America, there simply is no mental health or addictions workforce.*[4]

Workforce development is a main concern at the federal level evidenced by several key agencies including the Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) proclaiming it a priority area. "Workforce development is such an important issue to the substance abuse field that the Substance Abuse and Mental Health Services Administration (SAMHSA) identified it as a cross cutting principle affecting all of its major programmatic areas."[5]

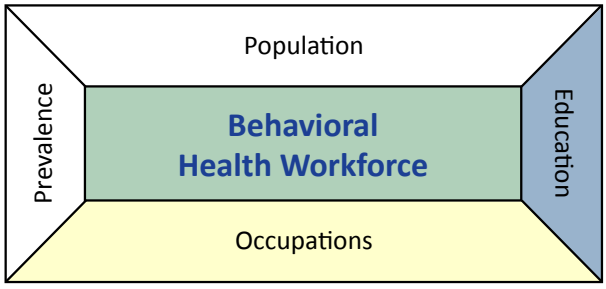
Components of a Strong and Effective Workforce

At any given time, the need for workforce development in behavioral health is determined by the prevalence of behavioral health disorders and the number and location of professionals to provide services. Prevalence rates are based on epidemiological studies of populations, while the number and location of clinicians is based on the interplay of education and occupational trends. Both are estimates, and there are multiple reasons beyond limited availability why those who need treatment do not seek it (e.g., lack of awareness of a problem, stigma, financial concerns, etc.). Additionally, a competent and adequate workforce has the right number of experienced and skilled people in the right jobs at the right time.

Thus, establishing and sustaining an effective behavioral healthcare workforce involves:

- A profile of present *population* and demographics;
- An estimation of the *prevalence* of mental illness and substance abuse issues;
- An analysis of the professional *occupations* available to serve the community;
- A picture of the *higher education* programs designed to supply well-trained professionals.

Each of these four components interrelates, and changes in one impact the others. For instance, large and rapid increases in population can translate into greater numbers of people with a behavioral health problem (if the percentage remains the same). It can also mean more people are available to enter the behavioral health field as clinicians. Thus, it is important to study previous trends to project future courses. More importantly, these projections allow decision-makers to identify potential areas of growth, as well as barriers and means of overcoming them.



* The first few sections serve as an introduction to behavioral healthcare workforce issues. If you are already familiar with these issues, you may want to begin your reading with the Colorado section.

[2] New Freedom Commission on Mental Health. *Subcommittee on Rural Issues : Background Paper*. DHHS Pub. No. SMA-04-3890. Rockville, MD : 2004.

[3] Ellis, A., Konrad, T., Thomas, K., Morrissey, J. (2009). County-Level Estimates of Mental Health Professional Supply in the United State. *Psychiatric Services, 60*, 1315-1322.

[4] Substance Abuse and Mental Health Services Administration. (2007). *An Action Plan on Behavioral Health Workforce Development* (280-02-0302). Washington, DC: U.S. Government Printing Office.

[5] Kaplan, L. (2003). *Substance Abuse Treatment Workforce Environmental Scan*. Center for Substance Abuse Treatment.

Behavioral Health Care Occupations

Behavioral health professions require specific education and training. However, many behavioral health jobs can be filled by individuals who have attained the necessary knowledge and skills through very different educational pathways (e.g., Certified Addiction Counselor [CAC] 2 or LCSW might serve a client with gambling addiction.) Even when client needs can be met by individuals with different credentials or licenses, reimbursement may be tied to a particular type of licensure and thus not all licensures are of equal value (e.g., LCSW, LMFT, LPC and Psychologist are not always eligible for the same reimbursements.) Capturing a complete picture of the "behavioral healthcare workforce" is a daunting task, made infinitely more so by the fact that no one in the field, e.g. the professional organizations, the employers, the education and training institutions, is incentivized to collect, share, and report workforce related data on a consistent basis and a standardized manner.

In 1979, J.D Matarazzo defined behavioral health as "promoting a philosophy of health that stresses individual responsibility in the application of behavioral and biomedical science, knowledge and techniques to the maintenance of health and the prevention of illness and dysfunction by a variety of self-initiated individual or shared activities."[6] However, there is a longstanding, and on-going debate in the professional field about what terms to use to describe those who provide and those who access behavioral health services.[7] This definition has been operationalized to include what had previously been referred to as mental health and substance abuse education, prevention and treatment. With respect to workforce, it has come to refer to those professionals whose primary focus is on the provision of counseling/psychotherapy and/or diagnostic services and/or psycho-pharmaceutical evaluation, prescription or monitoring for individuals with mental health and/or substance abuse issues. Whether or not to include prevention specialists is an ongoing debate.

Core mental health providers for Health Professional Shortage Areas-Mental include "clinical psychologists, clinical social workers, marriage and family therapists, and psychiatric nurse specialists to provide mental health services, in addition to psychiatrists."[8] The Bureau of Labor Statistics has its own classification system and includes the following "broad occupations classifications:"

> Psychologists; Counselors; Substance Abuse and Behavioral Disorder Counselors; Educational, Guidance, School, and Vocational Counselors; Marriage and Family Therapists; Mental Health Counselors; Rehabilitation Counselors; Counselors, All Other; Social Workers; Child, Family, and School Social Workers; Healthcare Social Workers; Mental Health and Substance Abuse Social Workers; Social Workers, All Other; Miscellaneous Community and Social Service Specialists; Health Educators; Probation Officers and Correctional Treatment Specialists; Social and Human Service Assistants; Community Health Workers; Community and Social Service Specialists, All Other; Psychiatrists; Registered Nurse (Psychiatric Nurse); Nurse Practitioner (Psychiatric Mental Health Nurse Practitioner).[9]

The National Alliance on Mental Illness (NAMI) lists psychiatrists, psychologists, social workers, and licensed professional counselors as mental health professionals.[10] While there is often significant overlap within definitions, many focus on mental health professionals and without mentioning professionals who provide prevention, education or treatment related to addiction disorders. Adding to the confusion, licensing and registration of individuals providing behavioral healthcare services is a responsibility of and varies a great deal by the state in which the individual is practicing.

According to the Department of Labor's *Occupational Outlook*[11], in 2008 about "34 percent of psychologists were self-employed, mainly as private practitioners and independent consultants. Educational institutions employed about 29 percent of psychologists" in non-teaching positions, such as counseling, testing, research, and administration. Another 21 percent were primarily employed in offices of mental health practitioners, hospitals, physicians' offices, outpatient mental health and substance abuse centers or other healthcare settings. Government agencies at the state and local levels employed psychologists in correctional facilities, law enforcement, and other settings.

[6] Matarazzo, J.D. (1980). Behavioral health and behavioral medicine: Frontiers for a new health psychology. *American Psychologist, 35*, 807-817.
[7] Hyde, P. (2010). *SAMHSA News, 18*, 2. Retrieved from <http://www.samhsa.gov/samhsanewsletter/Volume_18_Number_2/MarchApril2010.pdf>
[8] U.S. Department of Health and Human Services. (n.d.). Shortage Designation: Health Professional Shortage Areas (HPSAs). Retrieved from <http://bhpr.hrsa.gov/shortage/hpsaguidement.htm>
[9] Department of Labor. (n.d.). *Occupational Outlook Handbook 2001-11 Edition*. Retrieved from <http://www.bls.gov/oco/>
[10] National Alliance on Mental Illness. (n.d.). *Mental Health Professionals: Who They Are and How to Find One*. Retrieved from <http://www.nami.org/Content/ContentGroups/Helpline1/Mental_Health_Professionals_Who_They_Are_and_How_to_Find_One.htm>
[11] Department of Labor. (n.d.). *Occupational Outlook Handbook 2001-11 Edition*. Retrieved from <http://www.bls.gov/oco/>

Occupational Outlook groups several types of counselors e.g. mental health, vocational, rehabilitation and substance abuse under the term "counselor." While a Master's Degree is required for licensure, licensure requirements differ greatly for each of these occupational specialties. Additionally, counselors working in certain settings or in a particular specialty may experience different licensure requirements. For example, a career counselor working in private practice may need a license, but a counselor working for a college career center may not. In addition, substance abuse and mental health counselors generally are governed by different state agencies or boards than are other counselors e.g. vocational, school, or rehabilitation. Bachelor degree programs typically prepare graduates for direct service positions, such as caseworker, mental health assistant, group home worker and residential counselor. The criteria for licensure can vary greatly by state but also across counseling specialty areas, and in some cases e.g. substance abuse counselors may need only a high school diploma and certification, while mental health counselors need a Master's Degree.

The Occupational Outlook details similar educational and training preparation for Social Workers as it does for Counselors. Additionally, it lists similar places of employment and career trajectories. However, because there is more homogeneity in Social Work employment, it was possible to determine that about 54 percent of Social Worker's jobs were in healthcare and social assistance industries, and 31 percent were in government agencies in 2008.

An Action Plan on Behavioral Healthcare Workforce Development defined behavioral healthcare workforce, not in terms of specific degrees, but by their employment or provision of services to persons with behavioral health issues. This group included individuals in training or currently employed to provide health promotion, prevention, and treatment services. These were professionals with graduate training, as well as individuals who have associate's or bachelor's degrees, high school diplomas, or even less formal education.[12]

Currently, there is no shared definition of behavioral healthcare occupations, and professionals with a variety of credentials and licenses can frequently fill the same position.

[12] Substance Abuse and Mental Health Services Administration. (2007). An Action Plan on Behavioral Health Workforce Development (280-02-0302). Washington, DC: U.S. Government Printing Office.

Behavioral Healthcare Workforce Shortage Areas

Many factors (e.g., geographic, economic, cultural) impact the behavioral health care of Americans including the presence or absence of behavioral health services and providers, along with knowing where and how to access services, and an individual's own willingness to utilize services.[13]

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups, or medical or other public facilities.

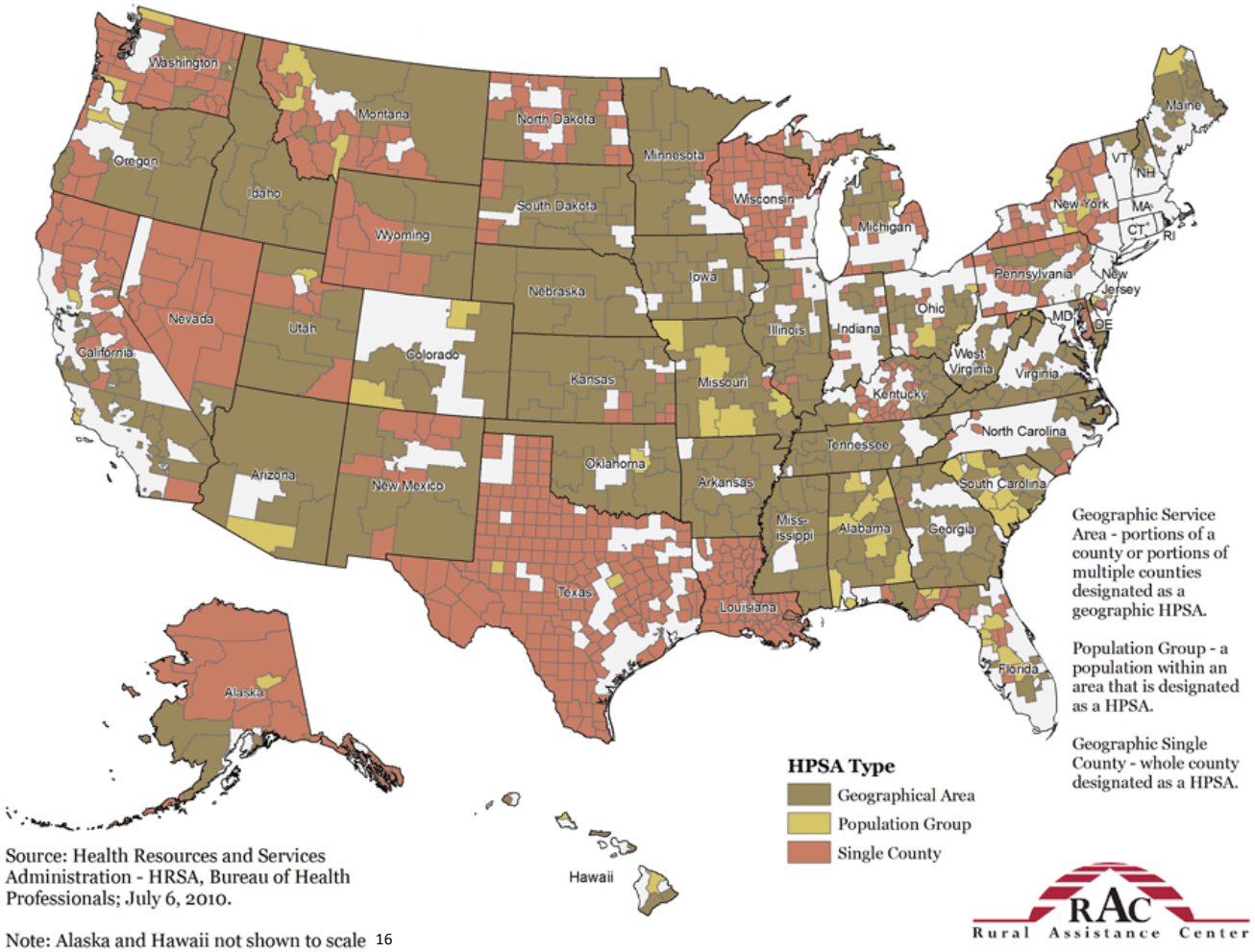
As of September 30, 2009, there were:

- **6,204 Primary Care HPSAs** with 65 million people living in them. It would take 16,643 practitioners to meet their need for primary care providers (a population to practitioner ratio of 2,000:1.
- **4,230 Dental HPSAs** with 49 million people living in them. It would take 9,642 practitioners to meet their need for dental providers (a population to practitioner ratio of 3,000:1).
- **3,291 Mental Health HPSAs** with 80 million people living in them. It would take 5,338 practitioners to meet their need for mental health providers (a population to practitioner ratio of 10,000:1).[14]

"Mental Health Professional Shortage Areas (MHPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility)."[15]

[13] Larson, M.L., Beeson, P. G., & Mohatt, D.F. (1993). *Taking rural into account: A report of the National Public Hearing on Rural Mental Health*. St. Cloud, MN: National Association for Rural Mental Health and the Federal Center for Mental Health Services.
[14] Health Resources and Services Administration. (n.d.). *Shortage Designation: HPSAs, MUAs & MUPs*. Retrieved from <http://bhpr.hrsa.gov/shortage/>
[15] Health Resources and Services Administration. (n.d.). *Find Shortage Areas: HPSA by State & County*. Retrieved from <http://hpsafind.hrsa.gov/HPSASearch.aspx>

Health Professional Shortage Areas (HPSA) – Mental Health HPSA Designated Type



Rural Behavioral Healthcare Workforce

The behavioral healthcare workforce scenario worsens as rurality increases. Health and human services workforce development is a concern in many rural areas, due to limited availability and access to these services, relative to urban areas. The National Advisory Committee on Rural Health (2009)[17] noted that:

> Rural communities face many challenges in acquiring and maintaining an adequate supply of health and human services workers; the majority of rural areas do not currently have a sufficient workforce to meet their populations' needs. Primary care physicians are much less likely to work in rural counties than in urban counties. More than one-third of rural residents live in a federally designated Health Professional Shortage Area (HPSA) and more rural than urban counties are designated as a mental health HPSA or dental HPSA. In general, counties with a primary care HPSA designation are also more likely to lack allied health resources, suggesting that the overall rural health care system has workforce shortages.[18]

In order to develop and maintain a qualified workforce, rural communities need the capacity and infrastructure to train, recruit and retain a sufficient health and human services workforce. By concentrating on workforce development,

[16] Health Professional Shortage Areas (HPSA)-Mental Health HPSA Designation Type. (n.d.). Retrieved from <http://www.raconline.org/maps/mapfiles/hpsa_mentaltype.png>

[17] The National Advisory Committee on Rural Health and Human Services. (2009). *The 2009 Report to the Secretary: Rural Health and Human Service Issues*. Retrieved from <http://ruralcommittee.hrsa.gov/publications/2009_NAC.pdf>

[18] The National Advisory Committee on Rural Health and Human Services (2009), p 6. *The 2009 Report to the Secretary: Rural Health and Human Service Issues*. Retrieved from <http://ruralcommittee.hrsa.gov/publications/2009_NAC.pdf>

rural communities can simultaneously address local employment concerns and increase job opportunities.

The challenge facing rural communities today is not only how to meet current workforce needs but also how to address future workforce shortages. The current training and education programs in rural areas have been insufficient in developing a workforce to meet the present needs; improvement is essential to meet the projected workforce need.[19]

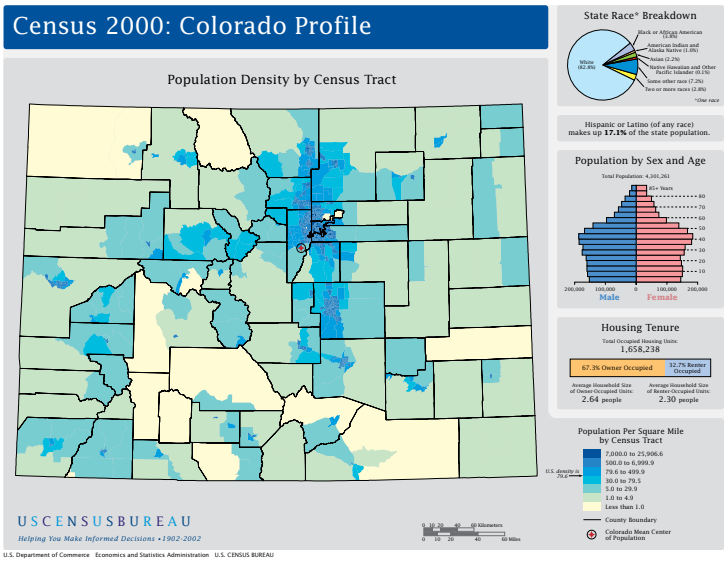
Overall, there is a lower educational attainment for rural areas; a higher percentage of rural adults had not completed high school and 15.6 percent of rural adults had completed a degree from a four-year college compared to 26.6 percent of urban adults, in 2000. Rural residents must also overcome a geographic barrier, because there are fewer opportunities for education and training in health and human services professions in rural communities. There are fewer post-secondary schools located in rural areas than in urban areas; there are few allopathic medical schools or dental schools, and less than a third of social work schools are in rural areas.[20]

Historically, rural communities have relied on providers trained as generalists and on an informal network of other community based supports such as ministers, nursing homes, school personnel, and volunteer organizations. Strengthening the existing informal system and training persons who are rural-committed (currently live or have a desire to live in a rural setting) may be realistic and worthwhile approaches to workforce development in rural communities.

Colorado

Colorado's Population

According to the U.S. Census Bureau's county estimate files, Colorado's population in 2009 was 5,024,748. Seventeen counties qualify as metropolitan and 4,338,362 individuals or approximately 86 percent of the state's population, live in those counties. However, people are not evenly distributed throughout the individual counties. Frequently, very specific locations within the state are densely populated, and vast



expanses are sparsely populated (see Census 2000: Colorado Profile map below). Hispanic or Latino of any race comprise 17.1 percent of Colorado's population. [21]

Prevalence of Behavioral Health Concerns in Colorado's Population

Colorado Population in Need (COPIN) 2009 published prevalence rates, indicators of unmet need, and penetration rates for serious behavioral health disorders (SBHD) for behavioral health services for low income Coloradans. SBHD includes children and adolescents with serious emotional disturbance (SED), and adults with serious mental illness (SMI), substance use disorders (SUD), and co-occurring disorders (COD includes SUD and SMI or SED). Children and adolescents with co-occurring disorders and substance use disorders are included with SED. For the purposes of this report and at the request of the Division of Behavioral Health low income was defined as three hundred percent of the federal poverty level.

In 2007 there were an estimated 169,751 adults in Colorado with serious behavioral health disorders living at or below three hundred percent of the federal poverty level. This included 89,803 adults with serious mental illness only (SMI Only), 13,958 adults with co-occurring mental health and substance use disorders (COD), and 65,990 adults with substance use disorders only (SUD Only).[22] Statewide there were an estimated 49,364 children and adolescents living at or below three hundred percent of the federal poverty level with serious emotional disturbances (SED) in Colorado in 2007.[23]

[19] The National Advisory Committee on Rural Health and Human Services. (2009), p 7-8. *The 2009 Report to the Secretary: Rural Health and Human Service Issues*. Retrieved from <http://ruralcommittee.hrsa.gov/publications/2009_NAC.pdf>
[20] The National Advisory Committee on Rural Health and Human Services. (2009), p 6. *The 2009 Report to the Secretary: Rural Health and Human Service Issues*. Retrieved from <http://ruralcommittee.hrsa.gov/publications/2009_NAC.pdf>

[21] U.S. Census Bureau. (n.d.). *Census 2000: Colorado Profile*. Retrieved from <http://www2.census.gov/geo/maps/special/profile2k/CO_2K_Profile.pdf>
[22] Western Interstate Commission for Higher Education. (2009). *Colorado Population in Need 2009*. (p 17). Boulder, CO: McGee, C. & Flory, M.
[23] Western Interstate Commission for Higher Education. (2009). *Colorado Population in Need 2009*. (p 22). Boulder, CO: McGee, C. & Flory, M.

State Fiscal Year 2007 data on behavioral health service provision were obtained from four agencies: the Department of Health Care Policy and Financing (State Authority for Medicaid and Medicare); the Department of Human Services, Division of Behavioral Health; the Division of Vocational Rehabilitation; and the Division of Child Welfare.[24] Service utilization data were not limited to individuals with serious behavioral health disorders; all individuals receiving behavioral health services were included, even those with less serious conditions. Since the prevalence estimates include only persons with serious behavioral health disorders, including all individuals in the behavioral health service utilization data ensures that the estimate of unmet need is a conservative estimate.

For the purposes of this study, unmet need was defined as how many people who need and could benefit from services who did not receive them and calculated by prevalence estimate minus the number of unique individuals served. Penetration rate was defined as the percent of people in need of services who were served in SFY 2007 and calculated by dividing the prevalence estimate by the service use count. Unmet need and penetration rates provide standardized data that may be used to inform policy and planning decisions. The study offers a very conservative estimate of Colorado's behavioral health safety net needs from a public health perspective and a summary of those findings follows. The Division of Behavioral Health requested the data be reported out by mental health service area and substance abuse planning area.

Summary of Adult Indicators:

- Number of Colorado adults in SFY 2007 who were in need and could benefit from services who did not receive services=Unmet Need = 108,496.
- Percent of adults in need of services who were served in SFY 2007=Penetration Rate = 36 percent.
- Denver (12,813) and Pikes Peak (12,749) mental health service areas had the largest unmet need.
- Metropolitan Denver (43,597) the substance abuse planning area with the largest unmet need had more than twice the unmet need of the Northeast substance abuse planning area (18,789), who had the second largest unmet need.
- Variations in penetration rates across mental health service areas ranged from 26 percent to 54 percent, disregarding extremes. Substance abuse planning area penetration rates were comparable.

[24] Western Interstate Commission for Higher Education. (2009). *Colorado Population in Need 2009*. (p 9). Boulder, CO: McGee, C. & Flory, M.

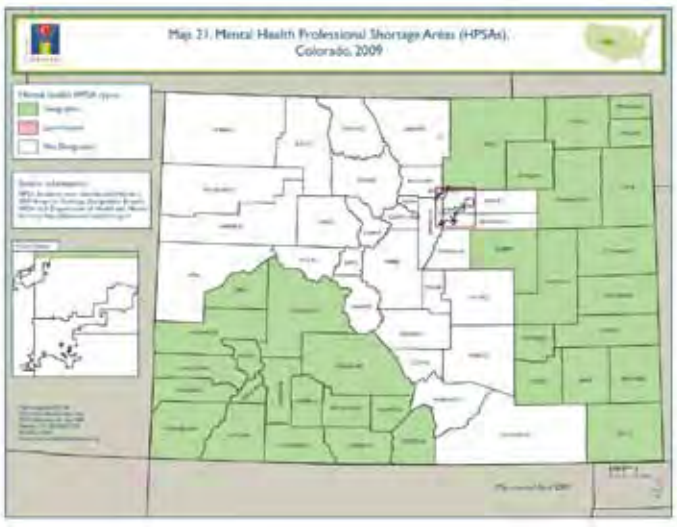
Summary of Child and Adolescent Indicators:

- Number of Colorado youths in SFY 2007 who were in need and could benefit from services who did not receive services=Unmet need = 18,525.
- Percent of youths in need of services who were served in SFY 2007=Penetration rate = 62 percent.
- Denver (3,554) and Pikes Peak (3,447) mental health service areas had the largest unmet need.
- Substance abuse planning area with the largest unmet need was Metropolitan Denver with 9,599, more than twice the number as the Central and Colorado Springs substance abuse planning area (3,431).
- The overall penetration rate for youths was 62 percent, much higher than the 36 percent for adults. Variations in penetration rates across mental health service areas ranged from 49 percent to 88 percent, disregarding extremes. Again, substance abuse planning areas have comparable rates. Of note, penetration rates were highest for ages 6-11 (91 percent) and lowest for ages 0-5 (30 percent), meaning a greater percentage of the 0-5 population in need did not receive a single service.

