UTAH DEPARTMENT
OF COMMERCE
Office of Professional Licensure Review

2023 Periodic Review

Behavioral Health

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Foreword

Executive Director's Message

On behalf of the Department of Commerce, I am pleased to present the following report from our Office of Professional Licensure Review (OPLR) on the regulation of behavioral health occupations in the state of Utah.

OPLR was launched in 2022 with the objective to ensure that Utah's regulation of the workforce is effective, efficient, and relevant in a constantly changing and growing economy. OPLR's remit includes conducting systematic and substantive reviews of occupational regulation at regular time intervals to reduce unnecessary regulatory burdens. OPLR's work integrates a continual review of statutes and rules into the work of policymaking to ensure that regulations remain right-sized and relevant in today's fast-changing world. This research enables the workforce of the future by providing information on how to regulate in order to optimally balance consumer safety with the need for adequate workforce supply and access to services for the public.

During the course of this review, the OPLR team worked diligently to collect and evaluate the best possible evidence to inform policymakers on how targeted reforms to occupational licensure can help to improve access to safe and competent behavioral health care services for all Utahns. This process involved engaging numerous stakeholders—from industry associations and government leaders to educators, insurers, and consumer groups—and consulting with numerous academic and policy researchers and experts in the field. Further, OPLR's work on this review involved collecting and analyzing a substantial amount of primary and secondary data—not only to bring together critical insights and feedback from among Utah stakeholders, but also to highlight important learnings from other jurisdictions. OPLR's approach to this review was especially focused on balancing the critical need to improve access to care for Utah consumers alongside the important work of ensuring public safety.

OPLR plays a critical role in the Department of Commerce's mission to strengthen trust in Utah's commercial activities through regulation, enforcement, and education. Their work also aligns more broadly with the Cox-Henderson administration's focus on both reducing unnecessary barriers in professional licensing as well as solving the state's mental health crisis. We are optimistic that the recommendations in this review of behavioral health occupational regulation will enable Utah to take steps to promote economic growth and opportunity, improve Utahn's access to behavioral health care services, and promote the safety of this care. As we work together to address the mental health crisis that is impacting us here in Utah and around the world, OPLR's recommendations present a few of many important solutions and efforts that will be needed to improve the system as a whole.

One of OPLR's key takeaways is the need for cross-agency and cross sector action to solve the current crisis. We are grateful for the partnership of the Utah System of Higher Education and Talent Ready Utah, the Utah Department of Health and Human Services, the Utah Insurance Department, and the Utah Substance Use and Mental Health Advisory Council, all of whom made critical contributions to this report and with whom we are privileged to work. Similarly, there are numerous industry associations, employers, insurers, experts, and academics who have contributed to this report. We thank each of them for their time, attention, and expertise.

Working together, we at the Department of Commerce, along with these critical partners, hope to create the conditions for all Utahns to thrive.

Respectfully,

Margaret Busse, Executive Director
Utah Department of Commerce

OPLR Mandate

The Office of Professional Licensure Review (OPLR) was created to fulfill the vision laid out by Governor Spencer Cox in his Executive Order 2021-01 and in the statute enacted by the Utah State Legislature in SB 16 (2022 General Session).

OPLR reviews all proposals for new occupational regulation (licensing, certification, registration) in the state, as well as the regulation of each currently regulated occupation at least once every 10 years. This report is the first of these periodic reviews of currently regulated occupations required by statute.[1] The purpose of each periodic review is to provide a regular, systematic, objective review of each regulated occupation in the state of Utah. This provides legislators, industry, consumers, and licensed individuals with an opportunity to provide input as well as more certainty about when and how licensing requirements might change.

By statute, OPLR applies the following three review factors when evaluating the need for licensure: 1) public safety and potential harm (including financial), 2) access to services and workforce entry, and 3) healthcare reimbursement where applicable. In performing its work, OPLR seeks to balance protecting the health, safety, and financial welfare of the public with minimizing the burden for qualified individuals to practice in their chosen occupations and thereby to provide needed services to the Utah public.

