Executive Summary

Introduction

This report presents recommended changes to the regulation of core behavioral health (BH) professionals to **improve access to and the safety of care for Utah consumers.**

- BH covers both **mental health and substance use-related conditions**; the BH field includes a variety of practitioners (e.g., therapists, extenders) working across different settings (e.g., hospitals, clinics) using various treatments (e.g., talk therapy, medication).
- Regulation of BH practitioners is **necessary to protect the public** from harm, but there are many opportunities to **reduce regulatory burdens and open economic opportunities** for the workforce while maintaining or improving safety.[3]
- This review explores the regulation of the following licensed or regulated occupations:[4]
    - Social Work
    - Marriage and Family Therapy
    - Clinical Mental Health Counseling
    - Substance Use Disorder Counseling
    - Psychology
    - Behavior Analysis
    - Recreation Therapy
    - Vocational Rehabilitation Counseling
    - Music Therapy
    - Case Management
    - Crisis Work
    - Peer Support

The review methodology involved:

- **Extensive primary data collection and stakeholder input** through industry focus groups, **100+ interviews**, expert consultations, and group discussions, as well as a statewide workforce survey with **~4K total respondents** and **~1.1K open-ended comments.**
- Analysis of national and state secondary data related to access and safety.
- Review of **800+** relevant publications and a state-by-state review of regulation.

Access to Care

- Utah has a substantial BH **access problem** that is both well-documented and widespread. This finding strongly supports policy reforms that first prioritize improving access to care.
    - As many as **515K Utahns who need BH care** services are not currently receiving them; of these, **210K report a perceived unmet need** for care.[5]
- Utah's unmet need for BH care has serious consequences.

[3] Occupational Licensing: A Framework for Policymakers (2015)
[4] Although they form a critical part of the BH care workforce, this review does not consider the regulation of medical and educational personnel (e.g., primary care providers, psychiatrists, psychiatric nurses, school psychologists).
[5] National Survey of Children's Health (2021); National Survey on Drug Use & Health (2019); The State of Mental Health in America (2022)

- **15-23K more adults and 7-10K more youth** in Utah will suffer from **suicidal ideation** in any given year because they have an unmet need for BH care.[6]
- Unaddressed BH issues lead to a **2-10x increase in burdens** of healthcare and criminal justice spending and decreased economic productivity; **Utahns will earn $2.8 billion less** in any given year because they have an unmet need for care.[7]

Safety of Care

- Unsafe care **harms patients' health, safety, or welfare.** Existing data has significant limitations, so the nature and magnitude of safety issues in BH care in Utah is unknown.
  - Many BH care safety issues arise and are addressed at the entity level, through the licensure of healthcare facilities and human service programs.[8]
  - Safety issues that may be of specific concern in BH care include incidents related to medication, diagnosis, patient absence (e.g., premature discharge), accidents (e.g., falls), seclusion and restraint, victimization (e.g., self-harm, sexual abuse), and administration (e.g., confidentiality breaches, billing fraud).
- Utah may have a BH **safety problem.**
  - Annually, **~370 complaints** are made against Utah BH licensees, ~120 of which are substantiated.[9] These complaints are filed against an average of **~295 licensees**—or 2% of the licensed BH care workforce.
  - **37% of complaints** are filed against licensees with other previous complaints.[9]
  - A separate, national data source ranks Utah **4th worst** for the proportion of repeat offenders with **almost half of past offenders having reoffended**.[10]

Recommendations

Based on these findings, policymakers **should take immediate steps to improve access to care** for Utah consumers, while also seeking to better understand and address potential safety concerns. Utah's well-documented, widespread lack of access to care represents a **pressing public safety** issue in and of itself. Addressing these issues fully will require understanding the drivers of access and safety, and implementing needed changes both within and beyond occupational regulation. In order to improve access to care, while also addressing safety, we recommend that Utah implement the following changes to the licensure of BH professionals:

1. Train Smarter, Not Harder

1a. Supervisor Requirements. Improve the quality of clinicians' postgraduate supervised experience, while also addressing supervision capacity constraints by 1) requiring supervisors

[6] Ali, Lackey, Mutter, & McKeon (2018); National Survey on Drug Use & Health (2021); DHHS Student Health & Risk Prevention (SHARP), Prevention Needs Assessment Survey (2021)
[7] McDaid, Park, & Wahlbeck (2019); Kessler, Heeringa, Lakoma, Petukhova, Rupp, Schoenbaum, Wang, & Zaslavsky (2008).
[8] For definitions, see UCA 26B-2-201(13)(a) and UCA 26B-2-101(23)(a)
[9] Based on Division of Professional Licensing (DOPL) data from the past 5 years (2018-2022); Substantiated complaints result in disciplinary action of some kind (e.g., letter of concern, license suspension).
[10] 44% vs. a 25% U.S. median. The National Practitioner Data Bank shows that of Utah's 360 BH licensees with an NPDB report (e.g., malpractice claim, adverse action against license) from 2010-2022, 159 have 2 or more reports.

to complete targeted training in effective supervision techniques, 2) requiring that a portion of supervisors' continuing education hours directly relate to supervision, and 3) implementing one or more measures to increase supervision capacity.