Colorado Behavioral Healthcare Workforce and Shortages

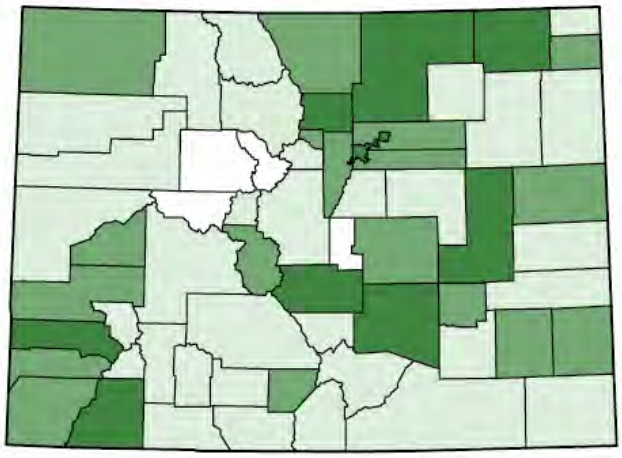
Issues surrounding healthcare availability are recognized throughout Colorado. As the map below indicates, much of Colorado is designated as a federal Mental Health Professional Shortage Area (MHPA).[25] In addition to identifying Medically Underserved Areas (MUA), Medically Underserved Populations (MUP) can be designated. For both MUA and MUP designation a ratio of the full time equivalent [FTE] of physicians serving the population, the percent of population with incomes at or below 100 percent of the poverty level, percent of population age 65 and over, and the infant mortality rate are considered. MUP designation involves application of the Index of Medical Underservice (IMU) to data on an underserved population group within an area of residence to obtain a score for the population group. Population groups requested for MUP designation should be those with economic barriers (low-income or Medicaid-eligible populations), or cultural and/or linguistic access barriers to primary medical care services.[26]

[25] Health Resources and Services Administration. (n.d.). *Shortage Designation: HPSAs, MUAs & MUPs*. Retrieved from <http://bhpr.hrsa.gov/shortage/>
[26] Health Resources and Services Administration. (n.d.). *Shortage Designation: Medically Underserved Areas & Populations*. Retrieved from <http://bhpr.hrsa.gov/shortage/muaguide.htm>



Only four (4) counties do not have some type of shortage designation (mental health, physical health and/or dental providers).[27] White colored counties on the map indicate no HPSA designation for mental health, dentistry or primary care. However, HPSA designation is in response to application and therefore lack of designation does not mean there is not a shortage in that area. Fifty-one of Colorado's counties are in health professional shortage areas (Colorado Department of Public Health and Environment) [28]and 47 of Colorado's 64 counties are designated rural.[29]

All HPSA Disciplines - Colorado



[27] Health Resources and Services Administration. (n.d.) *HRSA Geospatial Data Warehouse*. Retrieved from <http://datawarehouse.hrsa.gov/hpsadetail.aspx>

[28] Colorado Rural Development Council. (2009). *Rural Colorado-Real Colorado An Annual Report on the Status of Rural Colorado 2009*. Retrieved from <http://crdc.gafyd.net/2008CRDC-AnnualRpt.pdf>

[29] United States Department of Agriculture Economic Research Service. (April 2010). *County Level Population Data for Colorado*. Retrieved from <http://www.ers.usda.gov/Data/Population/PopList.asp?longname=Colorado&st=CO&sortBy=Beale03&sortMsg=rural-urban+continuum+code&sortColumn=2&priorSortBy=CountyName#table>

The main challenge with mental health HPSAs is that the service area generally must be the SAMHSA/CDHS catchment area for mental health. The catchment areas are aggregations of counties in terms of how people acquire or have access to care. For example, Walden, near Rocky Mountain National Park is aggregated with Grand Junction rather than Fort Collins, which is much closer. Until recently, Grand Junction had enough psychiatrists to make the whole northwest region of Colorado ineligible for designation. The existing methodology may not be discreet enough to capture and designate real provider shortages in many parts of the state. Further explanation of this methodological issue is available from the Colorado Primary Care Office (Department of Public Health and Environment), who is responsible for processing shortage designation applications. Federal reform may shift shortage designation requirements to a better methodology, but it will take several years to work through the federal approval system. The Colorado Primary Care Office updates their MH-HPSA maps quarterly.[30]

HRSA ideally prefers geographic areas or population group designations. Facility designations are granted with some reluctance after other possibilities are exhausted. Mental health providers potentially feels the policy more acutely because FQHCs and most rural health clinics get an automatic facility designation, so they do not have to submit an application. Several people interviewed for this report identified that they had submitted applications to be designated as a MH-HPSA but were denied and little feedback was provided regarding how the determination was made or how to improve their applications. Another challenge is that shortage designation requires that you serve medically underserved people AND that you have insufficient provider capacity to meet the needs of the community . Many providers may not be aware that both of these conditions must be present in order to be eligible for a designation.[31]

Colorado's Current Behavioral Health Care Workforce

It is extremely challenging to understand what the current behavioral healthcare workforce looks like.[32] Neither state agencies nor professional associations routinely collect and make available to the public workforce data, and what information is available is not standardized across professional disciplines or

[30] Personal communication with Steve Holloway, Primary Care Office, Department of Public Health and Environment.

[31] Personal communication with Steve Holloway, Primary Care Office, Department of Public Health and Environment.

[32] For the purposes of this report, behavioral health workforce includes providers, administrators, and researchers in both the mental health and substance abuse arenas.

across state agencies. Recently, the State of Colorado's Department of Regulatory Agencies began making it possible and free for the public to access limited information about professionals registered or holding a license as a licensed social worker (clinical and non-clinical), marriage and family therapist, licensed professional counselor, unlicensed psychotherapist, licensed addictions counselor, certified addictions counselor, psychchological techniction-mental health, and psychological technician-developmental disability. However, information about state licensed physicians with board certifications in psychiatry is not easily or inexpensively available to the public.

Table 1, on the following page, breaks out the Colorado 2010 licensing and registration information by county and combines it with 2009 population data, Rural-Urban Continuum data and HRSA MH designation. It is important to note that while a provider must be registered and list an address, it does not mean that the provider is actively providing client care, is providing client care at the address listed or is providing client care at only the address listed. One can see where the population and the providers are concentrated and low in number and notice extremes such as the number of provders per person in Boulder County verses Arapahoe County who has a significantly larger population but fewer providers. It is also interesting to note the difference in provider numbers for counties such as Alamosa and Archuleta who have similar populations, are both MH HPSA designated, and have the same rural designation of 7 Urban population of 2,500 to 19,999, not adjacent to a metro area, but Alamosa County has two psychiatrists while Archuleta County has none, and Alamosa County has more LCSW, LPCs and CACs than Archuleta County. It is also possible to note that Cheyenne County has relatively few people, and only one clinical provider, Sedgwick County has only one Social Worker who is not a licensed clinician, and San Juan County does not have a single provider of any type. In looking at Denver and El Paso Counties, it is noticeable that counties with large populations can have very different provider populations.

The following notes refer to the table on page 15.

*Only those health professionals holding an active license in 2010 through DORA and a Colorado address listed with their license are included here. Majority of the provider by county data was provided by The Colorado Health Institute.

Source: Colorado Department of Regulatory Agencies (DORA). For more information go to: <https://www.doradls.state.co.us/lic_database_req.php, Division of Registration>

**Peregrine Management Corporation master dataset for April 2010. For more information, go to http://www.peregrine.us

*** <http://www.ers.usda.gov/Data/Population/PopList.asp?longname=Colorado&st=CO&sortBy=Beale03&sortMsg=rural-urban+continuum+code&sortColumn=2&priorSortBy=CountyName#table>

Rural-Urban Continuum (RUC) codes

Metro counties:

1 Counties in metro areas of 1 million population or more

2 Counties in metro areas of 250,000 to 1 million population

3 Counties in metro areas of fewer than 250,000 population

Nonmetro counties:

4 Urban population of 20,000 or more, adjacent to a metro area

5 Urban population of 20,000 or more, not adjacent to a metro area

6 Urban population of 2,500 to 19,999, adjacent to a metro area

7 Urban population of 2,500 to 19,999, not adjacent to a metro area

8 Completely rural or less than 2,500 urban population, adjacent to a metro area

9 Completely rural or less than 2,500 urban population, not adjacent to a metro area

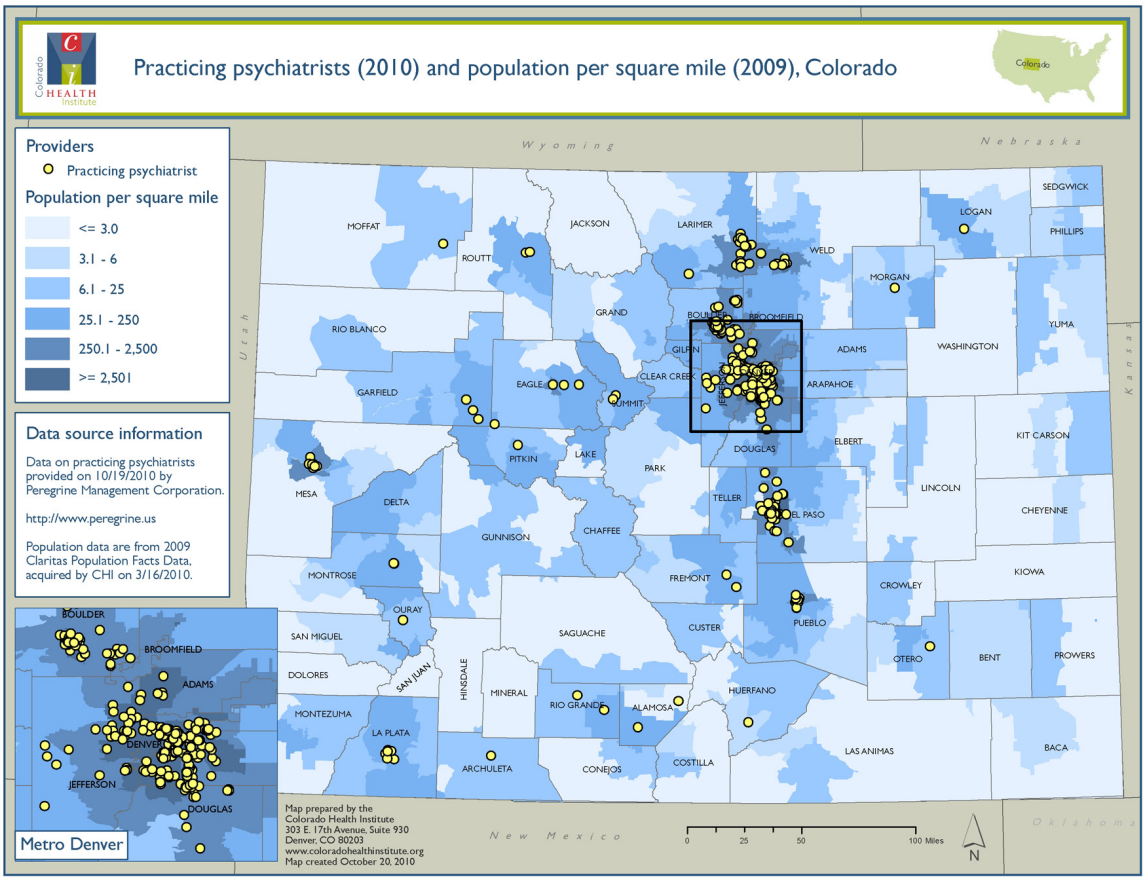
**** 1= County is designated as MH HPSA 0= County is NOT designated as MH HPSA; only notes designation at the county level and not at the geographical area or facility level <http://hpsafind.hrsa.gov/HPSASearch.aspx>

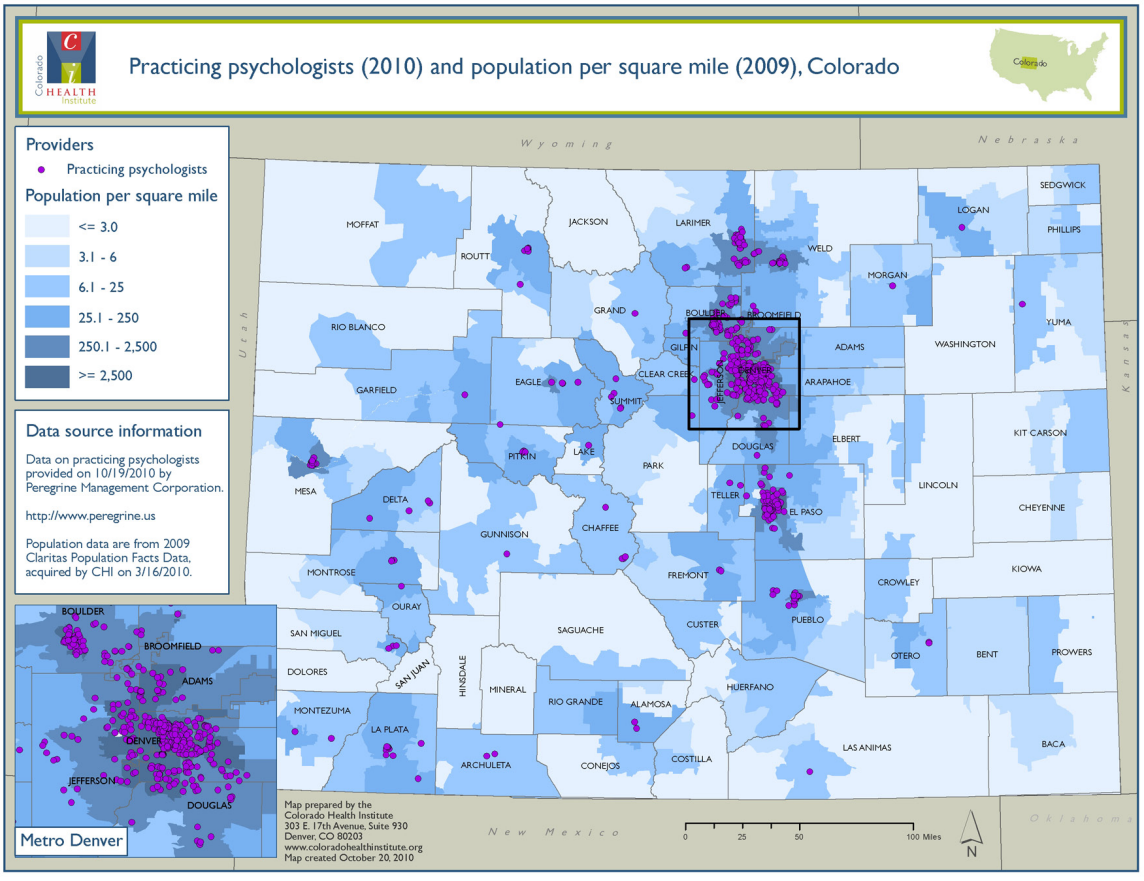
The maps that follow highlight Colorado's behavioral healthcare provider and population distribution by county. Recall that in reality the population is not evenly distributed, so even though these visuals make it easier to see the distribution of providers compared to the distribution of the population, it is still possible for parts of any county or segments of a county's population to be underserved. Distance, traffic patterns, terrain and other factors influence how accessible a provider actually is to a client. The first four maps below indicate where psychiatrists, psychologists, social workers, other mental health counselors report they practice. These are followed by maps detailing Certified Addictions Counselors (CAC I II, III) and LAC's locations based on the address they report to the Department of Regulartory Agencies. (See Appendix A for the table of data used by CHI to generate the following maps.)

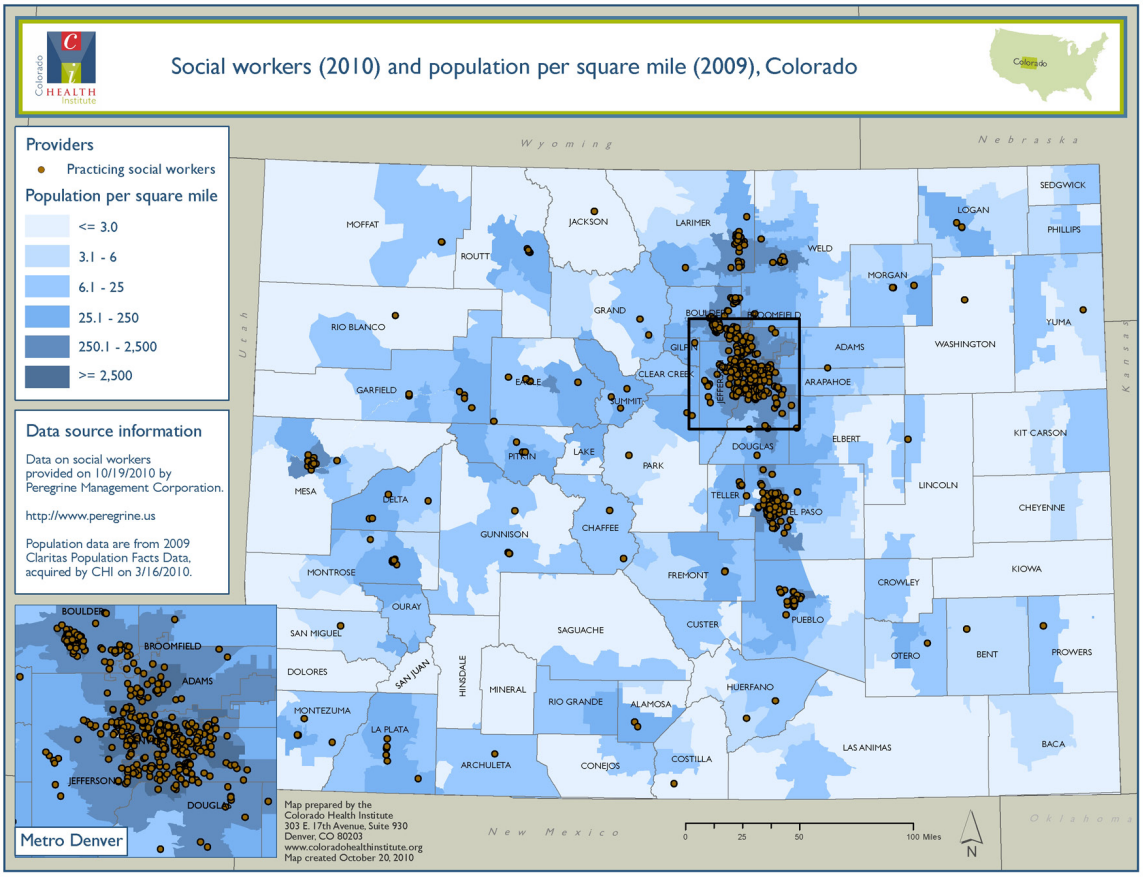
Currently, it is not possible to know how many of the individuals from the Department of Regulatory Agencies

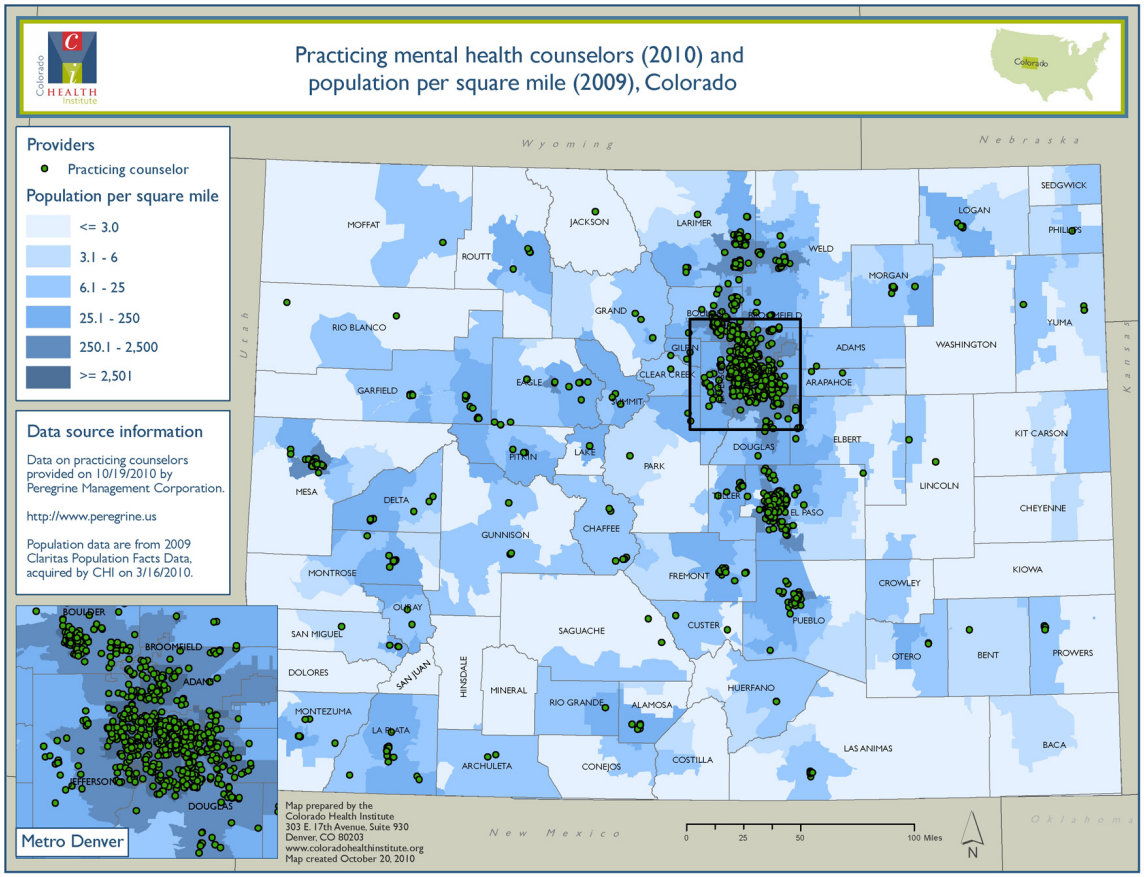
Table 1. County Counts of Specified Health Professionals, 2010*