As an independent research and analysis body, OPLR's findings and recommendations do not bind the Department of Commerce nor any regulatory body to any specific actions. This review is meant to inform the legislature and relevant agencies, who then have full discretion to adopt or reject particular recommendations.

[1] UCA 13-1b

Acknowledgements

As a group of policy analysts and researchers with no training in behavioral health care, OPLR relied extensively on experts, licensees, educators, industry groups, DOPL boards and others to learn about the behavioral health care system in Utah and to understand its dynamics. We are grateful to all the behavioral health practitioners, leaders, and experts who gave generously of their time to inform this review.[2] In particular, we want to thank each of the survey respondents and focus group participants who engaged with us. We logged thousands of responses and comments from these participants, directly influencing our thinking and recommendations.

We are similarly grateful for highly capable and motivated partners across the executive branch of government in the state. As the agencies responsible for administering the licenses included in this review, we wish to thank the Division of Professional Licensure (DOPL) and the Department of Health and Human Services (DHHS) and their respective leadership teams for the many, many hours they spent graciously answering our questions and adding to our understanding. The Utah System of Higher Education, and especially Talent Ready Utah, were key partners in understanding and addressing the challenges of educating the workforce. Lastly, the Utah Substance Use and Mental Health Advisory Council (USAAV+) within the Utah Commission on Criminal & Juvenile Justice (CCJJ) became our de facto sounding board, providing early and frequent access to a wide range of representatives across the state to refine our findings and recommendations.

This review was undertaken simultaneously with an effort by the Utah Hospital Association (UHA) and the Kem C. Gardner Institute to create a Behavioral Health Master Plan. We are deeply grateful to the lead investigators and their advisory council for the exchange of information and collaboration. We hope that this review has proven complementary and helpful to that effort.

Lastly, OPLR expresses our thanks for all those working in behavioral health across the state. This review has highlighted not only the tremendous need for their services, but also the dedication of the many highly motivated professionals working in often difficult settings to help our family members, friends, and neighbors who are facing mental health and substance use challenges.

[2] For a non-exhaustive list of contributors, please see the Appendix.

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).

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Introduction

Review Motivation & Objectives

Utah is in the midst of a behavioral health (BH) crisis, and BH professionals are essential to confronting this crisis. While the causes of suicide, depression, substance use, and other BH disorders are multi-faceted and complex, unmet need for BH care has been associated with increases in disability,[32] unemployment,[33] substance use,[34] homelessness,[35] incarceration,[36] suicide,[37] and poor quality of life.[38] A sufficient supply of BH professionals that is prepared to intervene early can save lives and resources.[39] Licensing is not the only determinant of workforce size, but it does set the requirements in terms of education, exams, training, and experience required for new entrants. Thus, licensing can be the fulcrum for changing the supply of professionals in the BH field, and thereby the availability of BH services for Utahns. For additional information on the rationale for prioritizing this review, please refer to the Appendix, which includes a copy of the proposal submitted to the Business & Labor Interim Committee in the fall of 2022.

The objective of this periodic review is to identify **changes to occupational regulation** that will help to improve the effectiveness of Utah's BH care system by **improving access to and the safety of BH care services** in the state. Based on this objective, this report is focused on answering the following research questions:

[32] GBD 2019 Mental Disorders Collaborators (2022). Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry*, 9(2), pp.137–150. doi:https://doi.org/10.1016/s2215-0366(21)00395-3.
[33] Biasi, B., Dahl, M.S. and Moser, P., 2021. *Career effects of mental health (No. w29031)*. National Bureau of Economic Research. https://www.nber.org/system/files/working_papers/w29031/w29031.pdf.
[34] Cafferky, B.M., Mendez, M., Anderson, J.R. and Stith, S.M., (2018). Substance use and intimate partner violence: a meta-analytic review. *Psychology of Violence*, 8(1), p.110. https://psycnet.apa.org/buy/2016-44359-001.
[35] Padgett, D.K. (2020). Homelessness, housing instability and mental health: Making the connections. *BJPsych Bulletin*, [online] 44(5), pp.1–5. doi:https://doi.org/10.1192/bjb.2020.49.
[36] Greenberg, G.A. and Rosenheck, R.A. (2008). Jail Incarceration, Homelessness, and Mental Health: A National Study. *Psychiatric Services*, 59(2), pp.170–177. doi:https://doi.org/10.1176/ps.2008.59.2.170.
[37] Ali, M.M., Lackey, S., Mutter, R. and McKeon, R. (2018). The Relationship Between Perceived Unmet Mental Health Care Needs and Suicidal Ideation and Attempt. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(5), pp.709–715. doi:https://doi.org/10.1007/s10488-018-0856-z.
[38] Wang, Y., Henriksen, C. A., ten Have, M., de Graaf, R., Stein, M. B., Enns, M. W., & Sareen, J. (2017). Common mental disorder diagnosis and need for treatment are not the same: Findings from the NEMESIS study. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(4), 572–581. https://doi.org/10.1007/s10488-016-0745-2.
[39] Steinberg Institute (n.d.). *Fact Sheet: The cost benefits of early intervention in mental illness – Steinberg Institute*. [online] steinberginstitute.org. Available at: https://steinberginstitute.org/fact-sheet-cost-benefits-early-intervention-mental-illness/

- How can we change occupational regulation to **improve access to care?**
- How can we change occupational regulation to **improve the safety of care?**

Given the remit of the Office of Professional Licensure Review (OPLR), this review focuses on ways to improve access and safety through changes to occupational regulation and licensing. This report also highlights additional ideas and opportunities across the BH care system, often related to factors beyond licensure itself, that may likewise help to improve these outcomes.

Review Scope & Methodology

Reviewed Occupations

The BH licenses and certifications listed in Table 1.1 were included in the scope of this review. While the BH system includes several other regulated occupations (e.g., psychiatry, medicine, nursing, and school psychology), those occupations will be reviewed separately.

Table 1.1 Regulated Behavioral Health Occupations Under Review

Division of Professional Licensing (DOPL)	
• Social Worker (9,200 active licensees)	Section 58-60-204
• Marriage & Family Therapist (1,400)	Section 58-60-304
• Clinical Mental Health Counselor (2,600)	Section 58-60-404
• Substance Use Disorder Counselor (500)	Section 58-60-504
• Psychologist (1,200)	Section 58-61-703
• Behavior Analyst (700)	Section 58-61-703
• Therapeutic Recreation Specialist (700)	Section 58-40-301
• Vocational Rehabilitation Counselor (200)	Section 58-78-301
• State Certified Music Therapist (70)	Section 58-84-201
Department of Health and Human Services (DHHS)	
• Certified Peer Support Specialist (109)	Section R523-5-4
• Child/Family Peer Support Specialist/ Family Resource Facilitator (23)	Section R523-6-2
• Certified Case Manager (1043)	Section R523-7-4
• Certified Crisis Worker (128)	Section R523-17-6

The Behavioral Emergency Services Technician and Advanced Behavioral Emergency Services Technician (Utah Code 26-8a-302) licenses were also included in this review. After

conversations with the relevant officials in DHHS, OPLR found that neither license has any active licensees. As such, these licenses will not be discussed further in this field-level report.

Data & Methods

OPLR utilized a broad range of data and methodologies during the course of this review, including primary data collection and stakeholder input, secondary data analyses, and a review of other jurisdictions' policies and of relevant academic and policy literature.

For more detailed information on OPLR's research methodology, please see the Appendix.

Primary Data Collection & Stakeholder Input. To gain an in-depth understanding of the varying perspectives of Utah's BH system stakeholders, OPLR conducted a survey of the BH workforce, along with focus groups, interviews, and informal meetings and discussions with many stakeholders.