- A **majority** of incoming clinicians struggle to obtain adequate supervision.[11]
- **Supervision quality matters for both access and safety:** high-quality supervision is associated with reduced burnout, stress, and turnover, and with improved retention.[12]
- **Revising capacity limits** (e.g., # of supervisees) may also help to **improve access.**

1b. Supervision Hours. Reduce the burden and increase the impact of incoming clinicians' postgraduate supervised experience hours by 1) eliminating general experience hour requirements 2) increasing required direct client contact hours 3) increasing required direct clinical supervision hours, and 4) creating a new requirement for direct observation hours.

- **General experience hours** may not meaningfully improve safety and **are burdensome.**
- **Direct client contact**, **direct clinical supervision**, and **direct observation** hours are more closely targeted to safety and more effectively promote practitioner competence.[13]

1c. Continuing Education. Reduce the burden and increase the quality of continuing education for BH professionals by allowing 1) case consultation (also known as peer supervision) and 2) direct observation to count toward required hours.

- **Many Utah practitioners** support retaining continuing education (CE) requirements but **want less burdensome alternatives.**
- Case consultation and direct observation are **beneficial and less burdensome** than traditional, didactic CEs,[14] which can be costly, hard to access, and less effective in improving safety.[15]

2. Expand Pathways and Portability

2a. Exam Alternate Path. Reduce barriers to entry while maintaining high standards of safety and competence for practitioners by providing an alternate pathway that accepts additional supervision hours and recommendations in lieu of clinical exams.

- A supervision-based alternative can maintain safety while **improving access to care.**[16] Utah's recent removal of exam requirements for Certified Social Workers and Social Service Workers has already resulted in substantially more licenses being issued.[17]
- **Exams may hold back qualified practitioners, unnecessarily limiting access.**[18]
- Many Utah **stakeholders are supportive** of a supervision-based alternate pathway.

2b. Interstate Compacts. Support interstate portability for practitioners (e.g., via multi-state compact licensure) while preserving Utah's ability to innovate with its own single-state licensure.

[11] Ellis, Berger, Hanus, Ayala, Swords, & Siembor (2013).
[12] Mor Barak, Travis, Dnika, Pyun, & Xie (2009); Paris & Hoge (2009).
[13] Bearman, Schneiderman, & Zoloth (2016); Borders, Glosoff, Welfare, Hays, DeKruyf, Fernando, & Page (2014); Choy-Brown & Stanhope (2018); Holloway & Neufeldt (1995); Milne & Reiser (2011); Sholomskas, Syracuse-Siewert, Rounsaville, Ball, Nuro, & Carroll (2005); Tugendrajch, Sheerin, Andrews, Reimers, Marriott, Cho, & Hawley (2021)
[14] Beidas, Edmunds, Marcus, & Kendall (2012); Holloway & Neufeldt (1995); Weck, Kaufmann, & Witthöft (2017)
[15] Daniels & Walter (2002)
[16] McGivern, Fischer, Ferlie, & Exworthy (2009)
[17] OPLR Analysis of DOPL Licensing Data; UT HB 250 (2023)
[18] Association of Social Work Boards (2022); OPLR Listening & Vetting Tour

- **Compacts promote consumer access** to BH services by 1) enabling more BH professionals to begin practicing in Utah, 2) allowing Utahns who travel to or live in compact states to maintain continuity of care with their Utah-based providers, 3) broadening consumers' access to specialized care that would otherwise be unavailable in Utah, and 4) attracting and retaining students in Utah's BH training programs.[19]
- Including single- and multi-state licensure paths enables compact participation while preserving state sovereignty and allows practitioners to choose either path.

3. Strengthen Upstream Monitoring

3a. Recovery Assistance (UPHP). Enable BH professionals to confidentially seek recovery assistance while maintaining their licensure by expanding the Utah Professionals Health Program (UPHP) to 1) include BH professionals and 2) cover mental health conditions for all covered professionals.