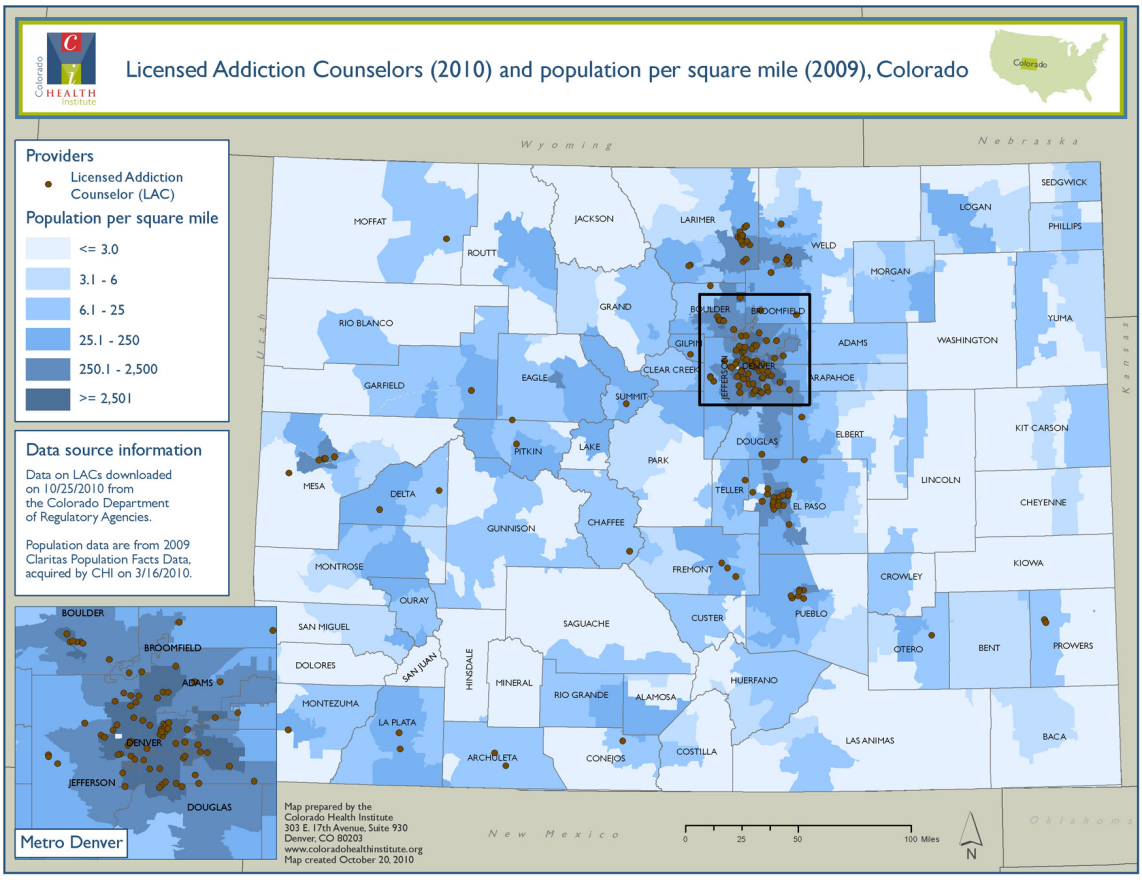
County Name	Pop. 2009	RUC code	HRSA MH HPSA ****	Practicing Psychia-trists**	Psycho-logist	LCSW	LSW	LMFT	Unlicensed Psycho-therapists	LPC	CAC1	CAC2	CAC3	LAC	Licensed Psychiatric Technicians	
															DD	MI
Adams	440,994	1	0	56	61	146	19	13	140	151	22	68	122	7	64	5
Alamosa	15,424	7	1	2	4	10	0	0	7	34	5	11	18	0	0	0
Arapahoe	565,360	1	0	83	260	396	34	48	310	385	33	70	213	8	29	3
Archuleta	12,430	7	1	0	4	9	0	0	5	11	0	3	1	1	0	0
Baca	3,723	9	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Bent	6,560	7	1	0	1	2	0	0	1	3	2	4	5	0	0	0
Boulder	303,482	2	0	58	265	425	29	68	490	478	16	58	141	9	0	1
Broomfield	55,990	1	0	0	16	23	2	1	3	37	0	1	1	0	3	0
Chaffee	17,156	7	1	1	5	8	2	4	5	22	2	4	7	0	1	0
Cheyenne	1,746	9	1	0	0	0	0	0	1	0	1	0	1	0	0	0
Clear Creek	8,706	1	0	0	3	6	0	1	8	9	0	2	3	0	2	0
Conejos	7,844	9	1	0	0	1	0	0	1	6	1	3	4	0	0	0
Costilla	3,148	9	1	0	0	1	0	0	1	0	1	1	0	0	0	0
Crowley	6,403	8	1	0	0	1	0	0	2	1	0	1	1	0	1	1
Custer	4,000	8	1	0	0	2	0	0	3	2	0	1	1	0	0	1
Delta	31,322	6	1	1	6	12	1	2	11	16	0	5	7	2	4	1
Denver	610,345	1	0	188	541	762	110	65	553	535	38	184	356	26	49	8
Dolores	1,940	9	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	288,225	1	0	7	61	132	14	25	125	153	10	26	32	4	5	3
Eagle	53,653	5	0	1	14	17	3	5	15	29	1	6	6	1	0	0
El Paso	604,542	2	0	37	210	392	49	109	431	566	16	56	158	23	5	3
Elbert	23,287	1	1	0	3	3	1	1	8	14	3	1	3	1	0	0
Fremont	47,815	4	1	3	15	22	1	2	31	45	5	12	25	2	0	5
Garfield	56,298	5	0	0	6	27	1	4	25	33	3	9	24	1	2	0
Gilpin	5,604	1	0	0	1	1	0	1	5	10	0	0	6	0	0	0
Grand	13,911	8	0	0	2	4	0	2	0	9	0	3	6	0	0	0
Gunnison	15,350	7	1	1	1	4	1	2	7	19	0	2	7	0	0	0
Hinsdale	821	9	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Huerfano	7,558	6	0	0	0	2	0	3	0	3	1	1	2	0	0	2
Jackson	1,369	9	0	0	0	0	0	1	0	0	0	0	1	0	0	0
Jefferson	536,922	1	0	38	199	415	33	55	335	424	37	105	205	24	131	5
Kiowa	1,238	9	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Kit Carson	8,402	7	1	0	0	0	0	0	2	3	2	0	3	0	0	0
La Plata	8,046	6	1	8	21	46	7	11	40	69	6	10	24	3	0	0
Lake	51,464	7	1	0	1	1	0	0	0	1	1	1	0	0	0	0
Larimer	298,382	2	0	24	158	226	26	79	182	225	25	61	111	19	4	2
Las Animas	16,020	7	0	0	0	0	0	1	5	5	3	6	1	0	0	0
Lincoln	5,169	8	1	0	0	3	0	0	2	5	0	0	2	0	0	0
Logan	20,772	7	1	1	3	3	0	2	9	15	3	5	14	0	0	0
Mesa	146,093	3	0	18	27	67	4	12	73	93	4	20	43	5	370	44
Mineral	912	9	1	0	0	0	0	0	0	2	0	0	0	0	0	0
Moffat	13,980	7	0	0	0	2	1	0	2	4	0	1	4	1	0	0
Montezuma	25,368	6	1	0	3	12	1	1	10	18	1	3	15	1	1	0
Montrose	41,412	7	1	3	2	20	0	1	9	26	0	2	9	0	1	0
Morgan	27,850	6	1	0	3	8	1	2	3	13	1	4	6	0	1	0
Otero	18,670	6	1	1	4	5	1	1	4	13	1	3	5	0	0	0
Ouray	4,602	9	1	0	8	4	0	2	2	4	1	0	1	0	0	0
Park	16,762	1	0	0	2	11	2	1	7	10	0	1	8	0	1	0
Philips	4,472	9	1	0	0	0	0	0	1	1	0	1	3	0	0	0
Pitkin	16,043	7	0	1	13	14	1	2	11	10	0	2	7	1	0	0
Prowers	12,982	7	1	0	0	1	0	0	3	3	3	1	3	1	0	0
Pueblo	157,224	3	0	38	48	126	6	9	77	119	19	55	110	9	193	196
Rio Blanco	6,534	9	0	0	0	2	0	1	0	3	0	0	1	0	0	0
Rio Grande	11,581	7	1	0	1	1	0	1	0	6	2	3	3	0	0	0
Routt	23,469	7	0	3	10	18	2	3	6	20	0	1	9	0	0	0
Saguache	7,097	9	1	0	0	1	1	2	3	8	0	0	0	0	0	0
San Juan	555	9	1	0	0	0	0	0	0	0	0	0	0	0	0	0
San Miguel	7,558	9	1	0	5	1	1	1	7	6	0	1	1	0	0	0
Sedgwick	2,326	9	1	0	0	0	1	0	0	0	0	0	0	0	0	0
Summit	27,239	7	0	2	13	14	1	0	10	26	1	4	4	1	0	0
Teller	21,685	2	0	0	5	17	0	2	16	26	0	5	12	1	0	0
Washington	4,420	9	1	0	0	1	0	1	0	1	1	0	0	0	0	0
Weld	254,759	3	1	7	50	59	5	5	77	132	17	29	76	9	0	0
Yuma	9,734	7	1	0	1	2	0	2	2	6	0	0	2	0	0	0
Colorado Total	5,024,748			582	1633	3488	110	554	3086	3868	288	856	1833	160	694	196

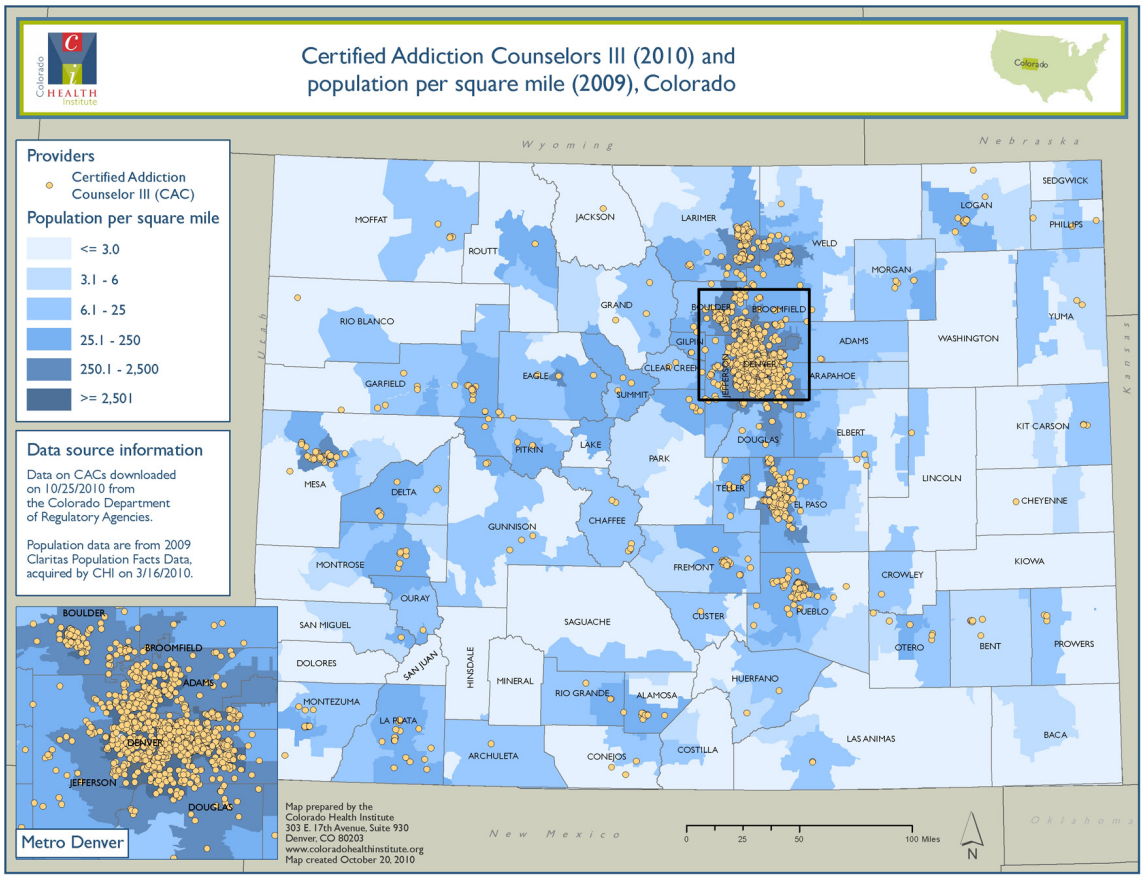

Practicing psychiatrists (2010) and population per square mile (2009), Colorado
Colorado
HEALTH Institute
Providers
Practicing psychiatrist
Population per square mile
<= 3.0
3.1 - 6
6.1 - 25
25.1 - 250
250.1 - 2,500
>= 2,501
Data source information
Data on practicing psychiatrists provided on 10/19/2010 by Peregrine Management Corporation.
http://www.peregrine.us
Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.
Metro Denver
Map prepared by the Colorado Health Institute
303 E. 17th Avenue, Suite 930
Denver, CO 80203
www.coloradohealthinstitute.org
Map created October 20, 2010
Wyoming
Nebraska
Utah
Kansas
New Mexico
Oklahoma
0 25 50 100 Miles
N


Practicing psychologists (2010) and population per square mile (2009), Colorado
Colorado
HEALTH Institute
Providers
Practicing psychologists
Population per square mile
<= 3.0
3.1 - 6
6.1 - 25
25.1 - 250
250.1 - 2,500
>= 2,500
Data source information
Data on practicing psychologists provided on 10/19/2010 by Peregrine Management Corporation.
http://www.peregrine.us
Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.
Metro Denver
Map prepared by the Colorado Health Institute
303 E. 17th Avenue, Suite 930
Denver, CO 80203
www.coloradohealthinstitute.org
Map created October 20, 2010
Wyoming
Nebraska
Utah
Kansas
New Mexico
Oklahoma
0 25 50 100 Miles
N


Social workers (2010) and population per square mile (2009), Colorado
Providers
Practicing social workers
Population per square mile
<= 3.0
3.1 - 6
6.1 - 25
25.1 - 250
250.1 - 2,500
>= 2,500
Data source information
Data on social workers provided on 10/19/2010 by Peregrine Management Corporation.
http://www.peregrine.us
Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.
Metro Denver
Map prepared by the Colorado Health Institute
303 E. 17th Avenue, Suite 930
Denver, CO 80203
www.coloradohealthinstitute.org
Map created October 20, 2010
Wyoming
Nebraska
Utah
Kansas
New Mexico
Oklahoma
0 25 50 100 Miles
N


Practicing mental health counselors (2010) and population per square mile (2009), Colorado
Providers
Practicing counselor
Population per square mile
<= 3.0
3.1 - 6
6.1 - 25
25.1 - 250
250.1 - 2,500
>= 2,501
Data source information
Data on practicing counselors provided on 10/19/2010 by Peregrine Management Corporation.
http://www.peregrine.us
Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.
Metro Denver
Map prepared by the Colorado Health Institute
303 E. 17th Avenue, Suite 930
Denver, CO 80203
www.coloradohealthinstitute.org
Map created October 20, 2010
Wyoming
Nebraska
Utah
Kansas
New Mexico
Oklahoma
0 25 50 100 Miles
N


Licensed Addiction Counselors (2010) and population per square mile (2009), Colorado
Colorado
Providers
Licensed Addiction Counselor (LAC)
Population per square mile
<= 3.0
3.1 - 6
6.1 - 25
25.1 - 250
250.1 - 2,500
>= 2,501
Data source information
Data on LACs downloaded on 10/25/2010 from the Colorado Department of Regulatory Agencies.
Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.
Metro Denver
BOULDER
BROOMFIELD
ADAMS
DENVER
JEFFERSON
DOUGLAS
Wyoming
Nebraska
Utah
Kansas
New Mexico
Oklahoma
MOFFAT
JACKSON
LARIMER
WELD
SEDGWICK
LOGAN
PHILLIPS
ROUTT
MORGAN
GRAND
RIO BLANCO
GILPIN
CLEAR CREEK
ARAPAHOE
YUMA
WASHINGTON
GARFIELD
EAGLE
SUMMIT
JEFFERSON
KIT CARSON
PITKIN
LAKE
PARK
DOUGLAS
ELBERT
LINCOLN
MESA
DELTA
TELLER
EL PASO
CHEYENNE
GUNNISON
CHAFFEE
MONTROSE
FREMONT
KIOWA
CROWLEY
OURAY
CUSTER
PUEBLO
SAN MIGUEL
SAGUACHE
OTERO
BENT
PROWERS
DOLORES
SAN JUAN
HINSDALE
MINERAL
RIO GRANDE
ALAMOSA
HUERFANO
MONTEZUMA
LA PLATA
ARCHULETA
CONEJOS
COSTILLA
LAS ANIMAS
BACA
Map prepared by the
Colorado Health Institute
303 E. 17th Avenue, Suite 930
Denver, CO 80203
www.coloradohealthinstitute.org
Map created October 20, 2010
0
25
50
100 Miles
N


Certified Addiction Counselors III (2010) and population per square mile (2009), Colorado
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250.1 - 2,500
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Data source information
Data on CACs downloaded on 10/25/2010 from the Colorado Department of Regulatory Agencies.
Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.
Metro Denver
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CROWLEY
OURAY
CUSTER
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COSTILLA
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Map prepared by the
Colorado Health Institute
303 E. 17th Avenue, Suite 930
Denver, CO 80203
www.coloradohealthinstitute.org
Map created October 20, 2010
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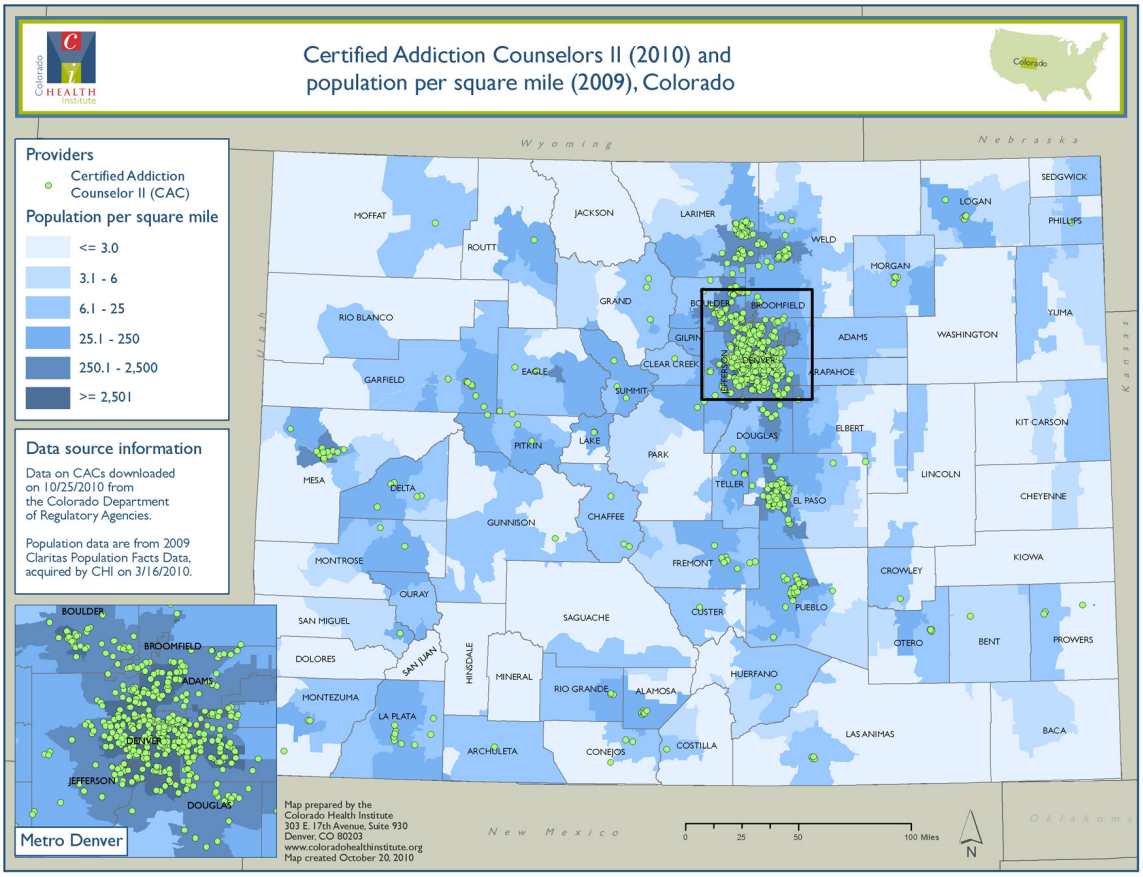
Certified Addiction Counselors II (2010) and
population per square mile (2009), Colorado
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Providers
Certified Addiction Counselor II (CAC)
Population per square mile
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3.1 - 6
6.1 - 25
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250.1 - 2,500
>= 2,501
Data source information
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Metro Denver
Map prepared by the Colorado Health Institute
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Wyoming
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New Mexico
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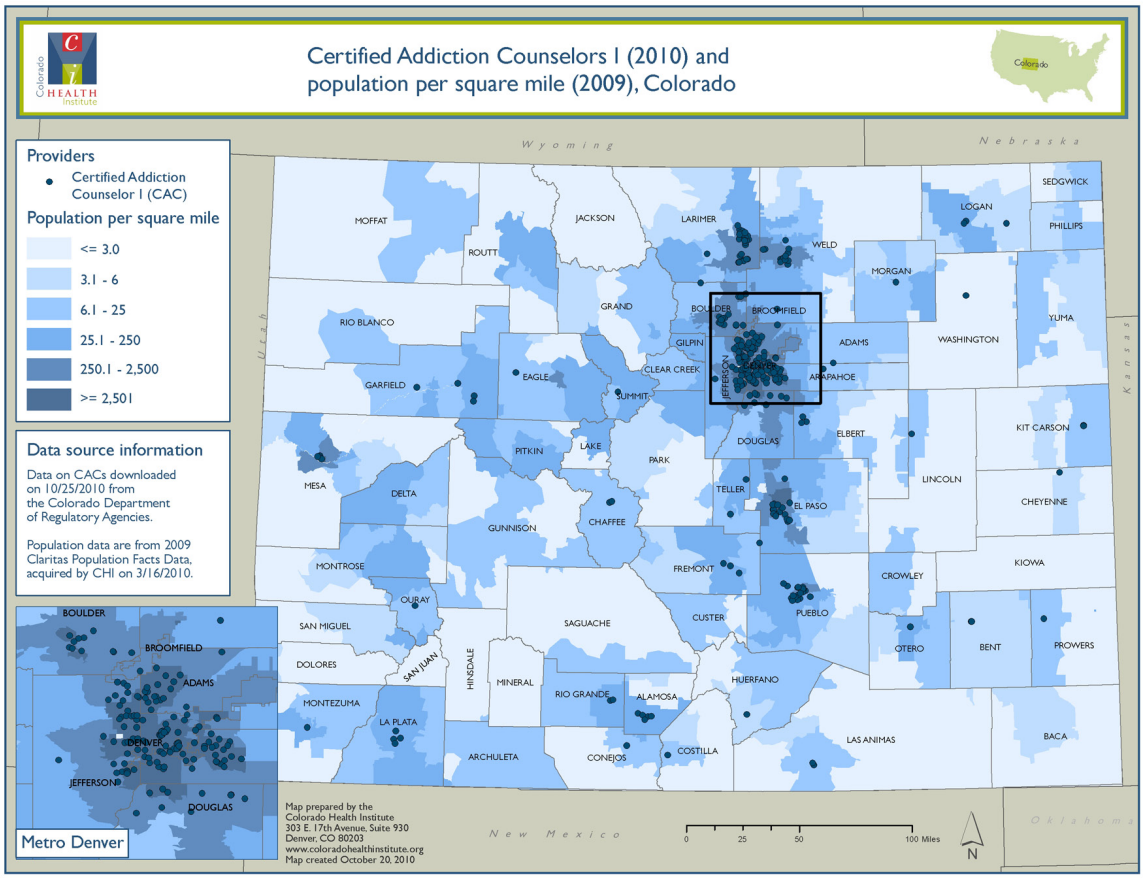
Certified Addiction Counselors I (2010) and
population per square mile (2009), Colorado
Colorado
HEALTH Institute
Providers
Certified Addiction Counselor I (CAC)
Population per square mile
<= 3.0
3.1 - 6
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database are actively providing direct services, and if they are, the amount of services they are delivering. However, data from *Mental Health, United States, 2004*[33] (see Table 2) shows that while most licensed behavioral healthcare professionals do provide some amount of direct service, not everyone does, and given the number of other types of work that some professionals are involved in, it is unlikely everyone is providing direct services on a full-time basis.

It would be valuable for behavioral health providers to have a general understanding of the minimum credentials needed to attain each license or category of behavioral health provider in Colorado (e.g., degree, clinical hours for licensure, supervision requirements, licensure exam requirement, etc.). See Appendix B for the minimum requrements for certification or licensing as an addictions counselor, social worker, psychologist, professional counselor, or marriage and family therapist.

Table 2. Percentage of clinically trained mental health personnel involved in each type of work activity, by discipline, for specified years[1]

	Discipline and Year							
Type of Work	Psychiatry 2002	Psychology[3] 2004	Social Work[4] 2004	Adv. Practice Psychiatric Nurses[10] 2003	Counseling[5] 2004	Marriage/ Family Therapy[6] 2004	Psycho-Social Rehab. 1994	School Psychology 2000[7]
(N)	(1,070)[2]	(51,354)	(103,128)	(7,759)	(100,533)	(50,158)	N/A	N/A
Patient care/ direct service	94.3	89.4	61.2	80.7	73.4	98.9	96.1	82.5
Research	20	24.5	0.3	1.3	0.4	N/A	N/A	2
Teaching	N/A	38.9	2.69	1.7	10.8	24	N/A	5.2
Administration	85.4	34.4	13.4	3.7	7.9	18.7	10.1	4.3
Other activities	85.1	39.4	8.8	12.6	7.5	36.5	N/A	6

[1] Percentages will not sum to 100 because clinically trained mental health personnel can be involved in more than one type of work activity.

[2] Respondents to the 2004 APA NSPP who are currently active in psychiatry (N = 1,095); data have been weighted. Note: 25 psychiatrists had missing information on type of work activity.

[3] Source: 2000 American Psychological Association Directory compiled by APA Research Office. Because 35,768 members did not specify work activities, percentages are based on the 25,298 members who responded and applied to the estimated number of clinically active psychologists in 2004.

[4] Source: National Association of Social Workers (NASW) PRN survey, 2004, which requested the principal role in the primary area of practice; thus, data are not comparable to other disciplines.

[5] Estimates are based on the 2000 National Study of the Professional Counselor, with growth rate taken from National Certified Counselor data.

[6] Estimates are based on 2004 national survey of clinical members of the American Association for Marriage and Family Therapy (AAMFT), which asked for primary and secondary job function.

[7] Data are from Thomas (2000) and replace earlier data.

[8] Includes staff supervision.

[9] Mainly consultation as other activity.

[10] Data are based on the total number of PMH-APRNs board certified by the American Nurses Credentialing Center (ANCC) as of October 2003, including clinical nurse specialists (adult and child) and psychiatric nurse practitioners (family and adult). Missing data are excluded.[34]

[33] Substance Abuse and Mental Health Service Administration. (n.d.) *Mental Health, United States, 2004*. Retrieved from <http://mentalhealth.samhsa.gov/publications/allpubs/SMA06-4195/>

[34] Substance Abuse and Mental Health Service Administration. (n.d.) *Mental Health, United States, 2004*. Retrieved from <http://mentalhealth.samhsa.gov/publications/allpubs/SMA06-4195/chp22table7.asp>

Colorado's Current Safety Net System

While Colorado is moving towards a better behavioral health system and integration of mental health and substance use disorder services, currently there is no *one system*. The state has created the Division of Behavioral Health by merging the Division of Mental Health and the Alcohol and Drug Abuse Division. "A mix of systems and providers, including community mental health centers (CMHCs), community health centers (CHCs), hospitals, schools, correctional facilities and other community-based organizations serve as Colorado's de facto mental health care system. Many of these providers act as the *mental health safety net* for low-income and medically indigent individuals."[35] Consequently, services frequently do not exist in a consistent fashion.