- **Behavioral Health Care Workforce Survey**: OPLR distributed this survey to all active DOPL BH licensees to collect workforce data such as licensees' employment status and setting, education, geographic distribution, and demographics.[40]
- **Listening & Vetting Tour**: OPLR worked closely with a wide variety of stakeholders, conducting 12 industry focus groups and over 100 interviews with practitioners, DOPL board chairs, DHHS administrators, and a wide variety of other experts, leaders, and groups in both BH care and licensing policy. After developing initial recommendations, OPLR presented its findings and draft recommendations to over 200 key stakeholders for feedback. This feedback was used to revise and refine the specifics of the final recommendations.

Secondary Data Analyses. To better understand the prevalence of BH conditions in Utah and to assess consumers' access to safe and competent care, OPLR drew on several extant datasets to inform the analysis.

- **Access Data**: OPLR analyzed national- and state-level data on BH disorder prevalence, treatment, and outcomes measures from sources such as the National Survey on Drug Use and Health (NSDUH) from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Survey of Children's Health (NSCH) from the Health Resources and Services Administration.
- **Safety Data**: OPLR analyzed DOPL licensing complaint data relevant to BH licensees, as well as national data on malpractice payments and adverse action reports (e.g., disciplinary action against a licensed BH professional) from the National Practitioner Data Bank (NPDB).

[40] The survey used core questions from the Cross Profession Minimum Data Set (CPMDS) survey instrument. CPMDS was developed by Dr. Hanna Maxey (Director of the Bowen Center for Health Workforce Research and Policy, Indiana University School of Medicine) in collaboration with multiple national health professions' associations.

Policy Landscape & Academic Literature Reviews. Finally, to gain a better understanding of patterns and variation in approaches to regulating the BH workforce, and to examine evidence regarding the impact of various policies on access and safety outcomes, OPLR conducted a nationwide review of regulation, alongside an in-depth review of academic and policy literature.

- **National Regulation Review**: OPLR reviewed licensing laws and policies for all 50 states plus territories for every major BH occupation under review.[41] Data collected included structure and governance policies (e.g., license types, levels, titles, and scopes of practice), entry requirements (e.g., education, supervision hours, exams, and criminal history), and practice requirements (e.g., continuing education, renewal cycles, fees).
- **Literature Review**: OPLR identified and reviewed over 850 relevant resources (e.g., academic journal articles, policy reports) to conduct foundational research on BH care systems and related workforce policies, as well as to locate evidence on the impact of various licensing regulations' impact on consumer access and safety.

Behavioral Health Background & Definitions

Overview

Behavioral health (BH) care encompasses the prevention and treatment of both mental illness and substance use disorders.[42] **Mental illness** includes the presence of mental, behavioral, or emotional disorders that cause individuals to experience distress and impairment, and which may "substantially [interfere] with or [limit] one or more major life activities." **Substance use disorders** "occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[43] Mental illness and substance use disorders often occur together—researchers estimate that between 50-80% of people who have a substance use disorder also have another mental health condition.[44]

Currently, the most common treatment methods for both mental and substance use disorders fall into two broad categories: (1) psychotherapy, counseling, and other behavioral interventions and (2) medication. Psychotherapy, also commonly known as "talk therapy," is usually delivered in one-on-one, family, or group sessions with a therapist. Other examples of behavioral interventions include psychoeducation, support groups, psychosocial rehabilitation following in-patient treatment, supported employment and vocational rehabilitation, or case management