- Working in BH poses unique challenges, including **high levels of stress and burnout,** which may increase the risk of developing mental health and substance use disorders; suffering professionals who remain untreated pose a **risk to consumers**.[20]
- UPHP effectively assists in recovery; **71% of program participants are sober, licensed, and employed after 5 years**.[21] Retaining them **promotes access to care.**

3b. Safety Checks & Disclosures. Empower consumers and regulators to identify and intervene in unprofessional, unlawful, and unsafe conduct by 1) requiring all clinicians to be enrolled in the FBI "Rap Back" service for ongoing criminal activity checks, 2) authorizing state licensing agencies to query the National Practitioner Data Bank, and 3) requiring clinicians to provide clients with licensing- and safety-related disclosures.

- Safety checks can **prevent consumer harm** without reducing access to care.[22]
- Client disclosures that provide basic information regarding licensing, regulation, and appropriate standards of care promote safety **without being overly burdensome.**[23]

4. Fill Gaps in Career Ladders and Care

4a. Extenders. Provide additional opportunities for individuals to enter the BH workforce in extender roles by 1) expanding existing certification programs, 2) creating a 1-year 'BH Technician' voluntary state certification and 3) creating a bachelor's-level generalist BH license.

- New extender licenses may **attract and retain entry-level BH workers** by providing advancement opportunities and the potential for increased wages.
- Expanding the extender workforce may help to **improve both access and safety** by **enabling clinicians** to spend more of their time working at the **top of their scope**.[24]

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[19] Johnson & Kleiner (2020); Nunn (2016); OPLR Listening & Vetting Tour; OPLR Behavioral Health Care Workforce Survey (CPMDS)
[20] Collins & Cassill (2022); Yang & Hayes (2020)
[21] Utah Professionals Health Program
[22] Roberts, Amirkhanyan, Meier, & Davis (2022); Waters, Parsons, Warnecke, Almagor, & Budetti 2003.
[23] Darby & Weinstock, 2018
[24] OPLR Listening & Vetting Tour; SAMHSA (2022)

4b. Master Addiction Counselors. Provide a path for existing clinicians to work in Utah at their highest level of competence and for prospective clinicians to advance in the substance use disorder counseling subspecialty by creating a Master Addiction Counselor (MAC) license.

- Utahns lack sufficient access to substance use disorder treatment services, creating longer wait times and negative outcomes for those suffering from these disorders.[25]
- A MAC license may help to **address the clinician shortage and associated bottlenecks** by providing a portable pathway for existing MACs to practice in Utah at their highest level of competency and by enabling Substance Use Disorder Counselors' advancement from an extender to a clinician role.[26]

4c. Prescribing Psychologists. Increase access to advanced, specialized BH care services by granting limited prescriptive authority for psychotropic medications to psychologists (RxP) who complete additional training and supervision in psychopharmacology.

- Although their training differs, **prescribing psychologists may be as safe as or safer than current prescribers.**[27] Their malpractice claim rates are as low as psychiatrists', and their performance has been found comparable to that of psychiatrists, psychiatric nurse practitioners, and general physicians on a side-by-side exam of clinical psychopharmacology content knowledge.
- Controlling for other factors, recent research suggests that RxP legislation is associated with a **reduction in rates of mental health-related deaths**.[28]
- RxP legislation **may improve access to care, especially in rural areas.**[29]

5. Streamline Governance

5a. Multi-Profession Board. Foster system-level thinking and consumer focus by 1) creating a multi-profession board to fulfill policy functions and 2) forming subcommittees to fulfill direct licensing functions.

- Single-profession boards may inhibit collaboration/consistency, while multi-profession boards **support system-level thinking and coordination**—a key need for BH in Utah.[30]
- More public and expert representation on regulatory boards **encourages consumer-focused policies** that are geared toward improving both access and safety.[31]

[25] Williams & Bretteville-Jensen (2022)
[26] Johnson & Kleiner, 2020
[27] Curtis,Hoffmann, & O'Leary Sloan, (2022); Cooper (2020); Wautier & Tolman (2007); Mojtabai & Olfson (2011); Beck, Page, Buche, Schoebel, & Wayment (2019).
[28] Choudhury & Plemmons (2023); Hughes, McGrath, & Thomas (2023); Hughes, Phillips, McGrath, & Thomas (2023)
[29] Peck, McGrath, & Holbrook (2020); Shoulders & Plemmons (2023) Forthcoming in Contemporary Economic Policy
[30] Finnochio, Blower, Blick, & Gragnola (1998). Leslie, Bourgeault, Carlton, Balasubramanian, Mirshahi, Short, Carè, Cometto, & Lin, (2022);OPLR Listening & Vetting Tour; Utah Behavioral Health Assessment & Master Plan (2023)
[31] Allensworth (2017); Finnochio, Blower, Blick, & Gragnola, C. (1998); Graddy & Nichol (1989); Hyman (2004); Leslie, Demers, Steinecke, & Bourgeault (2022).