Because much of the behavioral healthcare workforce is employed by the safety net system, more detail about that system, who it serves and how, is included. The Colorado Health Institute (CHI) established the *Safety Net Indicators and Monitoring System (SNIMS)* in 2006 to inform communities and policymakers about the changing dynamics of Colorado's safety net system that provides primary health, mental and oral health care to the state's most vulnerable residents, and to arm them with the information needed to ensure the system's sustainability. A wide array of providers and systems, often but not always working together, constitutes Colorado's behavioral healthcare safety net[36]:

Behavioral Health Organizations (BHOs) - Medicaid managed mental health care organizations designated by the Colorado Department of Health Care Policy and Financing (HCPF) that represent five geographic service areas encompassing the entire state.

Community Mental Health Centers (CMHCs) - nonprofit or publicly operated clinics providing or arranging for core services to low-income individuals residing in designated geographic service areas. There are 17 CMHCs in Colorado; serving 89,213 adults and children in 2008.

Mental Health Specialty Clinics. The state contracts with these seven specialty clinics to serve the needs of special populations.

Hospital emergency departments have increasingly become de facto sites of mental health care for individuals with chronic and serious mental illness and substance abuse problems who find themselves in crisis.

Federally Qualified Health Centers (FQHCs) - provide comprehensive primary health care services to low-income populations of all ages. In 2007, Colorado's FQHCs provided 59,271 mental health visits to 16,502 individuals. Federally qualified health centers include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. [An FQHC Look-Alike is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, receives many of the same benefits as and FQHC, but does not receive grant funding.] FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.[37]

Rural health clinics (RHCs) - federally designated clinics that receive cost-based reimbursement for Medicare and Medicaid patients and are located in non-urban areas with documented shortages of health care providers or who serve medically underserved populations.

Other community-based clinics - nonprofit clinics and community-based programs, free clinics, faith-based clinics, clinics staffed by volunteer clinicians and family practice residency clinics that provide free or low-cost primary care services to low-income uninsured and underinsured families and individuals.

School-based health centers (SBHCs) - link low-income children to comprehensive coordinated health care services. The vast majority of SBHCs arrange for mental health services through collaborating community organizations that include CMHCs and other public and private mental health care providers. There are 45 SBHCs in Colorado.

Mental health triage centers - operate in certain areas of the state to provide an alternative to hospital emergency departments and jails for individuals experiencing a mental health crisis or requiring urgent care. Current triage centers are in place in Colorado Springs, Grand Junction, Durango

[35] Colorado Health Institute. (May 2009). *Colorado's Mental Health Safety Net*. Retrieved from <http://www.coloradohealthinstitute.org/~/media/Documents/sn/mental_health_primer.ashx>

[36] Note: Individuals with mental health only or co-occurring mental health and substance abuse issues are served by this system. However, individuals with substance abuse only frequently need to access services outside this system.

[37] Rural Assistance Center. (n.d.). *Federally Qualified Health Centers*. Retrieved from <http://www.raconline.org/info_guides/clinics/fqhc.php>

and Ft. Collins. A center is currently being planned for the Denver Metro Area.

Veteran's mental health resources - include veterans' organizations that provide mental health services in some Colorado communities to individuals who otherwise would have no access to such services.[38]

Colorado Mental Health Institutes - Voluntary and involuntary inpatient services are provided at two state-operated mental health institutes, the Colorado Mental Health Institutes at Ft. Logan and at Pueblo.

Very little is known about the behavioral healthcare workers employed in Colorado's safety net system. There is no public information on know how many employees, number of full-time equivalent (FTE), number of vacancies, length of vacancies, racial/ethnic/linguistic make up of workforce, age, credentialing/licensing of workforce, percent of FTE spent providing direct client care, etc. While individual executive directors may know a great deal about their own workforce, there are currently no efforts to collect, aggregate, and report on uniform data about the safety net behavioral healthcare workforce.

Even where services exist, there are almost no publically reported measures of the quality of the behavioral healthcare service delivery system. The Division of Behavioral Health (DBH) completes the Universal Reporting System (URS) tables and the National Outcome Measures (NOMS) for the Substance Abuse and Mental Health Services Administration (SAMHSA) as a requirement of receiving federal block grant money. DBH reports data provided by the Community Mental Health Centers and the Behavioral Health Organizations (BHO)[39] in Colorado. These data are available in the Mental Health Block Grant Implementation Reports submitted annually, every December. These data are reviewed by a Planning Council and are public, however, the data in its reported form is not the most meaningful for the public unless further analyzed and interpreted. Additionally, there is a plan to develop a web-based reporting application to allow the Mental Health Centers on-line access to their performance against the indicators.

The National Alliance on Mental Illness is the nation's largest grassroots organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI focuses on support, education and advocacy. In 2009 NAMI published the second version of Grading the states: A Report on America's Mental Health Care System for Serious Mental Illness, to provide a baseline for measuring progress toward the transformation envisioned by the New Freedom Commission[40] NAMI's report card shows (Appendix C), Colorado's overall grade on their healthcare system was a C, which is better than the National grade of a D and neighboring states which ranged between D's and F's. Colorado highest score (B) was in the category "Financing & Core Treatment/Recovery Services" - many of the components within this category graded much higher than the national score. Those components that Colorado scored below the national average within this category included: Inpatient Psychiatric Bed Capacity; Share of Adults with Serious Mental Illness Served; Assertive Community Treatment (ACT) (availability); State Supports Co-occurring Disorders Treatment; Access to Antipsychotic Medications; Clinically-Informed Prescriber Feedback System; Supported Employment (availability); and Integrated Dual Diagnosis Treatment (availability). Colorado scored lowest (F) in the category "Health Promotion & Measurement." This score was most likely low because eight of the sixteen components were graded with a zero including Workforce Development Plan and Workforce Development Plan-Diversity Components. Opinions vary as to how valid NAMI's report card is, however, there is very little other data available on quality of services.

Colorado's Pipeline

In order to meet the current unmet and future needs of those with behavioral health problems, a large number of professional positions in behavioral health need to be filled. Additionally, to foster workforce retention and quality services, those trained to become behavioral health clinicians require exposure to issues facing underserved populations and rural residents. A majority of the jobs in the behavioral healthcare field require a minimum of a Masters degree; therefore graduate higher education plays a very important role in the development of a majority of the workforce. According to the National Center for Public Policy and Higher Education[41], strengths and weaknesses in Colorado's higher education system include:

[38] Colorado Health Institute. (2009). *Primer: Colorado's Health Care Safety Net*. Denver, CO. Retrieved from <http://www.coloradohealthinstitute.org/~/media/Documents/sn/mental_health_primer.ashx>

[39] Behavioral Health Organizations contract with the Department of Health Care Policy and Finance to manage the Medicaid mental health benefit.

[40] National Alliance on Mental Illness. (n.d.) *Grading the States 2009*. Retrieved from <http://www.nami.org/Content/NavigationMenu/Grading_the_States_2009/Overview1/Overview.htm>

[41] The National Center for Public Policy and Higher Education. (2008). *Measuring Up in 2008 The National Report Card on Higher Education*. Retrieved from <http://measuringup2008.highereducation.org/states/report_cards/index.php?state=CO>

Preparation

Colorado performs well in preparing its young people for college, but there are large gaps by ethnicity. High school students score well on Advanced Placement tests, and Colorado is the top state in student performance on college entrance exams. However, only 69 percent of Hispanics have a high school credential, compared with 92 percent of whites.

Completion

Colorado performs fairly well – and has improved – in awarding certificates and degrees relative to the number of students enrolled. Fifty-three percent of college students complete a bachelor's degree within six years. However, only 42 percent of Hispanics graduate within six years, compared with 56 percent of whites.

Benefits

A large proportion of residents have a bachelor's degree, but gaps by race and ethnicity persist. Twelve percent of Hispanics have a bachelor's degree, compared with 42 percent of whites – one of the largest gaps in the nation. If all racial/ethnic groups had the same educational attainment and earnings as whites, total annual personal income in the state would be about $10 billion higher. It should be noted, that this example makes some unrealistic assumptions. The economy could not, in the short run at least, absorb the additional number of college graduates at current earnings levels, regardless of race. We cannot talk about adding providers to the current workforce and maintain the assumption that it is a value neutral position. The increased competition for the current number of higher level jobs would likely push earnings down for all graduates.

Participation

College opportunities for Colorado residents are only fair. The likelihood of enrolling in college by age 19 is fairly low, but a fairly high percentage of working-age adults are enrolled in higher education. Nineteen percent of Hispanic young adults are enrolled in college, compared with 41 percent of whites.

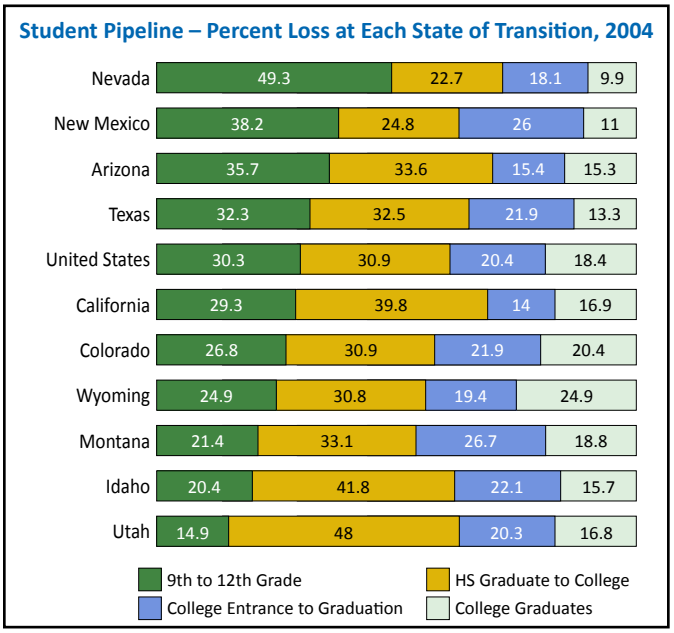
Affordability

Higher education has become less affordable for students and their families. Poor and working-class families must devote 43 percent of their income, even after aid, to pay for costs at public four-year colleges. Financial aid to low-income students is low. For every dollar in Pell Grant aid to students, the state spends only 41 cents.

Even in areas where Colorado is considered to be performing reasonably well e.g. Preparation and Completion, Colorado's racial and ethnic minorities are not performing nearly as well as their White peers. The racial and ethnic minority pipeline is already very constricted by high school graduation, and is almost non-existent at the baccalaureate degree level.

The size and nature of the workforce is determined, in part, by the numbers of new workers entering the workforce and the education levels of these entrants. The table below shows how Colorado stacks up to the mountain states, California, Texas, and the U.S.

Student Pipeline[42]



Notice that no state does predominantly well. Furthermore, across the U.S., Hispanics and African Americans have a much lower college attainment rate than other populations. Also, the nature of the loss differs considerably from state to state, even for states with similar overall performance. When considering the pipeline from student to behavioral healthcare professional, understanding the nature of the loss at each juncture is imperative.

42 Western Interstate Commission for Higher Education. (2007). *The Emerging Policy Triangle: Economic Development, Workforce Development and Education*. Retrieved from: <http://www.wiche.edu/pub/11558>

Colorado's Higher Education Behavioral Health Programs

Colleges and Universities within Colorado offer a wide variety of training options for those interested in degrees in psychology, social work, and counseling. There are fifteen different institutions offering almost forty different types of behavioral health degrees at the Masters level and over a dozen Doctoral opportunities, though most of these are in psychology. However, some of the Masters programs offered are "non-clinical" degrees, which do not prepare the student for licensure. Some of these programs are intended to prepare students for study in the non-clinical branches of psychology or are intended to prepare individuals to perform better in their chosen field, such as business or education. For example, the General Psychology Masters at the University of Colorado Denver "is not designed to prepare students for such licensure. Our program does not require enough credits, and does not include courses in such areas as group counseling and career counseling. Most states require that applicants for licensure have 48 credits from their M.A. degree program."[43] Non-clinical graduate degrees can be earned through online/distance educational experiences.

Many of Colorado's universities offer students the opportunity to take a small number of introductory courses online, but because "counseling" as it is practiced across the disciplines is a very interactive skill, most Master's and Doctoral programs require their students to spend a significant amount of time in classes on campus under the immediate supervision of a faculty member. Thus, students are trained in communities large enough to support a college campus. A majority of the terminal Master's programs take one to three years to complete if the student attends full-time with clinical degrees requiring some type of internship prior to graduation. Table 3 identifies which Colorado universities confer graduate behavioral health degrees.

[43] University of Colorado Denver Department of Psychology. (n.d.). *Related Graduate Programs*. Retrieved from <http://clas.ucdenver.edu/psychology/otherGradPrograms.html >

Table 3. Colorado's Clinical Behavioral Health Graduate Degree Granting Institutions

Institution	Psychologists*	Social Worker	Licensed Professional Counselor	Licenses Marriage and Family Therapists	Psychiatric/ Mental Health Nurse	Pastoral Counselor	Behavioral Mental Health Educators	School Counselor
Adams State								MA School Counseling
Argosy University Denver Campus	PsyD & MA Clinical Psychology; MA Forensic Psychology		EdD Counseling Psychology; MA Clinical Mental Health Counseling**	MA and Doctorate in Marriage and Family Therapy			EdD Counselor Education and Supervision	
Colorado Christian University @ Lakewood			MA in Counseling					
Colorado State University Ft. Collins	PhD Counseling Psychology	MSW Advanced Generalist	MEd Counseling/ Career Development	MS Couples and Family Therapist				
Denver Seminary			MA Clinical MH Counseling			MA Counseling Ministries; MA Youth & Family Ministries (non-licensure degrees); Doctorate of Ministry in Marriage & Family Therapy		
Iliff School of Theology						MA Pastoral & Spiritual Care		
Metro State University		MA Social Work (starting Fall 2011)						
Naropa University @ Boulder			MA Contemplative Psychotherapy; MA Applied Transpersonal Psychology; MA Somatic Counseling Psychology					
Regis University @ Denver				MA Marriage & Family Therapy				
University of Colorado @ Boulder	Clinical Psychology PhD (non-terminal MA Awarded); MA & PhD Educational & Psychological Studies							
University of Colorado @ Colorado Springs	MA Clinical Psychology; PhD Clinical Psychology (geropsychology)		MA Clinical Mental Health Counseling		Correctional Nursing & Forensic Nursing Certificates			MA School Counseling

Continued on next page

*To be licensed as a psychologist, one must possess a doctorate (PhD or PsyD) in psychology. MA & MS degrees in psychology are seen as part of the psychology pipeline.

**The 2009 CACREP standards require moving from the community counseling title to the clinical mental health counseling title.

NOTE: This information was gathered from the websites of the institutions during the summer of 2010.

Table 3. Colorado's Clinical Behavioral Health Graduate Degree Granting Institutions (continued)

Institution	Psychologists*	Social Worker	Licensed Professional Counselor	Licenses Marriage and Family Therapists	Psychiatric/ Mental Health Nurse	Pastoral Counselor	Behavioral Mental Health Educators	School Counselor
University of Colorado @ Denver	MA Clinical Psychology		MA Educational Psychology; MA Counseling Psychology & Counselor w/ concentrations in Clinical MH Counseling, Clinical MH/ Multicultural Counseling, Couples & Family Counseling, Shcool Counseling; EdS School Psychology		MS Family Psychiatric Mental Health Nurse Practitioner			
University of Denver	PsyD Clinical Psychology; MA Forensic Psychology; MA International Disaster Psychology; MA & PhD Counseling Psychology: PhD	MSW & PhD						MA & PhD & EdS Early Childhood School Psychology
University of Northern Colorado @ Greeley	PhD Counseling Psychology						PhD Counselor Education & Supervision	
University of Phoenix 6 CO Campuses	MS Psychology		MS Counseling/ Community Counseling; MS Counseling/ Mental Health Counseling	MS Counseling/ Marriage, Family and Child Therapy				MS Counseling/ School Counseling
University of the Rockies @ Colorado Springs	PsyD Clinical Psychology; MA General Psychology		MA Mental Health Counseling	MA Marriage & Family Therapy				

*To be licensed as a psychologist, one must possess a doctorate (PhD or PsyD) in psychology. MA & MS degrees in psychology are seen as part of the psychology pipeline.

**The 2009 CACREP standards require moving from the community counseling title to the clinical mental health counseling title.

NOTE: This information was gathered from the websites of the institutions during the summer of 2010.

Colorado Completion Rates for Graduate Behavioral Health Degrees

Colorado Completion Rates for Graduate Behavioral Health Degrees shows the number of advanced degrees granted by Colorado Colleges and Universities for the 2007-08 and 2008-09 academic years. In addition to the over thirteen hundred graduate behavioral health degrees granted, about 1,775 Bachelor's degrees were also granted each year. It is important to note that institutions do not indicate which degrees are clinical and which degrees are non-clinical when reporting the number of completions, thus the numbers below are an over estimate of potential clinicians.

Table 4. Colorado Completion Rates for Graduate Behavioral Health Degrees*

College/University	Degree Classification	Degree Type	2007-08	2008-09
Adams State College	Counseling Psychology	Masters	65	74
Argosy University-Denver	Counselor Education/ School Counseling & Guidance Services	Doctors (old classification)	0	
	Counseling Psychology	Masters	0	11
Colorado Christian University	Counseling Psychology	Masters	39	50
Colorado State University	Psychology, General	Masters	21	12
	Psychology, General	Doctors (old classification)	12	16
	Social Work	Masters	50	79
Denver Seminary	Counseling Psychology	Masters	56	56
Naropa University	Counseling Psychology	Masters	96	80
Regis University	Counseling Psychology	Masters	73	56
	Counseling Psychology	Post-masters certificate		1
	Marriage and Family Therapy/ Counseling	Post-masters certificate		1
University of Colorado at Boulder	Psychology, General	Masters	9	12
	Psychology, General	Doctors (old classification)	9	19
	Educational Psychology	Masters	1	1
	Educational Psychology	Doctors (old classification)	2	1
University of Colorado at Colorado Springs	Counselor Education/ School Counseling & Guidance Services	Masters	50	66
	Psychology, General	Masters	9	8
	Gero-psychology	Doctors (old classification)	1	
University of Colorado at Denver	Counselor Education/ School Counseling &Guidance Services	Masters	43	54
	Psychology, General	Masters	8	11
	School Psychology	Post-masters certificate	19	7
	Educational Psychology	Masters	73	68
University of Denver	Psychology, General	Masters	6	4
	Psychology, General	Doctors (old classification)	8	8
	Clinical Psychology	Masters	22	23
	Clinical Psychology	Doctors (old classification)	31	36
	Counseling Psychology	Masters	24	24
	Counseling Psychology	Doctors (old classification)	8	6
	School Psychology	Masters	3	2
	School Psychology	Post-masters certificate	5	8
	School Psychology	Doctors (old classification)	6	1
	Forensic Psychology	Masters	28	30
	Social Work	Masters	220	207
	Social Work	Doctors (old classification)	1	5
University of Northern Colorado (continues on next page)	Counselor Education/ School Counseling & Guidance Services	Masters	23	15
	Counselor Education/ School Counseling & Guidance Services	Doctors (old classification)	3	
	Counseling Psychology	Masters	61	48
	Counseling Psychology	Doctors (old classification)	5	5
	School Psychology	Post-masters certificate	15	7

	School Psychology	Doctors (old classification)	3	11
	Educational Psychology	Masters	4	5
University of Northern Colorado	Educational Psychology	Doctors (old classification)	2	2
	Counselor Education/ School Counseling & Guidance Services	Masters	97	74
	Counseling Psychology	Masters	1	22
University of Phoenix-Denver Campus	Mental and Social Health Services and Allied Professions, Other	Masters	27	
	Psychology, General	Masters		1
	Counselor Education/ School Counseling & Guidance Services	Masters	15	26
	Counseling Psychology	Masters	5	16
	Mental and Social Health Services and Allied Professions, Other	Masters	17	
University of Phoenix-Southern Colorado Campus	Mental Health Counseling/ Counselor	Masters		1
	Clinical Psychology	Masters	11	0
	Clinical Psychology	Doctors - research/ scholarship (new classification)	21	13
	Clinical Psychology	Doctors - research/ scholarship (new classification)		39
University of the Rockies	Counseling Psychology	Masters		0
Colorado Totals			**1308**	**1322**

Note: This analysis was run on data made available through the National Center for Educational Statistics utilizing the Classification of Instructional Programs (CIP) codes. These degree classifications are from a list of possible classifications. Each reporting institutions choose how they want to report each type of degree they confer. It is highly likely that degrees that with similar requirements have been assigned different CIP codes. These degree classifications do not have a one-to-one correspondence with the way institutions market the degrees they grant.

Innovations in Instruction

Several Colorado institutions of higher education are currently offering professional training programs that are non-traditional in some respect, e.g. how they are delivered, where they are delivered, and the focus of the training program. Additional information about each of these programs is available in Appendix D.

Colorado State University

The School of Social Work offers a Master of Social Work distance education program in Brighton, Colorado and also on-campus through the Division of Continuing Education in Colorado Springs. The degree program is designed for working professionals who are looking for a part-time degree program that allows them to continue working while they earn an advanced degree. Colorado State University-Pueblo Continuing Education operates in the military education centers on the Ft. Carson and Peterson Air Force Base installations offering Social Work baccalaureate degree completion programs on base.

University of Denver

The Graduate School of Social Work (GSSW) Programs of Study Four Corners MSW Degree Program located in Durango, Colorado offers a weekend schedule of Friday afternoon and Saturday classes. Because 25 percent of the student enrollment comes from the area's many Native tribes, the Four Corners program includes a special focus on Native social work content. GSSW's Four Corners MSW program has been available to area students at a reduced-tuition rate since 2002. Additionally, GSSW and Fort Lewis College have a partnership that enables students in the Four Corners area to earn both a Bachelor's degree in psychology or sociology and Master of Social Work (MSW) degree in less time that it typically takes to earn both degrees.

Peace Corps Fellows/USA and Teach for America Partnership Programs

In recognition of their commitment to service, GSSW provides extra financial assistance and other benefits for Returned Peace Corps Volunteers (RPCVs) and Teach for America alumni who pursue a Master of Social Work (MSW) degree.

Metropolitan State College of Denver Master of Social Work Program at Metropolitan State College beginning Fall 2011

"The focus of the department is on problems that often affect oppressed minorities representing people of color (African American, Hispanic, Native American, Asian

American) and other diverse populations (women and children, gays and lesbians, the developmentally delayed and the aging). The department is committed to helping those individuals in need and working toward leadership in the social, economic and political context that often fosters painful and socially unjust human conditions."

University of Colorado Denver School of Medicine

Fellowships in Advanced Clinical Infant Mental Health Training

The Irving Harris Program in Child Development and Infant Mental Health offers a training program for postdoctoral graduates and experienced infancy and early childhood professionals who are seeking "community-based" training in infant and early childhood mental health.

Postdoctoral Fellowship in Developmental Disabilities Psychology

JFK Partners--The University Center of Excellence in Developmental Disabilities offers a post-doctoral fellowship focused on the development of disciplinary and interdisciplinary expertise, leadership and consultation skills and research as well as clinical growth in interdisciplinary approach to research, assessment, and intervention, family support, service coordination, and community integration to meet the needs of persons with developmental disabilities.

Postdoctoral Fellowship in Administration and Evaluation Psychology

The UCD Department of Psychiatry in partnership with community stakeholders developed the program in response to perceived gaps in the higher education of psychologists. Fellows experience an intensive 12-month training which uniquely positions them for the healthcare marketplace. In 2004 the program won the award for educational innovation from the Annapolis Coalition on Behavioral Health Workforce Education. This program is designed to provide behavioral health training in the areas of program evaluation, administration/ management, public policy, and leadership for new or mid-career psychologists.

Clinical Training Programs for Substance Abuse

Addiction counselors work with individuals with substance use disorders or other behavioral addictions. They provide counseling for individuals, families, and groups and work to help their clients focus on life problems and behaviors that relate to their addictions. Addiction counselors also work with mental health and health professionals, the police and courts, as well as schools to prevent substance abuse problems.[44] In Colorado there are four levels of credentialing for addiction professionals: Certified Addiction Counselor, Level I (CAC I); Certified Addiction Counselor, Level II (CAC II); Certified Addiction Counselor, Level III (CAC III); and the Licensed Addiction Counselor (LAC). The amount of training and field experience determines the level of credentialing or licensure. A Licensed Addiction Counselor has a clinical Masters degree along with specialized training and supervised practice and has passed a national examination. Those individuals who do not possess a clinical Masters degree or above, may receive specialized training at colleges or training centers. The Addiction Counselor Certification and Licensure Rules were revised effective 09-01-2010 and have increased the requirements in several areas. See Appendix E for the Guide to the CAC Rules.

In summary, it is not clear that higher education programs include sufficient training on how to understand, navigate, and respond to a changing health care system (e.g., evidence based practice training in their curricula, training on the public behavioral health system and how it is financed, increased diversification of placing students in community, public, non-profit settings, training on alternative job opportunities and settings in the behavioral health field). One innovation that was conspicuously missing from the university websites was any advances being made in training about integrating behavioral healthcare into primary care settings.

Colorado Behavioral Healthcare Workforce Interview Data

The Colorado Health Foundation requested individuals with knowledge about Colorado's behavioral healthcare workforce and its pipeline be interviewed. A total of ten individuals from the Division of Behavioral Health, non-profit clinical service agencies, training institutions, and policy groups were interviewed, several were interviewed more than once to ensure clarity. Data from these interviews is presented below. Because interviewees were granted anonymity, the number of respondents giving any particular response is referred to in a general manner. The intent of the analysis is to

[44] Colorado Health Career Guide. (n.d.). *Mental Health Substance Abuse Counselor*. Retrieved from <http://www.coloradohealthcareers.org/find_career.asp?id=41>

add a level of detail and specificity not found in many of the other data sources. We asked interviewees to give us their impression of the current behavioral healthcare workforce, including defining who they were talking about; to talk about issues unique to Colorado; to discuss training, education and continuing education; and to talk about what they believe needs to happen to increase the **quantity** and **quality** of Colorado's behavioral health care workforce both in the short and the long term.

When asked to describe Colorado's current behavioral healthcare workforce interviewees agreed that it is a "patchy," "disjointed," "diverse mix of providers that is fragmented," "that is woefully inadequate" to meet Coloradan's behavioral health needs, especially the needs of those who access the safety net system, live in rural/frontier areas, live in urban uninsured or underinsured areas, or who need services in a language other than English. Deepening the understanding of the scarcity of provider issue, an interviewee offered the following example: a northeastern Colorado community might have enough work to keep a Child Psychologist busy for two full days/week but not enough need to keep a Child Psychologist busy for five full days per week, so if a Child Psychologist was to go to the community to live, it would be difficult for him/her to earn enough, because the need is simply not big enough for a full-time job.

With respect to providers, some interviewees noted that the most extreme scarcity exists with psychiatrists and clinical providers with specialties such as geriatric, infants, or extreme psychological disorders. Interviewees said that in addition to lack of available services, many times these same people must also deal with difficulties accessing the service and issues related to lack of privacy. There is general agreement that the more metropolitan areas tend to have an adequate workforce and fewer issues related to access and privacy. Several interviewees commented that the issues of scarcity, accessibility and privacy are evident across the country and are not limited to Colorado or the western states with one individual taking exception by noting that there are some areas where people want to live but providers cannot afford to live: "in areas such as Aspen the cost of living is very high, making it difficult for behavioral health professionals to make a living and such areas tend not to attract professionals who desire to work with individuals with more serious disorders."

Interviewees were very consistent in defining the behavioral healthcare workforce as: LPCs, LSCWs, MFTs, psychiatrists, psychologists, PCPs, physician assistants, nurse practitioners, CAC I, II & IIIs, LACs – licensed addiction counselors, and importantly – primary care providers and care managers. Some interviewees also included: the clergy, navigators, promatoras, culenderas, crisis counselors and peer support specialists.

Several interviewees commented on the role of para-professionals. The general consensus was that para-professionals in the form of peer specialists "fit nicely in with care managers – with providing patient/family support"…"they can co-facilitate groups, implement specific curriculum that is already developed" and "play a meaningful role in areas such as suicide prevention."

Current concerns were summed up nicely by this interviewee: "People's intentions are good but that is not sufficient to achieve good client outcomes; mental health work is sometimes counter intuitive. Training, supervision, licensing and continuing education are important in achieving effective outcomes." Interviewees are anxiously awaiting the development of state oversight of paraprofessionals including a definition of a scope of practice, core competencies, quality assessment/improvement activities, and training and licensing/registration requirements.

Interviewees report that the larger system has not yet created a place for peer specialists in the workforce. They report few people are currently employed as peer specialists, and there is little incentive for providers to hire them without reimbursement possibilities. A few interviewees noted that if peer specialists are to be utilized as behavioral health providers then it will become necessary for the larger system to address reimbursement issues. One interviewee noted that "with current full-time Master's prepared positions being advertised at $34,000, it is difficult to imagine how the system will be able to offer peer specialists a living wage."

Nowhere is the overlap of scope of practice of the various clinical disciplines more evident than at the agency/provider level. "[We] do not classify staff by their degree. They are classified by their job description – if we wrote down all the degrees on paper, the public would have no idea who the workforce is. When they go to a MH center – they go to a case manager, psychiatrist, etc., they don't necessarily know or understand the degree." Many interviewees commented that Colorado's education and training programs are producing workers who are generally well prepared for entry level jobs, and that current licensing requirements are working fairly well across disciplines. However, several interviewees noted that "An overarching structure" that ameliorates the fact that type of degree often matters most when an agency

or provider is seeking reimbursement and little to not at all when a client is being served.

Colorado's Current Behavioral Healthcare Workforce Efforts

The information included in this section illustrates some of the current activities that are related to behavioral healthcare workforce development in Colorado. These activities vary in objective and scope with regard to their relevance to behavioral healthcare workforce development. When possible, the relevance of these activities is noted in the respective description to help readers understand how they are connected to behavioral healthcare workforce development.

The Colorado Health Professions Workforce Policy Collaborative

Administered by the Colorado Rural Health Center and funded by The Colorado Trust, the Colorado Health Professions Workforce Collaborative consists of policy leaders, health care providers, educational institutions, economic development, and workforce planning authorities working collectively to establish a strategic public policy framework for Colorado that will advance health professions workforce priorities to alleviate provider shortages and strengthen the health care system. In 2010, the Collaborative released a public policy agenda addressing Colorado's primary care provider shortage. For more information on the Collaborative, please see http://workforcecollaborative.blogspot.com/.

Relevance to Behavioral healthcare workforce: This active workgroup, while often focused on health workforce in general, will be making some policy recommendations related to mental/behavioral health and oral health. A few collaborative members represent behavioral health and will be involved in obtaining input from other stakeholders to inform recommendations that may impact behavioral health providers.

The Partnership for Mental Health and Substance Abuse Reform

The Partnership for Mental Health and Substance Abuse Reform (Partnership) consists of WE CAN! (Wellness and Education Coalition and Advocacy Network of Colorado), the Federation of Families for Children's Mental Health-Colorado Chapter, Mental Health America of Colorado, Colorado Psychiatric Society, Colorado Psychological Association, Colorado Behavioral Health Care Council, NAMI-CO, National Association of Social Workers—Colorado Chapter and the Colorado Association of Alcohol and Drug Service Providers. The group meets once a month. The mission of the partnership is to raise awareness of mental health and substance abuse issues and ensure quality systems of care and treatment, policy and funding for mental health and substance abuse through collaborative cooperative efforts and action.

Relevance to Behavioral healthcare workforce: This is an example of a cross-behavioral health group that convenes to discuss ways to collaborate. It could be a model for other cross-discipline work or a platform for behavioral healthcare workforce development planning discussions.

Lay/Peer-Based Programs

Peer Specialist Programs

Peer Specialists are mental health consumers who have completed a peer counseling training course, and have demonstrated the skill, motivation, and desire to help their peers in a counselor role. They are trained to help consumers set goals, make decisions, solve problems, deal with conflicts, and deal with the stress of everyday living. They are trained to listen, support, and encourage consumers. They help consumers locate food, shelter, and other community resources. Peer Specialists are **not** therapists, and are trained to refer therapeutic issues to therapists. Referenced from the http://www.peertraining.com/ website.

There are two main peer specialist training programs in Colorado, each originating in one of the Behavioral Health Organizations (BHO) who contract with the Department of Health Care Policy and Finance to manage the Medicaid mental health benefit. One program, managed by Nate Rockiter, is called Peer to Peer (peertraining.com) who works primarily with Behavioral Healthcare Inc. (a BHO) and teaches the curriculum through the Community College of Denver. The other program is delivered by Ed Knight, Ph.D., who provides his week-long training to anyone in the state who is interested. Dr. Knight is connected to Colorado Health Partners and ValueOptions in Colorado Springs.

While all community mental health centers in Colorado use peer specialists and family advocates in some way, many do not have formal peer specialist programs with allocated staff positions for these services (e.g., case management, self-help groups, Drop-in Centers, and Club Houses). Many peer-driven services are more informal, with peers doing things such as transporting consumers to various appointments on a volunteer basis. They are

not really doing peer specialist work – case manager/ groups – they are driving the van.

In order to be formally called a peer specialist, one must complete a training course that teaches toward a set of core competencies for this type of position. While there was a set of core competencies developed at the Advocate Forum in Colorado, there is no credentialing system in Colorado to formally recognize this work on a statewide basis. Please see Appendix E for a document identifying an overview of the Colorado Peer Network training plan and Appendix F for a table summarizing the use of peer services in Community Mental Health Centers in Colorado.

Relevance to Behavioral healthcare workforce: Persons in recovery from mental illnesses and their family members are essential members of the workforce, as they have both formal (i.e., peer specialist programs and family support services) and informal roles (self-help and family caregiving) in caring for themselves and other consumers of behavioral health care. Some people recover well enough to pursue further education and are able to be licensed and provide treatment services.

Mental Health First Aid (MHFA) Colorado

Mental Health First Aid (MHFA) is an innovative program for community-level enhancement of mental health services (Jorm, Kitchener, Kanowski, & Kelly, 2007). The MHFA Course gives community members skills to help someone with a developing mental health problem or someone who is in a mental health crisis situation. The MHFA Course has been thoroughly evaluated using randomized controlled trials and a qualitative study and has been effective at improving participants' knowledge of mental disorders, reducing stigma, and increasing the amount of help provided to those with mental health problems.[45] [46] [47] [48] Individuals who have undergone MHFA training show better identification of mental health disorders, greater likelihood of advising individuals to seek professional help, decreases in stigmatizing attitudes, and improved mental health in the participants themselves.[49] [50] Similar to First Responder Training in the Emergency Medical Services (EMS) system, MHFA prepares non-healthcare professionals to identify, support, and facilitate the referral of individuals experiencing mental distress.

Approximately two years ago, several stakeholders met to discuss how Colorado could coordinate statewide MHFA efforts and potentially evaluate their effectiveness. This was, and still is, an informal group made up of individuals representing the Colorado Behavioral Healthcare Council (CBHC), the Colorado Division of Behavioral Health (DBH), National Alliance for the Mentally Ill-Colorado (NAMI), Mental Health America-Colorado (MHAC), The Colorado Federation of Families, and the Western Interstate Commission for Higher Education (WICHE) Mental Health Program. This group has met consistently over the past few years to identify the primary needs related to rolling out MHFA across the state. Currently, there are over 80 instructors across Colorado. Over the past year, the main stakeholders noted above, opened the meetings to MHFA instructors in Colorado as a way to facilitate connection to other instructors across the state. To date, this group has not secured funding to formalize its efforts to provide infrastructure and evaluation to the MHFA in Colorado. This formalization would put Colorado in a leadership position as many states do not have a systemic understanding of MHFA statewide efforts, nor are they able to demonstrate the potential effectiveness of this model.

Mental Health America of Colorado (MHAC) has two MHFA trainers on staff. Mental Health First Aid training forms an integral part of the mental health resources MHAC brings to Charter Schools in Colorado. By educating school staff and other school personnel in MHFA, MHAC succeeds in extending the protection of at-risk youth in these schools. As a direct result of the training, school personnel are more able to provide effective interventions to students experiencing mental health crises, and refer these students appropriately for professional follow-up care.

Relevance to Behavioral healthcare workforce: Mental Health First Aid (MHFA), a mental health literacy program, could be an important part of expanding lay behavioral healthcare workforce capacity (broadly defined) in communities in Colorado. In addition, the MHFA program may decrease stigma and enhance

[45] Jorm, A. F., Kitchener, B. A., O'Kearny, R., & Dear, K. B. G. (2004). Mental health first aid training of the public in a rural area: a cluster randomized trial [ISRCTN53887541]. *BMC Psychiatry*, 4, 33.
[46] Kitchener, B. A., & Jorm, A. F. (2002). Mental health first aid training for the public: Evaluation of effects of knowledge, attitudes, and helping behavior. *BMC Psychiatry*, 2, 10.
[47] Kitchener, B. A., & Jorm, A. F. (2004). Mental health first aid training in a workplace setting: A randomized controlled trial [ISRCTN13249129]. *BMC Psychiatry*, 4, 23.
[48] Kitchener, B. A., & Jorm, A. F. (2006). Mental health and first aid training: Review of evaluation studies. *Australian and New Zealand Journal of Psychiatry*, 40, 6-8.
[49] Jorm, A. F., Kitchener, B. A., O'Kearny, R., & Dear, K. B. G. (2004). Mental health first aid training of the public in a rural area: a cluster randomized trial [ISRCTN53887541]. *BMC Psychiatry*, 4, 33.
[50] Kitchener, B. A., & Jorm, A. F. (2004). Mental health first aid training in a workplace setting: A randomized controlled trial [ISRCTN13249129]. *BMC Psychiatry*, 4, 23.

understanding of mental illness, how to intervene, and potentially encourage a training participant to consider a behavioral health career.

Colorado Loan Repayment Programs

Colorado State Loan Repayment Program

The Colorado State health care professional loan repayment program (Colorado Health Service Corps) helps health and behavioral health care providers working in health professional shortage areas repay their educational loans.

Certain behavioral health professionals may be eligible to receive repayment of qualified student loans if they practice in a Health Professional Shortage Area (HPSA), delivering health services, in a public or nonprofit clinic. The practice must accept public insurance and offer discounted services to low-income, uninsured patients. Nontaxable awards may be made up to $35,000 for each year of service. All contracts are for two to three years, though the program's goal is to facilitate long-term retention of the provider in an underserved Colorado community beyond his or her contract with the state.

Eligible health and behavioral health providers include (behavioral health providers noted in lighter text):

1. CNM - Certified Nurse-Midwives
2. CP - Clinical or Counseling Psychologists (Ph.D., Psy.D. or equivalent)
3. DDS & DMD - Dentists (general and pediatric practice)
4. DO & MD - Doctors of Osteopathic or Allopathic Medicine (family medicine, geriatrics, general internal medicine, general psychiatry, general child psychiatry, general pediatrics, and general obstetrics/gynecology)
5. LCSW - Licensed Clinical Social Workers (master's or doctoral degree in social work)
6. LPC - Licensed Professional Counselors (master's or doctoral degree with a major study in counseling)
7. MFT - Marriage and Family Therapists (master's or doctoral degree with a major study in marriage and family therapy)
8. NP - Primary Care Certified Nurse Practitioners
9. PA - Primary Care Physician Assistants
10. PNS - Psychiatric Nurse Specialists
11. RDH - Registered Dental Hygienists

The State Health Care Professional Loan Repayment Program is administered by the Primary Care Office at the Colorado Department of Public Health and Environment with funding from the State of Colorado, the U.S. Health Resources and Services Administration, the American Recovery and Reinvestment Act, and The Colorado Health Foundation. For more information on specific eligibility requirements and to complete the online application, visit www.cdphe.state.co.us/pp/primarycare/shplrp.

National Health Service Corps in Colorado

The National Health Service Corps (NHSC), is a federally-sponsored program through the Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (HHS). NHSC offers scholarship and loan repayment programs for health and behavioral health providers who work in Health Professional Shortage Areas (HPSAs) in the U.S.

Eligible providers include (behavioral health professions noted in lighter text):

- Physician (MD or DO)
- Dentist (general or pediatric)
- Nurse Practitioner (primary care)
- Certified Nurse-Midwife
- Physician Assistant
- Dental Hygienist
- Psychologist (health service)
- Licensed Clinical Social Worker
- Psychiatric Nurse Specialist
- Marriage and Family Therapist
- Licensed Professional Counselor

To become a NHSC approved site, Colorado provider organizations must meet several requirements (e.g., practice address is in a Health Professional Shortage Area, practice designated site serves rural or underserved populations). Sites need to be designated before they can post job opportunities connected to the loan repayment option. The more sites that are eligible for NHSC providers, the more providers can capitalize on this opportunity and the more provider agencies can increase recruitment and retention of these professionals. For more information on the NHSC site application process, please see http://www.nhsc.hrsa.gov/communities/apply.htm).

NHSC Data for Colorado

As of 8/16/10, there were a total of 231 NHSC-Approved Sites and 104 sites with NHSC Clinicians. The total count for NHSC participants was 197. These numbers include both health and behavioral health NHSC providers. Sixty (30 percent) of these participants represent mental health disciplines. This number may be slightly higher if the number of psychiatrists (out of the 48 physicians) were identified. Of the 124 NHSC vacancies in Colorado, 26 (approximately 21 percent) of these are mental health provider positions.

NHSC data does not provide the whole picture. The number of sites is driven by how many sites are NHSC approved, therefore, there are likely many more provider sites that are eligible for NHSC status or would be if their facility was a designated Health Professional Shortage Area, a requirement to be an NHSC site. The number of vacancies is driven by how many sites post jobs in a given discipline. So just because the number of vacancies for a particular discipline may be low, this does not indicate that the need does not exist for these providers outside of the NHSC provider sites. Another complicating factor is that sites are not classified as a mental health site versus primary care versus dental. One site can have three types of HPSAs, therefore it is difficult to determine if sites have increased over a period of time in a specific category. For more information on the sites, they are all listed online at: http://datawarehouse.hrsa.gov/HGDWReports/OneClickRptFilter.aspx?rptName=NHSCAppSiteList&rptFormat=HTML3.2.

NHSC Participants

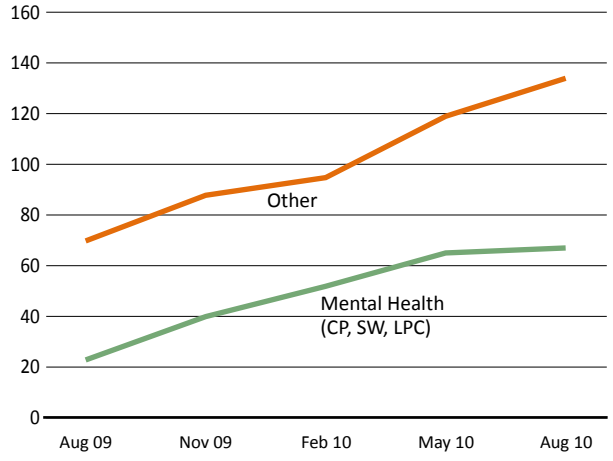
Discipline	FTE
Physician	48
Physician Assistant	38
Nurse Practitioner	25
Nurse Midwife	8
Licensed Professional Counselor	36
Social Worker	22
Marriage and Family Therapist	1
Clinical Psychologist	7
Dentist	10
Dental Hygienist	2
TOTAL	**197**

Posted NHSC Vacancies in Colorado

Discipline	Current Vacancies
Social Worker	7
Psychiatrists	0
Clinical Psychologist	4
Marriage and Family Therapist	0
Licensed Professional Counselors	15
Nurse Practitioner or Physicians Assistant	30
Physician	62
Dentist	4
Dental Hygienist	2
TOTAL	**124**

The chart below shows the increase in NHSC providers in Colorado over the past 12 months. While the numbers in both the mental health providers and all other NHSC clinicians categories increase, the increase for mental health providers is slightly more flat than for all other NHSC clinicians. It is unclear why the increase in mental health providers is less pronounced than for other NHSC clinicians. It could be that more sites that employ other NHSC clinicians applied for and received approval to be a NHSC site than those organizations with mental health providers. A subcommittee of the Colorado Rural Recruitment and Retention Network (CoRRN), attempted to market new NHSC opportunities to mental health providers across the state in May 2010. An electronic announcement was disseminated to over 2500 Colorado providers and/or associations. The impact of this marketing blast in terms of whether this announcement led to any increase in NHSC sites among mental health providers is not understood at this time. The table after the chart identifies the numbers utilized to run the line graph.

Mental Health vs All Other NHSC Clinicians in Colorado



DATE	Other	Mental Health*	Total
25-Aug-10	134	67	201
25-May-10	119	65	184
25-Feb-10	95	52	147
25-Nov-09	88	40	128
25-Aug-09	70	23	93

*Includes Clinical Psychologist, Social Workers, Licensed Professional Counselors, and Marriage and Family Therapists (does not include psychiatrists that are folded into the physician category)

Additional loan repayment options are available at http://www.cdphe.state.co.us/pp/primarycare/chsc/loanrepaymentoptions.html.[51]

Relevance to Behavioral healthcare workforce: Loan repayment programs can be part of a strategy to recruit and retain professionals into positions of need in the state. Behavioral health professionals are eligible in the programs noted above. Therefore is important for both behavioral health professionals and providers to be aware of their existence in order to capitalize on the recruitment and retention benefits of such programs. For recruitment efforts, it is critical to identify people who have a desire to live and work in rural and underserved settings. Perhaps even more important is to identify people currently living and working in rural and underserved settings and provide them opportunities to "train up" into needed behavioral health positions in the community.

Clinical Training Opportunities for Behavioral Health Professionals in Colorado

The availability of clinical training opportunities (i.e., the geographic location, organization information, and for which discipline) is an area of behavioral healthcare workforce that is not well understood at a meta-level. In other words, the type of training opportunity (internship, practicum), for whom (social worker, psychologist), what type of organization (prison setting, community mental health center), and where it is located geographically is generally understood within each discipline but not across disciplines. Complicating this is the fact that a person with a different degree may be eligible for the same training opportunity (e.g., a LCSW and a LMFT may both be eligible for a clinical placement and then employment in a given agency).

For some disciplines, such as psychology, it is possible to determine the number of internship sites in Colorado. An internship in psychology is a training program that provides educational and clinical experience in order to prepare pre-doctoral students for the practice of professional psychology. Internships are typically year-long clinical work experiences that involve completing several major and/or minor rotations (e.g., inpatient, outpatient, neuropsychology, forensic, etc.) An APA-accredited internship is one that has met the standards set by the APA's Commission on Accreditation (CoA). The process of becoming accredited includes a self-study by the internship program, and a review and site visit by the CoA. APA accreditation is the highest level of certification that an internship program in psychology can attain, and it sets the standard for high quality training nationally. Achieving accreditation helps to ensure that internship programs are setting and achieving high but reasonable standards in education and service delivery. Additionally, licensure for clinical psychologists in most states requires the completion of an APA-accredited internship or equivalent. Without licensure, most psychologists cannot be reimbursed for services.

There are currently 16 doctoral level internships in Colorado and 11 of those are APA-accredited. All of these opportunities are centralized in the Front Range region (i.e., Denver, Aurora, Fort Collins). This speaks to the need for increased training opportunities in more rural parts of the state. See Appendix G for a list of the APA Accredited Psychology Internships in Colorado.

There is not one centralized location (organization or website) where an individual could determine training opportunities for other disciplines at the same time. While mapping the current behavioral health training opportunities in the Colorado would be a significant endeavor, it would be helpful to identify the gaps in training locations across disciplines and geographic areas.

Relevance to behavioral healthcare workforce: Understanding where clinical training opportunities exist across behavioral health disciplines is important in identifying gaps in need for providers in certain disciplines and/or geographic areas. It is also important to remember that individuals often make a decision to work near where they complete their training, so the more we can recognize the parameters of the training opportunities in Colorado, the better we can plan for maximizing and expanding on those prospects.

Behavioral Health Transformation Council

In 2007, the Colorado Legislature passed House Joint Resolution 07-1050, creating a task force to study behavioral health funding and treatment in Colorado ("1050 Task Force"). The 1050 Task Force's charge was to study mental health and substance abuse services

[51] Data in this section was received from the HRSA-Colorado Region VIII Office

in order to coordinate state agency efforts, streamline services provided, and maximize federal and other funding sources. The 1050 Task Force members consisted of six legislators, a representative of the Governor's Office, a representative from the Colorado Chapter of the Federation of Families for Children's Mental Health, and representatives from the following key departments of state government: Human Services; Health Care Policy and Financing; Public Health and Environment; Corrections; Public Safety; Education; and Law (McHugh, D., Lynn, J., Portman-Marsh, N., Kahn, R., 2008).

As a part of the final report, one of the recommendations was related to workforce development (see below in italics).

> *As Colorado develops its envisioned integrated behavioral health system, it will need to develop an appropriate workforce to address the behavioral health needs of Coloradans by providing Colorado's workforce with opportunities to develop the necessary skills and competencies through a variety of strategies. Colorado will also need to address the lack of certain specialty providers, such as child psychiatrists and providers for underserved cultural and linguistic groups.*
>
> *The 1050 Task Force recommends that the Commission develop and maintain an appropriate workforce plan to ensure capacity to meet the behavioral health needs of Coloradans across the state. Strategies considered at 1050 Task Force meetings include: standards for co-occurring training curricula and cross-training on mental health and substance abuse; the use of telemedicine; the availability of consultation services for primary care physicians; addressing compensation levels; and providing tuition reimbursement for needed behavioral health specialists in underserved areas of the state.*

However, it should be noted that it is uncertain whether or not this recommendation was implemented and whether it is a priority of the current Behavioral Health Transformation Council that was created in statute (SB 153) as a result of the 1050 Task Force to coordinate behavioral health efforts in Colorado.

Relevance to Behavioral healthcare workforce Development: One of the recommendations identified in this report related to workforce development for behavioral health providers. While this recommendation was embedded in a larger report, it is important to remember that workforce development in the public behavioral health system was addressed by this project.

Metro Crisis Services

"The Crisis Triage Project" began as a series of inter-agency discussions in 2006, convened and sponsored by Mental Health America of Colorado. The rationale for this project stemmed from the fact that hospital emergency departments were burdened with increasing numbers of people with behavioral health issues who were unable to get care elsewhere and the face that Denver (and most of Colorado) lacked a robust and coordinated crisis service system for people with behavioral health problems. By 2007, stakeholder consensus aligned in a plan to develop a seven-county behavioral health crisis intervention system that would include: 1) 24/7 professionally-staffed call center, 2) Resource database and encounter-based electronic health record (EHR), to be shared among behavioral health providers, and 3) Three 24/7 professionally-staffed walk-in crisis intervention clinics, each with 16 rapid stabilization beds.

"The Crisis Triage Project" is now called Metro Crisis Services, Inc. (MCS), a non-profit corporation. The purpose of MCS is to provide emergency behavioral health services, including suicide prevention, to the seven-county Denver Metro area (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson). Infrastructure planning and staffing has been underway and the first walk-in clinic will open in late 2010 or early 2011, contingent on funding availability. This 24-hour professionally-staffed clinic will be in the Denver-Aurora area, in a location easily accessible to EMS, police, and families.

Relevance to Behavioral healthcare workforce: The development of new crisis services in the Denver metropolitan area will provide new job opportunities for behavioral health providers. This project also has training implications in that it is important for the personnel staffing these crisis centers be qualified and competent to work in this specialized setting.

Recent or Upcoming Policy/Legislative Issues

One legislative issue in the near future is the sunset of the Mental Health Practice Act on June 30, 2011. This has potential implications on the practice of and continuing education requirements for multiple mental health professionals. Saul Larson, at DORA is the lead analyst on this issue. There are likely other relevant policy issues that impact behavioral health with implications for the workforce. Mental Health America of Colorado, as well as many of the behavioral health associations (Colorado Psychological Association, etc.), often identify these

issues and assist in educating the public about their potential impact on the behavioral healthcare workforce and provider systems in Colorado.

Relevance to Behavioral healthcare workforce: Understanding behavioral health legislative issues is important because statutory or regulatory changes may have implications on the preparation (licensing requirements) and practice of a particular group of behavioral health professionals.

Integrating Behavioral Healthcare into Primary Care in Colorado

There is a growing trend toward integrating behavioral health and primary care services in Colorado and at the national level. This "integration" can be bi-directional, meaning that behavioral health providers are located in primary care settings and/or that primary care providers are situated in behavioral health settings. The level of "integration" varies in intensity ranging from a consultative model to a person actually working collaboratively in an organization or practice.

Colorado has been called a "hotbed" of activity in integrated care and is poised to be a leader in this area as the movement toward integration and the Patient-Centered Medical Home[52] are discussed with fervor at the national level. It is likely that policy changes in this arena may be influenced by the work that is currently being conducted in Colorado. Individuals in Colorado are part of the leadership in the national integrated care movement. Colorado's integrated care portfolio includes national experts in integrated care who live and work here, a university department that has faculty devoted to research, practice, and policy implications of integrated care (University of Colorado, School of Medicine, Department of Family Medicine), and multiple model integrated care programs across the state to name a few examples.

The field of integrated primary care is very new and very different from traditional mental health models. When integrating behavioral health into primary care, three main issues arise:

1) Integrated records. This is complicated because of privacy issues, ethical issues, and legal standards.
2) Mental health statutes and disclosure law. Mandatory disclosure is not always practical in primary care and is often not aligned with mental health statutes.
3) Reimbursement. Integrated primary care and integrated care in other settings will not be sustainable until people can be paid for the work they do.

The move toward the provision of care in integrated settings is relevant to and has implications for behavioral healthcare workforce development in several critical ways. First, there are training implications for behavioral health and primary care providers. Educational programs will need to examine their current curricula to ensure that the content teaches toward building the competence of these providers working in a different environment, with different roles, and with potentially different treatment and consultation models. Second, the type of behavioral health providers the integrated care setting requires will need to be clarified – what level of education is sufficient, what is their primary role within the integrated care setting and its variations. Third, the behavioral health provider working in a medical setting (or integrating primary care providers into a traditionally behavioral health organization) may require some unique skills in order to successfully work in a different service system. Fourth, increased integrated care training opportunities in the field will allow students to be better prepared for real world work experience upon the completion of their training. The trend toward integrated care has workforce development implications for both existing behavioral health and primary care providers in Colorado. Understanding and anticipating some of these implications on the workforce that stem from working within different practice models, with different treatment protocols, and in different settings will be helpful in strategically planning for workforce needs in integrated care settings.

Colorado Happenings and Leadership in Integrated Care

- Advancing Care Together: Creating Systems of Care for the Whole Person (ACT) is a program where leaders in primary healthcare and behavioral healthcare join together to identify practical ways to integrate care for people whose health care needs include physical, emotional and behavioral issues. ACT is housed at the University of Colorado, Denver, Department of Family Medicine (Larry Green, Frank DeGruy, Ben Miller) and funded by the Colorado Health Foundation. ACT is currently in the first phase, a planning phase. Four other phases will follow, pending funding, that include small demonstration grants to practices in Colorado to implement innovative integrated care models. A mixed method evaluation of these demonstration projects will facilitate the understanding of what works and does

[52] American Academy of Family Physicians (AAFP). Defition of patient-centered medical home. 2008; Accessed August 13, 2009 from: <http://www.aafp.org/online/en/home/policy/policies/p/patientcenteredmedhome.html>

not work and what it will take to spread successful innovations across Colorado.

- Models of integrated care practices in Grand Junction (Marillac Clinic) and Fort Lupton (Salud Health Center) are considered innovators in the field and are promising practice models for the nation on how to incorporate behavioral health into a primary care setting.
- Benjamin Miller, Psy.D., at the University of Colorado, Denver, Department of Family Medicine is working on a Health Behavior Curriculum to assist providers in understanding behavior change in the Community Mental Health Center and Community Health Center settings. Dr. Miller is also the primary contact for the Collaborative Care Research Network (CCRN), a national research network devoted to identifying and disseminating practice-based effectiveness research on integrated care. He is also involved with the DARTNet project, a network of electronic health data, including information from practices in Colorado, to increase knowledge of practice-based effectiveness (see http://bit.ly/cAu3uK for more information).
- There has been an effort in Colorado to align mandatory disclosure laws in medical settings with the mental health statute. A small group has worked with DORA over the past few years to change the statute to allow the delay of mandatory disclosure in the medical setting until the second visit. The final determination will be made should this portion of the Mental Health Sunset Act pass into legislation.
- Several leaders in integrated care (Laurie Ivey, Psy.D., and Samantha Monson, Psy.D.) have worked with the University of Denver Graduate School of Professional Psychology over the past few years to persuade them to expand their curriculum to include a class on Integrated Primary Care. This course was taught for the first time in May, 2010. The program continues to discuss expansion in this area.
- Pre-doctoral and Post-doctoral Psychology Training Opportunities.
  - Deb Seymour, Psy.D., currently runs an APA accredited internship in Integrated Primary Care. The program includes a placement in Greeley, a more rural setting.
  - The Colorado Health Foundation currently funds an Integrated Primary Care Postdoctoral Fellowship, created by Laurie Ivey, Psy.D., that has a focus on serving underserved populations and exposes the fellow to three weeks in a rural area. There are currently two fellows in this program, one who will complete three years at Denver Health, and one who will spend one year training at both Denver Health and Swedish Family Medicine.
  - The Salud Clinic offers 2.5 post-doctoral positions in primary care integration with a rural emphasis under the direction of Andrea Auxier, Ph.D.
- The Colorado Behavioral Healthcare Council (CBHC)[53] is mapping all of the locations where providers are currently offering integrated services, totaling nearly one hundred sites to date. The information below was referenced from the following website: http://www.cbhc.org/integration/map/. This mapping project demonstrates the expanse of collaborative efforts underway throughout Colorado and serves as a tool for various health care providers and policy makers to learn about the different levels of collaborative arrangements that currently exist across the state.

  The Types of Systematic Collaboration Model was used by CBHC to categorize the types of collaborative efforts being undertaken by Colorado's community mental health system. This model was adapted from the Collaborative Family Healthcare Association's (CFHA) Five Levels of Primary Care/Behavioral Healthcare Collaboration Model by Macaran A. Baird, M.D., William J. Doherty, Ph.D., and Susan H. McDaniel, Ph.D. and modified by Bern Heath, Ph.D. and Pam Wise Romero, Ph.D, Axis Health System, for the Colorado Integrated Care Learning Community. The model provides a helpful framework to be used by organizations "to evaluate their current structures and procedures in light of their goals for collaboration, and to set realistic next steps for change," as suggested by its original authors.

  Regarding the efforts of CBHC, the mapping project reflects only those integrated care efforts that CBHC member organizations (CMHCs/Clinics/BHOs) are involved in. In that regard, there are 33 locations (of the 100 that are currently mapped) involving an FQHC and a CBHC member. There are FQHCs offering integrated care independent of a CMHC or in collaboration with a mental health provider outside of the community mental health system, but information about these efforts is not understood at this time. It may be that the Colorado Community Health Network (CCHN) is compiling this information. It would be helpful to better understand the status of the FQHC system and integration to get a more complete picture of the status of integrated care

[53] CBHC is a non-profit 501 (c) 3 membership organization that represents Colorado's statewide network of community behavioral healthcare providers inclusive of 17 community mental health centers (MHCs), 2 specialty clinics, and 5 behavioral health organizations (BHOs). Referenced from website: <http://www.cbhc.org/about-us/>

in Colorado. It should be noted that a committee representing FQHC and CMHC Directors (called the Joint Workgroup) has been meeting for a few years to discuss and plan for the integration of primary care and behavioral health as health care reform rolls out.

- Several Colorado Community Mental Health Centers (CMHC) are demonstrating leadership and innovation in integrating primary care into traditionally mental health settings.
  - The Mental Health Center of Denver (MHCD), a large public community mental health center, recently received a Primary Care Behavioral Health Integration Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).
  - In November 2008, The Colorado Health Foundation (TCHF) funded the establishment of a new integrated primary care and mental health services project in Denver. The project, Promoting Resources for Integrated Care and Recovery (PRICARe), is a partnership between MHCD, Colorado Access, and the University of Colorado Department of Family Medicine. The project is being implemented within a Community Mental Health Center (i.e., MHCD) and employs a primary care physician.
  - In Durango, the formation of Axis Health Systems (formerly Southwest Colorado Mental Health Center) demonstrates the evolution of a traditional approach to community mental health by integrating behavioral health and primary care health services in one organization. Leadership on this project includes Bern Heath (bheath@axishealthsystem.org) and Pam Wise Romero (pwise@axishealthsystem.org).
  - The Federally Qualified Health Center (FQHC) in Greeley has a bidirectional service provision agreement with the local CMHC.

What Colorado Does Not Know About Its Behavioral Health Workforce

Many unknowns about the behavioral healthcare workforce in Colorado became apparent through the process of compiling this report. These issues bubbled to the surface either because there is not adequate data to understand the whole picture of a given area, or because there is no one entity to assemble and analyze the information that does exist to sufficiently demonstrate trends from which to make recommendations. A fuller understanding of the issues noted below would be instrumental in guiding behavioral healthcare workforce development planning efforts.

When "we" is used in this section, it is understood to be a collective "we" - the behavioral health system and relevant stakeholders in Colorado. Within this "we", there are different levels of responsibility and capacity to collect and report behavioral healthcare workforce data to improve Colorado's ability to respond to the results and make data-informed decisions. Behavioral healthcare workforce data can only be improved by collective efforts of multiple sectors of the system (education institutions, provider systems, licensing bodies, etc.).

Understanding the Gaps in Data on the Current Behavioral Healthcare Workforce

- The licensing data from DORA does not indicate whether a given person works, how much they work, and where they work. This descriptive information would further clarify where (i.e., in what types of positions, and geographically) energy needs to be focused to decrease gaps in the current behavioral healthcare workforce.
- Colorado does not routinely track current demographic trends and how they might impact the need for different skills in the behavioral healthcare workforce. Tracking demographic trends both in terms of the ethnic backgrounds of people providing services and those who are receiving services would allow educational and training programs in behavioral health to target a particular population and/or to identify specific training content that teaches specific skills or competencies needed in the field.
- As the integration of primary care and behavioral health becomes more prevalent, we need to be able to understand and track how behavioral health providers are interacting with primary care providers and vice-versa. We think we have an idea how that will look, but in practice it may turn out differently (e.g., tracking across multiple practicing locations).
- Colorado does not collect data on the age of the behavioral healthcare workforce in Colorado. This information would help stakeholders in behavioral healthcare workforce (i.e., educators, providers, policy makers, funders) understand the age distribution of professionals, estimate how many providers are likely to retire from the system, thus providing an idea of how many new providers would be needed to fill these gaps.
- Colorado does not have a coordinated effort to identify the specific workforce needs of Colorado's safety net system. Prioritizing the workforce needs in

this system may be a way to get started in addressing behavioral healthcare workforce shortages in Colorado. This system treats the most underserved populations, thus, enhancing the workforce is this

sector would be a way to address the highest needs first.

- Colorado does not understand enough about how professionals with different credentials can serve in the same role (i.e., both an LCSW and a Psy.D., could be a clinical supervisor). What are the implications of understanding or "counting" the number of professionals with a given degree if the workforce is only accounted for by position title (e.g., how many clinical supervisors versus how many social workers are employed by a community mental health center)?
- Colorado does not know how the migrant population stresses the behavioral healthcare system. This includes people migrating through and around the state for agricultural work or other seasonal work (e.g., ski industry) and how these patterns impact the behavioral healthcare workforce.
- Colorado does not have a clear picture of "need," that drives the necessity for behavioral health providers to match those service and treatment needs. Prevalence estimates estimate Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), but don't address anything less severe. Utilization rates, even if we could get good data, do not explain if people are utilizing services that available but that are not the best match for their needs. We also do not know much about those who are not utilizing services and if this is due to lack of availability of services, or an appropriate provider, if the service is not provided at all, if the wait list is long, if the service is not reimbursable service, or if people are not willing to seek services due to stigma or for other reasons.

Training and Education

- Colorado does not have a good way of measuring the "success" of educational programs in terms of their contribution to meeting local workforce demands in the behavioral health sector. Understanding more about whether graduates of Colorado-based training programs actually work in the behavioral health system locally and how prepared they are to work in that system would help identify and plan for statewide retention techniques (i.e., keeping students who are educated in Colorado working in Colorado following graduation) and evaluation of their preparedness to work in the behavioral health system. Colorado does not know enough about what providers specialize in (e.g., child, family, geriatric specialists). Understanding specialty competencies would assist in identifying specific training priorities for educational programs in their preparation of future behavioral health providers in Colorado.
- Colorado does not currently have a good way of identifying where students go after they leave their training programs (i.e., did they enter the workforce in Colorado in a behavioral health job), or if graduates are employed in jobs that were linked to their educational pursuits. This information would be helpful in determining if more effort is needed to retain Colorado-trained behavioral health providers and/or improve the connection of community training experiences to job opportunities.
- Colorado's higher education system does not track whether students who attended an out-of-state postsecondary institution returned to Colorado to practice.
- Colorado does not know enough about the pipeline that feeds the behavioral healthcare workforce system. This information would allow for a better understanding of how individuals decide to enter the field. Engaging people early in the pipeline (i.e., youth programs designed to educate and encourage participation in a behavioral health career) may increase the interested pool of persons entering behavioral health fields.
- Colorado does not know how to **extend** the educational pipeline (e.g., certificate programs to doctoral level programs), and also **expand** it to include non-traditional students (e.g., retired individuals, retired military, ethnically diverse populations).
- Colorado needs to expand its understanding of the best ways to include consumers and family members who are passionate about mental health issues in the workforce. Colorado and many states do not fully capitalize on the potential of broadening the traditional concept of workforce and the potential impact of this expansion.
- For students in more rural areas of the state, we don't know if it makes a difference if a person completes an online degree program, versus a traditional classroom program, or some hybrid model. Further clarity on this issue would help educational institutions plan for distance-delivered training programs to rural committed individuals.

Competence/Scope of Practice

- There is no formal process to assess the degree to which the Colorado behavioral health workforce is competent to deal with co-occurring disorders, cultural diversity issues, returning veterans, homeless people, people recently released from incarceration, to name a few.

- We don't know if it would be better to think about the shortage of psychiatrists as a shortage of individuals who can prescribe psychiatric medications and potentially identify what other health and behavioral health providers can fill this gap (i.e., advanced practice nurses – APN, Physician's Assistants – PA, psychologists in the future?).

Career Progression

- The behavioral health community in Colorado does not know why people leave their job in behavioral health, and where they go. This information would inform strategies to potentially alleviate this out-migration of professionals.
- We don't know career path profiles for different professionals, and what degrees lead to different functions in behavioral health (e.g., academic, clinical, administrative).

This list of what we do not know about the behavioral healthcare workforce is a starting place from which to prioritize the most important issues to better inform the path to enhancing the recruitment, retention, and training of behavioral health professionals in Colorado.

Possible Solutions

The possible solutions[54] identified to improve behavioral healthcare workforce in Colorado were extrapolated from the key informant interviews conducted to inform this report and from examining the status and trends of behavioral healthcare workforce in Colorado. Some of the solutions in this section could be considered "low hanging fruit" and a place to potentially make an impact to improve the behavioral healthcare workforce in Colorado within a relatively small time frame. While some of these ideas may take significant planning to implement, they are included because there exists some infrastructure or model from which to expand. The solutions will be presented first, followed by "implementation next steps" or an idea of where to start in moving that solution forward. These solutions are not prioritized but this is a necessary next step for behavioral health stakeholders. In addition, the identification of an appropriate point person or group who has the capacity to execute or lead these solutions to reality is necessary.

> *The mental health community needs to be visible enough for people to get behind it.*

Possible Solutions: Planning and Collaboration

- Create a Colorado Behavioral healthcare workforce Development Strategic Plan: Colorado does not currently have a behavioral healthcare workforce development strategic plan. The complexity of the topic makes it difficult, without a plan, to identify the priorities and really make some impact in a few key areas. While fairly evident, the first solution might be to create a program that helps to plan for and coordinates statewide efforts focused on increasing the behavioral healthcare workforce.

  Implementation Next Steps: Convene an action-oriented group of stakeholders committed to behavioral health in Colorado to develop a plan with short-term and long-term objectives. It may be helpful to provide time and scope parameters (e.g., professional focus, geographic focus, within a given time period) to narrow the range of possibilities to address within the behavioral healthcare workforce rubric.

- Create a statewide Behavioral Health Training and Provider Planning Group to identify realistic ways to increase cross-system communication and collaboration (e.g., incorporating the public behavioral health providers' perspective and experience into course content).

  Implementation Next Steps: Identify key representatives from higher education training institutions (in behavioral health fields) and representatives from provider agencies in the public behavioral health system. This group could be a subset of the larger group that creates the statewide behavioral healthcare workforce plan noted above.

> *Any planning on behavioral health workforce should strategically look at creating more providers who will practice in areas of need. It is easy to open a program or to add on a behavioral health emphasis for individuals who would end up working in Denver or in less underserved settings.*

[54] A list of other solutions and comments identified by key informants or reviewers of this report can be found in Appendix H.

Possible Solutions: Program Support and/or Enhancements

- Expand coordinated Mental Health First Aid efforts in Colorado. Programs like Mental Health First Aid (MHFA) can help with anti-stigma efforts and prevention of mental health crises, which are very much needed. MHFA can also be a community-level strategy, especially in more rural areas where provider availability is limited, to increase the workforce.

  Implementation Next Steps: The MHFA-CO planning group, the Colorado Behavioral Healthcare Council, and the Mental Health America of Colorado (MHAC) are in the prime positions to provide information on the status of MHFA in Colorado (e.g., who is trained and what expansion is needed.) The MHFA-CO planning group has a proposal that outlines a project that would coordinate all MHFA activities in Colorado and evaluate their effectiveness. In addition, Mental Health America of Colorado currently has a small initiative to conduct MHFA in the school system. They also have a proposal to expand their efforts to college students in Colorado.

- Expand the loan repayment eligibility criteria to include a broader array of behavioral health professionals (e.g., Certified Addictions Counselors).

  Implementation Next Steps: Convene the administrator of the state loan repayment program to identify the process for expanding eligibility criteria. A longer term solution, and potentially more difficult would be to work with the National Health Service Corps representatives in the Health Resources and Services Administration (HRSA) regarding potential expansion of the national program.

- Expand the capacity of the Colorado Office of Rural Health's program to include behavioral health providers in their full service recruitment program that places health professionals in rural and underserved areas.

  Implementation Next Steps: Explore the feasibility of expanding the rural recruitment program to behavioral health providers. Convene stakeholders meeting including behavioral health-related organizations to discuss and estimate program infrastructure and administrative needs. Add behavioral health career postings to http://www.searchcolorado.org/maps/Alphalisting.htm.

- Increase data collection on behavioral health providers to inform gap and trend analysis in Colorado.

  Implementation Next Steps: The Colorado Health Institute (CHI) already has a robust system and capacity to collect data on health professions. CHI has collected some data on behavioral health professions in the past, and they already have a data infrastructure that may allow for expansion. The Colorado Health Professions Workforce Collaborative recently made a recommendation that DORA collect certain data elements from licensed professionals. A current effort is underway with DORA and CHI to collect more robust data across health professions including behavioral health.

- Examine the Mental Health Professional Shortage Area (MHPSA) designation process in Colorado. Many parts of Colorado are currently undesignated. Having a MHPSA designation makes facilities eligible to provide National Health Service Corps support for their employees.

  Implementation Next Steps: Convene the Primary Care Office at the Colorado Public Health and Environment and a group of currently designated and undesignated facilities or areas in Colorado to forge a plan to expand MHPSA to all needed regions or organizations.

> *We need to help students transition from academics to an environment where the need is the greatest.*

- Expand the pipeline for students pursuing behavioral health careers by exposing students to educational and employment options.

  Implementation Next Steps: Colorado already has a program devoted to encouraging students into health professions – The Colorado Area Health Education Centers. These programs geographically span the state and, with support, could expand their current efforts to include behavioral health careers in their current portfolio of activities.

> *We need to aggressively educate high school and community college students about opportunities in behavioral health ... right now the opportunities are a bit of a mystery.*

Possible Solutions: Training and Education

- Increase integrated care (behavioral health and primary care) training into existing educational programs for both future behavioral health and health care professionals.

  Implementation Next Steps: Leaders in the integrated care movement are already active in Colorado. This group could advocate for the infusion of integrated care principles and curricula into existing educational programs for behavioral health and health care providers.

- Develop an American Psychological Association (APA) accredited rural psychology internship consortium following a model in Alaska to increase training opportunities in Colorado. Training rotations and internships in rural areas of Colorado may increase the recruitment of behavioral health providers to these areas.

  Implementation Next Steps: The WICHE Mental Health Program has developed a rural psychology internship consortium in Alaska (and is working toward replication in Hawaii and South Dakota) and could share the feasibility of replicating the model in Colorado.

- Replicate the Rural Track model at the University of Colorado, Medical School (currently for primary care physicians) for behavioral health providers. This program could be housed at any appropriate higher education institution with sufficient behavioral health training programs and infrastructure to support the operations. This program would accept students to a rural behavioral health track where their training would be rural-focused with the expectation would be that they would practice in a rural area in Colorado upon graduation.

  Implementation Next Steps: Convene the leaders of the Rural Track program and interested academic institutions that offer behavioral health program options to determine the feasibility of replication, where the program would be housed, and identify the infrastructure needs of such an endeavor.

Find people who have a propensity to go to the places you need them to go and offer incentives to them for training. OR incentivize people who have the training to go to the places you need them to go to.

Universities are doing a good job of attracting good students and good rural students. However, students who make community connections where they complete their internships tend to be hired by those communities. If those opportunities are located in urban areas, recruitment to rural areas is hindered.

- Develop a statewide peer specialist certification program to ensure the safety of the peers working in the system.

  Implementation Next Steps: The Wellness Education and Advocacy Network (WE CAN!), is an independent peer-driven organization that is positioned to coordinate this effort, as they have been providing training to consumers in Colorado for the past nine years. WE CAN! has developed a comprehensive curriculum based on the National Association of Peer Specialists (NAPS) that meets and exceeds the Peer Specialist Core Competencies as set forth by Health Care Policy and Financing. By 2012, WE CAN! will implement a statewide peer specialist network through launching a website for support and rolling out a training program that meets the needs of peers looking to become specialists and for those who have training but seek to further their skills.

Schools, service clubs, religious organizations, volunteers all play a huge role in MH service provision.

Possible Solutions: Technology

- Develop a statewide tele-behavioral health professional network for training, clinical supervision, support, and service provision.

  Implementation Next Steps: Identify current telehealth networks already in use to better understand where increased connectivity could be developed. This would be helpful in providing enhanced access to technology-mediated services. Reimbursement and licensure issues would also need to be addressed in this solution to ensure that

providers (and which providers) can be compensated for services delivered through this medium.

- Create a Supervisor Technology Planning Group to increase the use of technology to provide supervision. Accessibility to supervision, especially in rural areas, is often cited as a barrier to the recruitment and retention of professionals. Formalizing a network of supervisors would be a step in providing a pool of trained professionals who could provide support and guidance throughout the state. Enhancing support via technology could decrease feelings of professional isolation, burnout, and job instability.

  Implementation Next Steps: Create a Supervisor Technology Planning Group and appoint a program coordinator to identify interested professionals, identify how and where to connect to technology, develop and execute a marketing plan to providers, etc. Reimbursement and licensure issues would also need to be addressed in this solution to ensure that providers (and which providers) can be compensated for services delivered through this medium.

The potential solutions are abundant. It will be important to prioritize the solutions based on what is feasible and what can be measured to demonstrate impact. While this may seem daunting, some strategic planning to organize the short- and long-term objectives and desired outcomes will make Colorado a leader and more forward thinking than most states who generally do very little behavioral healthcare workforce planning on a statewide basis.

> *What's needed for care in our community and what's needed for a sustainable behavioral health workforce is similar. Let's not try to solve one without the other. To do so would be a myopic view.*

Summary

Over the past several years, some momentum has formed behind behavioral healthcare workforce development. It is important to capitalize on this momentum, as largely rural states, such as Colorado, have had ongoing difficulties recruiting and retaining an effective behavioral healthcare workforce. A limited workforce translates into critical gaps in the availability and accessibility of services. At present, much of Colorado is designated as a mental health professional shortage area and as a whole has an inadequate amount of licensed professionals. This shortage is especially acute in rural areas. The shortage can result in those seeking services having to wait longer and/or have inconsistent treatment due to staff changes. As they wait, the severity of their problems often worsens, which can lead to mental health crises.

Also apparent is the disparity between the growing minority population versus that same population obtaining a higher education degree. In conjunction, the state needs to take a hard look at the low numbers of all populations even graduating from high school. The 25 to 64 year-old workforce continues to dwindle as the baby-boomers retire. Workforce development strategies can take this data into account as they target the future generations of clinicians who will replace a now-aging healthcare workforce.

Higher education institutions need to ensure that training curricula reflects the needs of the populations to be served and brings training opportunities to those who live and will likely stay in rural areas. This is often referred to as a "grow your own" approach, which is an adjunct to incentive-based programs, such as student loan repayment for working in rural areas. Loan repayment programs do provide a reason for many young professionals to live and practice in rural areas, but the period of repayment is limited, and it is unclear to what extent those participating in the program are trained in rural behavioral health. Additionally, loan repayment programs offer only a short-term incentive to experienced professionals to live and work in rural or underserved areas.

It is not clear that higher education programs include sufficient training on how to understand, navigate, and respond to a changing health care system (e.g., evidence based practice training in their curricula, training on the public behavioral health system and how it is financed, increased diversification of placing students in community, public, non-profit settings, trainig on alternative job opportunities and settings in the behavioral health field). One innovation that was conspicuously missing from the university websites was any advances being made in training about integrating behavioral healthcare into primary care settings.

With the advent of healthcare reform and the national trend toward the integration of primary care and behavioral health, the time is ripe with opportunity to capitalize on the existing energy and expertise in the state into a more coordinated effort to enhance the behavioral healthcare workforce in Colorado.

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Appendix A

County Counts of Specified Behavioral Healthcare Professionals, 2010

	DORA - licensed and/or certified providers				Peregrine - practicing providers			
County	CAC 1	CAC 2	CAC 3	LAC	MH Counselors	Psychiatrists	Psychologists	Social Workers
ADAMS	24	72	131	7	411	107	97	99
ALAMOSA	5	10	20	0	145	2	3	2
ARAPAHOE	32	74	225	11	533	141	202	214
ARCHULETA	0	3	1	2	4	0	4	1
BACA	0	0	0	0	0	0	0	0
BENT	2	1	9	0	1	0	0	1
BOULDER	16	60	144	10	611	102	205	192
BROOMFIELD	0	1	4	0	2	0	0	0
CHAFFEE	2	3	9	1	11	0	7	3
CHEYENNE	1	0	1	0	0	0	0	0
CLEAR CREEK	0	2	4	0	4	0	1	0
CONEJOS	1	3	3	1	0	0	0	0
COSTILLA	1	1	0	0	0	0	0	1
CROWLEY	0	1	1	0	0	0	0	0
CUSTER	0	1	1	0	2	0	0	0
DELTA	0	5	8	2	17	0	4	5
DENVER	38	187	368	26	792	294	422	443
DOLORES	0	0	0	0	0	0	0	0
DOUGLAS	10	27	35	4	72	25	31	23
EAGLE	1	5	7	1	22	4	6	7
EL PASO	17	63	164	23	672	89	197	259
ELBERT	3	1	3	1	13	0	0	2
FREMONT	5	12	26	3	51	4	2	16
GARFIELD	4	10	24	1	46	4	1	13
GILPIN	0	0	5	1	3	0	0	1
GRAND	0	3	6	0	4	0	1	3
GUNNISON	0	1	6	0	12	0	1	4
HINSDALE	0	0	0	0	0	0	0	0
HUERFANO	1	1	2	0	5	1	0	3
JACKSON	0	0	1	0	1	0	0	1
JEFFERSON	38	108	212	25	436	78	131	181
KIOWA	0	0	0	0	0	0	0	0
KIT CARSON	2	0	3	0	0	0	0	0
LA PLATA	5	11	26	2	83	13	23	31
LAKE	0	2	0	0	4	0	1	0
LARIMER	28	66	117	20	242	39	127	102
LAS ANIMAS	3	5	2	0	12	0	1	0
LINCOLN	1	0	1	0	5	0	0	1
LOGAN	3	5	16	0	25	1	1	5
MESA	5	22	47	5	134	24	28	49

MINERAL	0	0	0	0	0	0	0	0
MOFFAT	0	1	4	1	11	2	0	2
MONTEZUMA	1	3	16	1	18	0	2	8
MONTROSE	0	2	8	0	35	4	5	14
MORGAN	1	5	5	0	14	2	1	4
OTERO	1	5	7	1	31	1	2	1
OURAY	1	0	1	0	2	1	2	0
PARK	0	1	8	0	6	0	1	4
PHILLIPS	0	1	3	0	3	0	0	0
PITKIN	0	2	7	1	20	1	7	4
PROWERS	1	3	3	2	18	0	0	1
PUEBLO	18	53	116	8	286	47	43	65
RIO BLANCO	0	0	1	0	6	0	0	2
RIO GRANDE	2	3	3	0	1	2	0	0
ROUTT	0	1	9	0	19	4	9	12
SAGUACHE	0	0	0	0	2	0	0	0
SAN JUAN	0	0	0	0	0	0	0	0
SAN MIGUEL	0	2	1	0	7	0	3	1
SEDGWICK	0	0	0	0	0	0	0	0
SUMMIT	1	4	4	1	23	3	9	6
TELLER	2	5	12	1	17	0	3	7
WASHINGTON	1	0	0	0	0	0	0	2
WELD	15	31	79	12	242	14	35	29
YUMA	0	0	2	0	4	0	1	1
COLORADO TOTAL	**292**	**888**	**1921**	**174**	**5140**	**1009**	**1619**	**1825**

Peregrine data was provided to CHI by Peregrine Management Corporation in Oct. 2010. CHI downloaded data on Addictions Counselors from the DORA website in Oct. 2010. Note that these numbers differ slightly from the table in the text. First, DORA is updated on a daily basis and some licenses may have become active/inactive between the time that data was downloaded and when CHI downloaded the data. Second, CHI geocoded each practitioner address using the Centrus system, which may result in slightly different counties than the method DORA uses to classify addresses into counties.

Appendix B

Minimum certification/licensing requirements

Below are the minimum requirements for certification or licensing as an addictions counselor, social worker, psychologist or professional counselor or marriage and family therapist. The information on Certified Addictions Counselors was retrieved from <http://www.dora.state.co.us/mental-health/faqs.htm#MFTfaqs> and the information on all other licensed professions was retrieved from <http://www.dora.state.co.us/mental-health/Statute.pdf>

Certified Addiction Counselors

Q: What does it take to become a Certified or Licensed Addiction Counselor in Colorado?

A: Division of Behavioral Health (DBH) approved:

- Training and education
- Clinically supervised work experience
- National examination for CAC II and CAC III

There are two pathways to certification and licensure for addiction counselors:

- **Pathway 1** is for those individuals who hold a high school diploma or equivalent AND those who hold a bachelor's degree in the behavioral health sciences.
- **Pathway 2** is for those individuals who hold a clinical masters or doctoral degree.

The four levels of credentialing for addiction professionals are:

- CAC I - Certified Addiction Counselor, Level I
- CAC II - Certified Addiction Counselor, Level II
- CAC III - Certified Addiction Counselor, Level III
- LAC - Licensed Addiction Counselor (Masters Level)

Q: Where do I find the Addiction Counselor Certification and Licensure Rules?

A: **Find the rules on the DORA website:** www.dora.state.co.us/lmental-health/cac/licensing.htm

Q: Do training classes certificates expire if I do not submit an application within a certain amount of time?

A: Yes, all training class certificates for any level of certification will expire five years from the date of the class if no application is submitted to DORA.

Q: What are the CAC Requirements?

A: The requirements for certification for a CAC I, II, or III can be found in the CAC rules and the CAC Handbook for Addiction Counselors that lists the DBH **required trainings and other valuable information**.

Q: What are the Requirements for the LAC (Licensed Addiction Counselor)?

A. The applicant must have a clinical Masters or above degree to be eligible to apply for an LAC. See the CAC rules and the CAC Handbook for further information.

Social Workers

12-43-404. Qualifications - examination - licensure and registration.

(1) The board shall license as a licensed social worker, and issue an appropriate certificate to, any person who files an application therefor, accompanied by such fee as is required by section 12-43-204, and who submits evidence satisfactory to the board that he or she:

(a) Is at least twenty-one years of age;

(b) Has obtained a master's degree from a graduate school of social work; and

(c) Demonstrates professional competence by satisfactorily passing an examination in social work and a written, mail-in jurisprudence examination administered by the department of regulatory agencies.

(2) The board shall license as a licensed clinical social worker, and issue an appropriate certificate to, any person who files an application therefor, accompanied by such fee as is required by section 12-43-204, and who submits evidence satisfactory to the board that he or she:

(a) Is at least twenty-one years of age;

(b) Has obtained a master's or doctorate degree from a graduate school of social work;

(c) Has practiced social work for at least two years under the supervision of a licensed clinical social worker; and

(d) Demonstrates professional competence by satisfactorily passing an examination in social work as prescribed by the board and a written, mail-in jurisprudence examination administered by the department of regulatory agencies.

(2.5) (a) The examination by the board described in paragraph (c) of subsection (1) of this section and in paragraph (d) of subsection (2) of this section shall be given not less than twice per year at such time and place and under such supervision as the board may determine.

(b) The board or its designated representatives shall administer and score the examination and shall take any actions necessary to ensure impartiality. The passing score for the examination shall be determined by the board based upon a level of minimum competency to engage in social work practice.

Psychologist

12-43-304. Qualifications - examinations - licensure.

(1) The board shall issue a license as a psychologist, and issue an appropriate license certificate, to each applicant who files an application upon a form and in such manner as the board prescribes, accompanied by such fee as is required by the board, and who furnishes evidence satisfactory to the board that he or she:

(a) Is at least twenty-one years of age;

(b) Is not in violation of any of the provisions of this part 3 and the rules promulgated by the board;

(c) Holds a doctorate degree with a major in psychology, or the equivalent to such major as determined by the board, from an approved school;

(d) Has had at least one year of postdoctoral experience practicing psychology under supervision approved by the board; and

(e) Has demonstrated professional competence by passing a single, written examination in psychology as prescribed by the board and a written, mail-in jurisprudence examination administered by the department of regulatory agencies.

(1.5) (a) The examination by the board described in paragraph (e) of subsection (1) of this section shall be given not less than twice per year at such time and place and under such supervision as the board may determine.

(b) The examination shall test for knowledge of the following three areas:

(i) General psychology;

(ii) Clinical and counseling psychology; and

(iii) Application of the practice of clinical and counseling psychology, including knowledge of appropriate statutes and professional ethics.

(c) The board or its designated representatives shall administer and score the examination and shall take any actions necessary to ensure impartiality. The passing score for the examination shall be determined by the board based upon a level of minimum competency to engage in the practice of psychology.

(2) to (6) (Deleted by amendment, L. 2007, p. 137, § 1, effective July 1, 2007.)

(7) The board shall register as a psychologist candidate a person who files an application therefor, accompanied by such fee as is required by section 12-43-204, who submits evidence satisfactory to the board that he or she has met the requirements of paragraphs (a), (b), and (c) of subsection (1) of this section, and who has not been previously registered as a psychologist candidate by the board. Such candidate is not required to register with the database of unlicensed psychotherapists, and shall be under the jurisdiction of the state board of psychologist examiners. A person shall complete the requirements of paragraphs (d) and (e) of subsection (1) of this section within four years after initial registration with the psychology board. If such requirements are not met within four years, the registration of the psychologist candidate shall expire. A person whose psychologist candidate registration has expired shall not be precluded from applying for licensure or registration with any other mental health board for which the person is qualified.

Licensed Professional Counselor

12-43-603. Licensure - examination - licensed professional counselors.

(1) The board shall issue a license as a licensed professional counselor to each applicant who files an application upon a form and in such a manner as the board prescribes, accompanied by a fee as is required by section 12-43-204, and who furnishes evidence satisfactory to the board that he or she:

(a) Is at least twenty-one years of age;

(b) Is not in violation of any of the provisions of this article and the rules and regulations adopted under this article;

(c) Holds a master's or doctoral degree in professional counseling from an accredited school or college or an equivalent program as determined by the board. Such degree or program shall include a practicum or internship in the principles and the practice of professional counseling.

(d) Has at least two years of post-master's practice or one year of postdoctoral practice in applied psychotherapy under supervision approved by the board; and

(e) Has demonstrated professional competence by passing an examination in professional counseling demonstrating special knowledge and skill in applied psychotherapy as prescribed by the board and a written, mail-in jurisprudence examination administered by the department of regulatory agencies.

(3) The examination by the board described in paragraph (e) of subsection (1) of this section shall be given not less than twice per year at such time and place and under such supervision as the board may determine.

(4) The board or its designated representatives shall administer and score the examination and shall take any actions necessary to ensure impartiality. The passing score for the examination shall be determined by the board based upon a level of minimum competency to engage in the practice of licensed professional counseling.

Licensed Marriage and Family Therapist

12-43-504. Qualifications - examination - licensure and registration.

(1) The board shall issue a license as a marriage and family therapist to each applicant who files an application upon a form and in such manner as the board prescribes, accompanied by a fee as is required by section 12-43-204, and who furnishes evidence satisfactory to the board that he or she:

(a) Is at least twenty-one years of age;

(b) Is not in violation of any of the provisions of this article or the rule and regulations adopted under this article;

(c) Holds a master's or doctoral degree from an accredited school or college in marriage and family therapy or its equivalent as determined by the board, such degree to include a practicum or internship in the principles and practice of marriage and family therapy;

(d) Subsequent to receiving his or her master's or doctoral degree, has had at least two years of post-master's or one year postdoctoral practice in individual and marriage and family therapy, including at least one thousand five hundred hours of face-to-face direct client contact as determined by the board for the purpose of assessment and intervention under board-approved supervision; and

(e) Has demonstrated professional competence by passing an examination in marriage and family therapy prescribed by the board and a written, mail-in jurisprudence examination administered by the department of regulatory agencies.

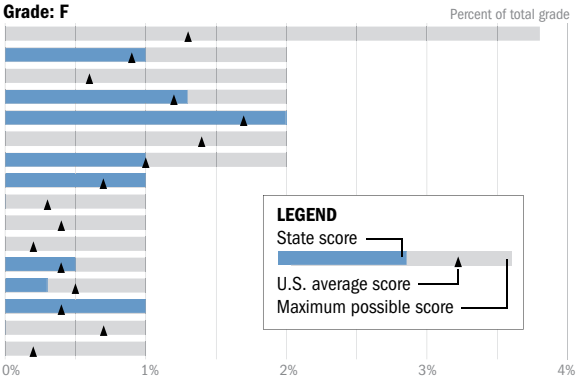
(2) (Deleted by amendment, L. 2007, p. 139, § 3, effective July 1, 2007.)

(3) The examination by the board described in paragraph (e) of subsection (1) of this section shall be given not less than twice per year at such time and place and under such supervision as the board may determine.

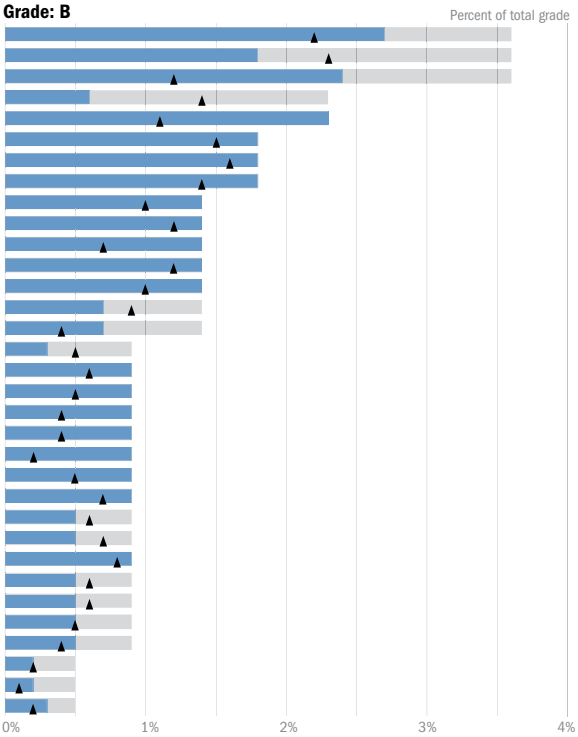
(4) The board or its designated representatives shall administer and score the examination and shall take any actions necessary to ensure impartiality. The passing score for the examination shall be determined by the board based upon a level of minimum competency to engage in marriage and family therapy practice.

NAMI Score Card: COLORADO — Grade: C

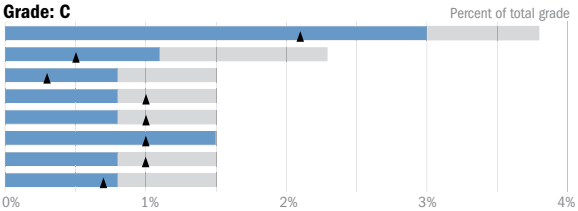
Category I: Health Promotion & Measurement — Grade: F



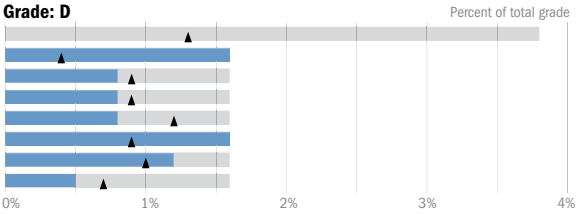
Category II: Financing & Core Treatment/Recovery Services — Grade: B



Category III: Consumer & Family Empowerment — Grade: C



Category IV: Community Integration & Social Inclusion — Grade: D



Appendix C

Innovations in Instruction

Several Colorado institutions of higher education are currently offering professional training programs that are non-traditional in some respect, e.g. how they are delivered, where they are delivered, the focus of the training program. The following information is taken directly from the respective websites.

Colorado State University

The School of Social Work at Colorado State University has announced that it will now offer its Master of Social Work distance education program in Brighton, Colorado to meet the growing labor market demand for trained social workers. The program, offered through the Division of Continuing Education, will be held at their Brighton Learning Center at the Brighton Learning and Resource Campus at 1850 Egbert St.

Colorado State University's nationally-ranked program is fully accredited by the Council on Social Work Education and is also currently offered on-campus and through the Division of Continuing Education in Colorado Springs. The degree program is designed for working professionals who are looking for a part-time degree program that allows them to continue working while they earn an advanced degree.

Classes are held four weekends per semester, three weekends in Brighton and one weekend in Fort Collins. Additional instructional hours are delivered online and through various distance education formats. Colorado State faculty travel to Brighton for classes, maintain regular contact with students online and by phone, and teach an advanced generalist curriculum. Courses include advanced content on individual, group and family practice, community practice, organizational practice, social welfare policy and program evaluation research.

80% of the instruction is received face-to-face and is classroom-based with the other 20% delivered using distance methods. Both Regular Admission and Advanced Standing cohorts meet one weekend per month, four weekends per semester. The first weekend of the semester is typically held in Fort Collins. The subsequent three weekends are held in Brighton for the Brighton cohort or Colorado Springs for the Colorado Springs cohort. There are three semesters of course work each year.

Military Bases

Colorado State University-Pueblo Continuing Education operates in the military education centers on the Ft. Carson and Peterson Air Force Base installations under Memorandums of Understanding with the Departments of the Army and Air Force to offer Social Work baccalaureate degree completion programs as well as others on base.

University of Denver Graduate School of Social Work Programs of Study

Four Corners MSW Degree Program (located in Durango, Colorado)

The Four Corners Program is a unique partnership among the Colorado Department of Human Services, Fort Lewis College, Southwest Colorado Community College and many other Four Corners agencies. Since 2002, this innovative program has met a need for graduate level MSW education in the rural and tribal communities of the Four Corners area.

Program objectives

- enhance social service delivery systems
- address community problems and the special needs of rural communities
- address the concerns and needs of multi-ethnic communities, with special emphasis on local Native American communities
- strengthen the professional social work infrastructure of Four Corners communities

Teaching methods

- Summer intensive courses taught on-site in the Four Corners region by GSSW faculty and local social work professionals
- Classes simulcast and broadcast from Denver using Interactive TV (ITV)
- Online and hybrid courses using Web-based technology.
- Field education internships throughout the Four Corners area
- Both you and your instructors have online access to the University of Denver Penrose Library.

Class schedule

The Four Corners program offers a weekend schedule of Friday afternoon and Saturday classes. This allows you to

be in your community during the week and also work at your field internship sites.

Social work with Native peoples

Because 25% of the student enrollment comes from the area's many Native tribes, the Four Corners program includes a special focus on Native social work content. Two specialized courses, both taught by Native faculty, add Native content to the curriculum.

For detailed curriculum requirements, please see the Four Corners Bulletin

DU Partners with Fort Lewis College on New Social Work Degree Option

The University of Denver Graduate School of Social Work (GSSW) and Durango, Colorado's Fort Lewis College are pleased to announce a new partnership that will enable students in the Four Corners area to earn both a Bachelor's degree in psychology or sociology and Master of Social Work (MSW) degree in just five years. The Cooperative Undergraduate/Graduate Degree program, set to begin in 2010, offers students an affordable alternative to the six years of study typically required to earn both degrees.

Under terms of the new program, Fort Lewis sociology and psychology majors may apply to spend their senior year enrolled in GSSW's Four Corners MSW program. Fort Lewis will accept course-by-course equivalency of the GSSW courses, so students will complete their Bachelor's degrees during their first year of the two-year MSW program.

GSSW's Four Corners MSW program has been available to area students at a reduced-tuition rate since 2002. Classes are taught in Durango or broadcast from the University of Denver campus via interactive television. Classes are scheduled on Friday afternoons and Saturdays to accommodate the needs of students who are employed. Sixty-four students have earned their MSW degrees since the Four Corners program began, and 19 additional students are currently enrolled.

Peace Corps Fellows/USA and Teach for America Partnership Programs

In recognition of their commitment to service, GSSW provides extra financial assistance and other benefits for Returned Peace Corps Volunteers (RPCVs) and Teach for America alumni who pursue a Master of Social Work (MSW) degree. These programs are open to both two-year and advanced standing MSW applicants who attend GSSW full-time.

Peace Corps Fellows/USA program

If you are a Returned Peace Corps Volunteer (RPCV) who is accepted for admission to GSSW as a full-time student, you may be eligible to receive a $5,000 Peace Corps Fellows Scholarship in addition to any merit-based and/or need-based scholarships you may be awarded.

Please complete the GSSW Peace Corps Fellows Application and submit it to GSSW along with the Master of Social Work Application Form and other required admission application documents by February 1. Scholarship decisions are made in late March, and a maximum of four Peace Corps Fellows Scholarships will be awarded each year.

To further honor your service in the Peace Corps, GSSW will waive your MSW application fee.

Teach For America (TFA) Partnership program

If you are a Teach for America alumnus/alumna who is accepted for admission to GSSW as a full-time student, you may be eligible to receive a $5,000 Teach for America Scholarship in addition to any merit-based and/or need-based scholarships you may be awarded.

Please complete the GSSW Teach for America Partnership Application and submit it to GSSW along with the Master of Social Work Application Form and other required admission application documents by February 1. Scholarship decisions are made in late March, and a maximum of four TFA Scholarships will be awarded each year.

To further honor your service in the Teach for America program, GSSW will waive your MSW application fee.

Applying to the Dual Undergraduate/Graduate MSW Program (open only to current University of Denver undergraduate students)

Dual Undergraduate/Graduate degree students begin the two-year MSW program in fall quarter of their fourth year of undergraduate study.

Certificate in Couples and Family Therapy

You may begin work toward this certificate during your concentration year through a cooperative program with the Denver Family Institute. The program provides you with:

- advanced learning and direct clinical training and practice with families, couples and individuals
- state-of-the-art, hands-on training with master practitioners and family therapy trainers, helping you to become a skilled practitioner

- the opportunity to develop a clinical specialty, thus facilitating you future job searches
- clinical supervision (live and video) for licensure and the opportunity for dual licensure in both social work and marriage and family therapy

You'll take ten quarter hours of course work at the Denver Family Institute, completing your first year of work toward the certificate while still at GSSW. After obtaining your MSW, you'll complete an additional year of course work, two years of post master's degree supervision requirements and 500 clinical contact hours.

The Denver Family Institute is accredited by the American Association for Marriage and Family Therapy (AAMFT) and offers the Rocky Mountain region's most extensive training in marriage and family therapy. Most supervisors are both Licensed Clinical Social Workers (LCSW) and AAMFT approved. Classes at the Institute are held in the evening, and every effort is made to accommodate your class and employment schedules.

Metropolitan State College of Denver Master of Social Work Program at Metropolitan State College beginning Fall 2011

The focus of the department is on problems that often affect oppressed minorities representing people of color (African American, Hispanic, Native American, Asian American) and other diverse populations (women and children, gays and lesbians, the developmentally delayed and the aging). The department is committed to helping those individuals in need and working toward leadership in the social, economic and political context that often fosters painful and socially unjust human conditions.

The information below is subject to change, but will give you a good idea of what to expect.

Regular (2-Year) Program students will spend the first five weeks of Field Experience I in "boot camp" which will help orient you to the demands of the field placement. For the remainder of the Fall semester (10 weeks) you will spend about 18 hours per week in your placement. Field Experience II will require 18 hours a week in your placement for the entire 15 weeks of the semester. Field Experience III and IV will require 15 hours a week over both semesters for a total of 30 weeks. Upon completion of your MSW degree you will have completed 900 hours at your placement(s). You will also be attending field seminar either on campus or online each semester.

Advanced Standing students will spend about 15 hours per week at their placement over the Fall and Spring semesters for a total of 450 hours. Each semester consists of 15 weeks. You will also be attending field seminar either on campus or online each semester.

University of Colorado School of Medicine

Fellowships in Advanced Clinical Infant Mental Health Training

The Irving Harris Program in Child Development and Infant Mental Health offers training for postdoctoral graduates as well as experienced infancy and early childhood professionals seeking “community-based” training. It is an advanced 1-year clinical fellowship in infant and early childhood mental health, consultation, and treatment, with a particular focus on the problems of infancy, toddlerhood and parenthood.

The primary focuses of the training are on infancy and early childhood, understanding growth from different cognitive and developmental theories, attachment theory, psychodynamic theory, and family development. The training includes didactic seminars as well as clinical experiences. The seminars cover a variety of topics, including normal infant and early childhood development, temperament, normal pregnancy and pregnancy loss, high-risk infants and parents, developmental psychopathology (including attachment disorders, failure to thrive, and behavior problems), the impact of child abuse and neglect, developmentally appropriate assessment, diagnosis and treatment of infants and toddlers, the treatment of infant-parent psychopathology, and mental health consultation in early childhood settings. The educational experience also includes a clinical component, working with infants, toddlers and their families at a number of settings (some being bilingual) at UCD programs and local mental health agencies.

One-year training positions are available for psychologists and child psychiatrists. In addition to a **demonstrated** interest in infancy and early childhood, applicants must have a PhD or PsyD in clinical psychology and have completed an APA-accredited internship, or an MD and have completed a residency in child and adolescent psychiatry. Minorities and bilingual candidates are encouraged to apply (must be a U.S. citizen) since most of the fellow clinical site placements are bilingual settings. Although most of the trainees in the program are full-time, occasionally arrangements may be made to pursue

training on a part-time basis. Selected candidates for fellowship positions must complete all graduate degree requirements prior to starting fellowship. Postdoctoral fellows receive a stipend plus benefits and paid leave during their training.

Community-based training positions for Master's-level mental health, social work, early childhood education professionals and allied health professionals are available. This training track is for individuals seeking training in infant mental health while continuing their current position and participating in the Harris Program on a part-time basis. Applicants interested in these training positions must have **at least 5 years prior experience** working professionally with young children. Community-based fellows need to commit to one day (Tuesday) a week to attend seminars and individual supervision as well as maintain an adequate clinical caseload of direct service with young children and their families to support supervision and case discussion in the didactic seminars. Community-based training applicants working in agencies will also need a commitment of appropriate "release time" from their agency duties to participate in the fellowship experience. Finally, the applicant's agency will need to be in a position to pay for the fellowship experience through a contract with the University of Colorado Denver to cover training and administrative costs.

Postdoctoral Fellowship in Developmental Disabilities Psychology

JFK Partners--The University Center of Excellence in Developmental Disabilities (UCEDD) is the major training facility for the Developmental Disabilities Program. The training emphasizes an interdisciplinary approach to research, assessment, and intervention, family support, service coordination, and community integration to meet the needs of persons with developmental disabilities. Development of disciplinary and interdisciplinary expertise, leadership and consultation skills and research as well as clinical growth is the goals of the postdoctoral training program. The fellow participates in interdisciplinary evaluations, interventions and consultation with a wide range of persons with developmental disabilities of various types and severity levels. The fellow also attends seminars offered at JFK Partners, in the Division of Psychology in the Department of Psychiatry, and in the Department of Developmental and Behavioral Pediatrics, and is expected to pursue a research project in developmental disabilities.

The post-doctoral fellowship will include: 50-60% specialized clinical training (assessment, treatment modes, consultation) in developmental disabilities with an emphasis on autism spectrum disorders, 30%-40% research (either independent with mentorship or collaborative), and 10% didactics (seminars, workshops, observations in various settings). There will be an attempt, within these general parameters, to match the training program to your specific learning goals. More information about JFK Partners, particularly regarding the range of clinical, research, and consultation programs available to trainees, is available at JFK Partners.

Appendix E

Pathways To Certification And Licensure

Certification and/or licensure for addiction counseling may be obtained through a combination of clinically supervised work experience, addiction specific training, education, and national examinations in the field of addiction treatment.

Two Pathways

There are two pathways to certification and licensure for aspiring addiction counselors in Colorado:

- **Pathway 1** is for those individuals who hold a high school diploma or equivalent who are eligible to obtain a CAC I or CAC II and those who hold a bachelor's degree in the behavioral health sciences who are eligible to obtain a CAC III.
- **Pathway 2** is for those individuals who hold a clinical Masters or doctoral degree.

Pathway 1:

- **CAC I** (Certified Addiction Counselor, Level I) CAC I is considered entry-level. Those individuals with a high school diploma or equivalent may obtain their CAC I by completing the required DBH approved training classes and clinically supervised work experience hours.
- **CAC II** (Certified Addiction Counselor, Level II) CAC II allows the counselor to practice independently with appropriate supervision. Those individuals with a high school diploma or equivalent may obtain their CAC II. The applicant must first obtain a CAC I or meet all the requirements for a CAC I, complete the required number of clinically supervised work experience hours, successfully pass the CAC II required training classes, and present proof of passing a national examination.
- **CAC III** (Certified Addiction Counselor, Level III) A CAC III is the supervisory level. A Bachelors degree in the behavioral health sciences is required. The CAC II must be awarded by DORA before an applicant is eligible to apply for a CAC III. The applicant for a CAC III must also complete the required number of clinically supervised work experience hours, successfully pass the CAC III required training classes, and present proof of passing a national examination.

Pathway 2:

Counselors holding a clinical Masters or doctoral degree may obtain their CAC II, CAC III or LAC by a combination of appropriately clinically supervised work experience hours, DBH approved training classes (or the equivalent, or a combination thereof) and proof of passing a national examination.

Appendix F

Colorado Peer Network

Program Overview

The goal of the Colorado Peer Network project is to adopt a nationally recognized Certified Peer Specialist (CPS) training curriculum, National Association of Peer Specialist Peer Training Manual, and modify it to develop a high quality training system in Colorado.

This training system will then be implemented statewide and serve as the first independent training program meeting all of HCPF's Core Competencies for peer specialists and backed by the Division of Behavioral Health.

Colorado's peer specialist training, employment and continuing education is extremely fragmented and only available to individuals receiving services through a community mental health center. This also prevents peer specialists from communicating with one another and gaining meaningful employment outside the mental health centers. The peers in Colorado also do not receive "certification" that is recognized universally or standardized to ensure quality and consistency. Furthermore, peers working in the system currently are not protected or backed by a third-party entity such as the Department of Regulatory Agencies or a provider organization.

Eventually WE CAN! would like to implement the aforementioned objectives across the state to ensure the safety of the peers working in the system and the individuals they are working with. The first step will be to develop a comprehensive curriculum that meets the state's standards and provide high quality instruction along with guided practice through an internship. After WE CAN! is able to establish the program and show positive outcomes to the state, WE CAN! will seek certification and regulation. WE CAN! is positioned to coordinate this effort and advocate for the best possible conditions and terms for peers in the state.

The Wellness Education and Advocacy Network is an independent peer-driven organization. WE CAN! already provides training to consumers and supporters all over the state, and has been doing so for the past nine years. Peer specialist training will serve as the next step in the process of leadership development for individuals seeking meaningful employment.

Peer Specialist Training and Job Duties in the Denver Metro Area

Denver Veterans Affairs Medical Center information is listed separately on page 61, to differentiate from the public health providers.

	BHI includes Aurora MH, Arapahoe MH, Community Reach	**Colorado Access**	MHCD 2 Succeed Program	Foothills BH partners MHC serving Boulder & Broomfield	Foothill BH partners Jefferson Center for MH
Contact Person	Jen Malloy JMalloy@bhiinc.org 720-490-4400	Robert Bremer Robert.bremer@coaccess.com 720-744-5240	Shahn Anderson Shahn.anderson@mhcd.org 303-504-6500	Moyra Powers mpowers@mhcbb.org 303-413-6393	Lucy Hausner lhausner@fbhpartners.com 303-432-5970 Lori Swanson-Lamm loris@jcmh.org
Description of Training/Trainer	Nate Rockitter is the developer and trainer. The training consists of two classes taught through the Community College of Denver. The first 3 credit course teaches the basic skills needed for peer support. This class is followed by a 4 credit, one semester internship. Total training time for the class is 64 hours (4 hours per week for 16 weeks) and 171 hours for the internship (11 hours per week for 16 weeks consisting of 10 hours of field work and 1 hour class work.) Peers receive 7 credits toward the 24 credits needed for the Human Service Certificate Program.	COAccess purchased training through BHI. Nate Rockitter is the trainer. See description under BHI.	Peers are not required to have training to be hired. They are hired based on skill level, empathy, and experience. In addition to training provided by Shahn Anderson, there are several weeks of on the job training shadowing other peer specialists. Two peers have completed training with Nate Rockitter.	Three types of training have been used. See description for Jefferson Center for MH.	Three types of training have been used: • Ed Knight provides 56 hours of training based on the Georgia model • In past, Keith Frankel provided 40 hours of training using the model from Recovery Innovations/META services. • Others have been trained by Trish Gonske using State Criteria.
Hiring Process	Open positions are selected from the pool of peer specialists trained by Nate Rockitter. BHI offers scholarships for qualified peers. Peers who complete the internship in good standing will be hired (depending on available positions).	Selected from the pool of peer specialists trained by BHI.	Jobs are posted and recommendations are accepted from MHCD case managers and other staff. Peers are selected based on their life experience, ability to relate with others, and their own recovery process.	They are hired from available pool of trained peers.	All are hired according to the Centers standard HR policy and process.
# of peers currently working	12 (two provide supervision to other peers as well as one on one support to consumers).	1	8 (The program has a limit of 10)	5	14
Part time/full time Describe setting and duties	1 full time (supervisor) 11 part time 4 peers working at BHI Aurora MH Community Connections Drop In Center has	Part time The program began September 1, 2009. They are still working out details. Job duties will include	Part time Assigned to work one on one with consumers who are working on their recovery goals. All peers work part time.	Part time 1 peer runs the Drop in Center. 3 peers work Center wide facilitating groups and classes.	10 Part time 4 full time 9 peers working at Jefferson Center Adult Outpatient are part time.

	BHI includes Aurora MH, Arapahoe MH, Community Reach	Colorado Access	MHCD 2 Succeed Program	Foothills BH partners MHC serving Boulder & Broomfield	Foothill BH partners Jefferson Center for MH
	3 peers are shared among BHI Community Reach Rainbow Drop In Center and N Hope older adult program and Park Forrest Nursing Home. 2 peers are shared among BHI Arapahoe MH Outreach Program, Sycamore Day Program (Bridge House and Star Reach clubhouse) and Bridge House in Arapahoe County. 3 peers provide services at Fort Logan. Job duties include facilitating support groups, providing one on one support, guidance, education, advocacy, and resources to consumers. Peer Specialists also provide insight to other staff on how to talk to consumers. BHI Peer Specialists are not part of a treatment team, but they do work jointly with treatment teams. They do not read or write mental health chart notes.	with consumers who are in the hospital, advocacy, and work on recovery.		1 peer works with the Interim Treatment Team.	4 peers working at intensive services are full time. 1 peer working part time at Evergreen Criminal Justice Program at Independence Corner. Duties include one on one sessions with consumers, focusing on life skills, fostering independence, financial literacy, meal planning and shopping, bus training. Other duties include co-facilitating recovery and support groups, transportation to appointments, medication delivery, residential services, helping with sign language class, handing out RTD discount cards, working at Cedar food bank. Jefferson Center peer specialists are part of the treatment team, confer with clinicians and enter notes into computer charts. They attend team meetings with clinicians.
Working in Inpatient or Crisis Settings?	Peers working at Fort Logan and Bridge House, an acute setting, provide services as outlined above.	Not at this time.	Not at this time.	Not at this time.	Peers work at the Hospital Alternative Facility and Fort Logan, providing services as outlined above. They also facilitate a Schizophrenics Anonymous group at Fort Logan.
Supervision and Support for peers	Peers receive 1 hour of team supervision weekly, and receive ½ hour individual supervision from the Peer specialist Supervisor. Generally a "site supervisor" is also assigned to each peer specialist. This person provides	This peer specialist attends the weekly supervision and support meetings for BHI peer specialists. This peer is jointly supervised by Jen Malloy and Nate Rockitter of BHI and the clinical staff at Colorado Access.	Weekly supervision meetings to discuss successes and problems and work together to come up with ideas.	Regular supervisory meetings with one of two supervisors.	Outpatient: supervised by director. Intensive services: 1 peer supervise 2 others, all supervised by Intensive Services Senior Case Manager.

	BHI includes Aurora MH, Arapahoe MH, Community Reach	Colorado Access	MHCD 2 Succeed Program	Foothills BH partners MHC serving Boulder & Broomfield	Foothill BH partners Jefferson Center for MH
	together with the Peer Specialist Supervisor.				Criminal Justice: supervise by Director.
Peer evaluation	Peers are evaluated every 4 months during the first year of service and then twice yearly after that. Consumers working with peer specialists are encouraged to complete satisfaction surveys which provide feedback on peer performance.	Not determined yet.	Evaluated by supervisor.	Evaluated as all employees are.	Performance is monitored by monthly data on how many hours they spend in direct service, how many progress notes they write and timeliness of notes. The evaluation process follows the same process as all other Jefferson Center Staff.
Program evaluation	Consumer satisfaction surveys are also used for program evaluation. They are completed 3 months after initial contact and at subsequent 6 month intervals.	Goal is to reduce readmission rates. No specific program evaluation is in place.	Not separate from MHCD's overall recovery evaluation.	No evaluation for the program is in place at this time.	Work is evaluated according to feedback from the referral base.
Ongoing Training	Ongoing training required by BHI for all staff (cultural competency, HIPPA, corporate compliance, etc) Peers are encourage to attend conference and train-	Not determined yet.	Weekly meetings and ongoing training are provided, but no requirements.	Weekly meetings and ongoing training is provided, but no requirements.	Training provided as opportunities arise: WRAP training, We Can Leadership Academy, etc.

Information on the Denver Veterans Affairs Medical Center is listed separately since it is not part of the public mental health system. The Veterans Administration is actively developing programs that support recovery, including peer services.

Denver Veterans Affairs Medical Center

Contact Person	Megan Harvey megan.harvey2@va.gov 303-399-8020
Description of Training/Trainer	Originally, the VA brought in trainers from Depression and Bipolar Support Alliance (DBSA), but have now purchased the curriculum from the National Association of Peer Specialists (NAPS). All VA programs across the country have adopted this curriculum. It is a forty hour training based on the Georgia Model, but further developed by NAPS. The trainer and trainee manuals are available for purchase at the NAPS website.
Hiring Process	Potential peers are recommended by providers and also internally at the VA. They are invited to the peer supervision meeting to see if they are a good fit. Volunteer peers commit to four hours of work per week. They would be considered first as paid positions became available. The VA system is in the process of developing a competency exam. In the future, peers will need to pass this exam to be considered for hiring. This will be an additional requirement to the peer training and certification.
# of peers currently working	4 are employed, but they also have volunteers working as peer specialists.
~~Part time/full~~ time	3 full time employees 1 part time employee 6 part time volunteers.
~~Describe setting~~ and duties	The VA contracts with providers in the community who provide services to veterans. The peer specialists work in these settings with the veteran population. Settings include: homeless programs, supportive employment, and live skills. Duties include providing one on one peers support, assisting consumers with goals, connecting them to resources, facilitating educational and support groups, and outreach. The peers have flexibility to develop services that are needed. The peer working with individuals who are homeless developed a support group for consumers who had new apartments.
~~Working in Crisis~~ Settings?	Not at this time.
~~Supervision~~ and Support for peers	Peers (including volunteer peer specialists) meet bi-monthly for group supervision and training. Currently they are using the NAPS training materials for ongoing training.
~~Peer Evaluation~~	Supervisors monitor peer and evaluate peer accomplishments.
~~Ongoing Training~~ Requirements	Ongoing training is part of the bi-weekly support meetings.

APA Accredited Internships in Colorado

(11 of the 16 total internship sites in the state)

Aurora Community Mental Health Center, Psychology Internship Program
Aurora, CO, United States — **Application deadline: 11/7**

Colorado Mental Health Institute at Fort Logan, Department of Psychology
Denver, CO, United States — **Application deadline: 11/15**

Colorado State University, CSU Health Network
Fort Collins, CO, United States — **Application deadline: 11/5**

Community Reach Center (Formerly Adams Community Mental Health Center), Psychology Internship
Commerce City, CO, United States — **Application deadline: 11/5**

Denver Health, Behavioral Health Services
Denver, CO, United States — **Application deadline: 11/5**

Metropolitan State College of Denver, Counseling Center
Denver, CO, United States — **Application deadline: 11/1**

The Children's Hospital, Department of Psychiatry and Behavioral Sciences
Aurora, CO, United States — **Application deadline: 11/1**

University of Colorado at Boulder, Wardenburg Health Center, Psychological Health and Psychiatry
Boulder, CO, United States — **Application deadline: 11/1**

University of Colorado Denver School of Medicine (previously UCDHSC), Department of Psychiatry, Division of Clinical Psychology
Aurora, CO, United States — **Application deadline: 11/1**

University of Denver, Graduate School of Professional Psychology, Internship Consortium
Denver, CO, United States — **Application deadline: 11/15**

VA Medical Center, Denver - Eastern Colorado Health Care System, Patient Focused Care (#116B)
Denver, CO, United States — **Application deadline: 11/8**

Non-accredited Internships in psychology in Colorado

Colorado Department of Corrections, Clinical Services
Canon City, CO, United States — **Application deadline: 12/1**

Colorado MH/Inst. Forensic Psychology, Psychology
Pueblo, CO, United States — **Application deadline: 11/5**

Colorado West Regional Mental Health, Inc.,
Grand Junction, CO, United States — **Application deadline: 11/8**

Pikes Peak Mental Health, Horizon Internship Team
Colorado Springs, CO, United States — **Application deadline: 11/8**

University of Northern Colorado Counseling Center
Greeley, CO, United States — **Application deadline: 11/15**

Appendix I

Other potential solutions or comments from key informants or reviewers

- The recent Administration Segregation unit addition for Offenders for Mental Illness (OMI) at Centennial is a fairly large permanent addition to the behavioral health workforce. I am wondering if we have the appropriate training in our education programs to treat and address this population.
- What we don't know: I think this section has important research questions and implications for Colorado. Is there a way to give this report lip service with higher education programs with students looking for research projects? Just a thought. I also see these pieces having some relevance to policy questions and directions. They could be used to create policy objectives within the Workforce Collaborative or just in general.
- To speak to the solutions section: I think the section makes sense and is really captures the immediate actions we need to work on. I would like to see the additional ideas not included as an appendix. As for prioritization, I see this as a task of the stakeholder group [on November 11] that will be convened, rather than needing to set those now.
- From the report: *We don't know if it would be better to think about the shortage of psychiatrists as a shortage of individuals who can prescribe psychiatric medications and identify what other health and behavioral health providers can fill this gap (i.e., advanced practice nurses – APN, Physician's Assistants – PA, psychologists in the future?).* This, then, brings up the question that we need to better track how these providers interact with the behavioral health system, time spent on MH/SA treatment, and where they practice (back to the gaps in data).
- Re: integrated care in Colorado. I would add that there needs to be cultural and policy shifts that need to occur to achieve this. Culturally, we need to increase and shift anti-stigma messages to encourage folks to talk to primary care providers about behavioral health concerns (and vice-versa). Policy shifts need to help create a more "friendly" environment for cross-practicing (coding, reimbursement policies, etc.)
- Would be interesting to analyze the representation of racial and ethnic diversity in the CAC training programs across the state.
- Other possible solutions in Training and Education
  - Develop a statewide prevention specialist certification program
  - Develop a statewide family advocate certification program
- There is a counterbalance happening in other professions where instead of retiring employees are remaining in there jobs longer. Do we know if this is true for the behavioral health professions? General healthcare professions?
- NHSC Vacancies: Do we have this by location? Geographical region? Where might there be gaps?
- Regarding data collection in Division of Behavioral Health: SAMHSA will be requiring us to collect wait list data for a new URS table that will be implemented sometime during the current Data Infrastructure Grant. We also have a performance indicator, Timeliness of a Routine Intake Appointment, but haven't implemented data collection yet. We do have some limited data on stigma through the CDPHE 2007 BRFSS. The optional K-6 module that year contained a couple of questions aimed at the prevalence of stigma. But that's fairly minimal.
- Increase pipeline for students pursuing behavioral health careers by exposing students to educational and employment options.
- *Implementation Next Steps: Colorado already has a program devoted to encouraging students into health professions – The Colorado Area Health Education Centers. These programs geographically span the state and, with support, could expand their current efforts to include behavioral health careers in their current portfolio of activities.*
- Integrate a one year behavioral health add-on to the current curriculum for advanced practice nurse and physicians assistant educational programs. This would increase their ability to serve patients with behavioral health needs and also could position them to better serve rural and underserved communities, where behavioral health providers are limited.
- Tie specific incentives to the state loan repayment program for behavioral health providers. Incentives are essential in driving providers into the biggest areas of need (e.g., within professions, geographically).
- Increasing the supply of and recruitment of psychiatrists is a critical area of need, especially those with pediatric expertise. It is difficult to get appointments with psychiatry and it is difficult for many to pay for these services.

- *Implementation Next Steps: Explore a psychiatric consultation program as has been developed and implemented in other states where psychiatrists are in limited supply.*
- Attract providers who have specialized training in areas such as prevention, child and adolescent populations, geriatric populations, and who speak Spanish.
- Need a way to compensate master's level prepared generalists at a rate that increases recruitment and retention of professionals in areas that are licensed by the State (e.g., Social Workers, PsyD, EdD, MFT, LPC).
- Utilize "grow your own" workforce strategies to build staff capacity in the long term. Grow-your-own workforce strategies are characterized by two important features. First, they use local labor markets as a key source of workforce supply. Second, they encourage organizations to use the skills and talents of their existing workforce more effectively, by providing training to develop and extend of staff roles.
- Integrate community mental health center staff into primary care locations if they have not done so already. The FQHCs do a great job with integrating mental health in the primary care setting, because they are required to do so by federal regulations, however, many rural hospitals and other safety net clinic types do not have access to the resources they need to serve their communities. These facilities could serve as training sites if funding and staff expertise were available.
- Decrease stigma to make behavioral health careers more appealing, especially to young people. Salaries and what money people can expect when employed in the field are factors related to recruitment to the field.
- Legitimize 'preventative specialists' in the State certification or licensing regulations.
- Examine the issue of reciprocity to increase the possibilities of behavioral health providers working across state lines.
- Develop stronger partnerships with other state agencies and educational institutions. Ideally SAMHSA could play a role in working with influencing higher education institutions and various training programs. There is significant variability in education across schools/programs placing greater reliance on the practicum site to 'educate and train'.
- Career ladder development is essential. This would allow someone to enter the field at a certificate level and move up to higher levels of educational attainment (e.g., bachelor's, master's, and doctoral level degree) in a behavioral health field.
- Develop more programs in rural colleges so folks can get educated and trained 'in place'.
- Develop better technology capacity among substance abuse providers.
- Increased outreach and education for the general public regarding behavioral health conditions, treatment options, and existing services.
- Examine the issue of prescribing authority in behavioral health, including the policy implications for changes to the scopes of practice for health and behavioral health providers.