[41] National licensing law & policy reviews were conducted for the following professions: social work, clinical mental health counseling, marriage & family therapy, substance use disorder counseling, psychology, recreational therapy, music therapy, prevention specialists, and clinical supervisors.
[42] BHI Collaborative (2021). *Behavioral Health Integration Compendium*. [online] American Medical Association. Available at: https://www.ama-assn.org/system/files/bhi-compendium.pdf.
[43] SAMHSA (2019). *Mental Health and Substance Use Disorders*. [online] Samhsa.gov. Available at: https://www.samhsa.gov/find-help/disorders.
[44] Commission on Narcotic Drugs (2022). *Comorbidities in drug use disorders*. [online] United Nations Office on Drugs and Crime. Available at: https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC_Comorbidities_in_drug_use_disorders.pdf

services.[45] Individuals may also be prescribed medications to manage their conditions, such as antipsychotics, antidepressants, anti-anxiety medications, or mood stabilizers. All of these services may be delivered both in inpatient (e.g., hospitals, skilled nursing facilities, and residential treatment programs) and in outpatient settings (e.g., mental health clinics and primary care settings).

For more background information on the BH care system, including information on models of care, payment systems, and the workforce, please see the Appendix.

National Trends

Millions of Americans experience BH disorders every year. In 2023, Mental Health America reported that 21% of American adults, or about 50 million individuals, were experiencing a mental illness, and 15% of adults had a substance use disorder in the last year (the vast majority of whom did not receive treatment).[46] U.S. youth are also suffering, with 16% of youth reporting at least one major depressive episode in the last year, 60% of whom did not receive treatment. These high rates of prevalence may be due in part to a lack of access to care across the country; many Americans report being unable to seek care due to financial issues, including a lack of health coverage, and many areas lack sufficient coverage by BH professionals. The COVID-19 pandemic has also been associated with an increase in BH issues across the country.[47]

Utah Trends

Utah's BH crisis is particularly acute as compared to the rest of the nation. Suicide is the leading cause of death in Utah for youth and young adults (aged 15-24), and the second- and third-leading causes of death for adults aged 25-34 and 35-44, respectively, placing Utah 9th in the nation for the highest rate of suicide.[48] Utahns report consistently higher rates of self-reported lifetime depression than the national average (23.1% vs. 18.8% in 2020),[49] and Mental Health America ranks Utah 48th among states (51st being the worst) for prevalence of adult mental illness in 2022.[50] For instance, data captured by the Household Pulse Survey in April and May of 2022 showed that the proportion of Utahns who had taken prescription

[45] National Alliance on Mental Illness (2020). *Mental health treatments* [online] Nami.org. Available at: https://www.nami.org/About-Mental-Illness/Treatments.
[46] Mental Health America (2023). *THE STATE OF MENTAL HEALTH I N AMERICA*. [online] *https://mhanational.org/*. Available at: https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf?eType=ActivityDefinitionInstance&eId=5768b343-b128-4de9-a180-20ed43f570d4.
[47] National Institutes of Health (2022). *COVID-19 Mental Health Information and Resources*. [online] covid19.nih.gov. Available at: https://covid19.nih.gov/covid-19-topics/mental-health.
[48] American Foundation for Suicide Prevention (2022). *Utah Suicide Facts*. [online] afsp.org. Available at: https://afsp.org/facts/utah
[49] Utah Department of Health (2022). *IBIS-PH - Health Indicator Report - Depression: Adult Prevalence*. [online] ibis.health.utah.gov. Available at: https://ibis.health.utah.gov/ibisph-view/indicator/view/Dep.html.
[50] Mental Health America (2022). *Ranking the States 2022*. [online] mhanational.org. Available at: https://mhanational.org/issues/2022/ranking-states#prevalence_mi.

medications for mental health in the past month (29.1%) was also higher than the national average (23.1%).[51]

Behavioral Health Licensure in the U.S.

Relative to the physical health care workforce, regulation of the BH care workforce has emerged much more recently and is much more varied across the United States. Licensure of BH professions emerged in a patchwork pattern across the country, beginning in the mid-20th century. The result is a regulatory landscape in which some professions, such as psychology and social work, have relatively well-established and consistent licensure laws in most states (although not to the degree of the medical professions), while other professions, such as addiction counseling, recreational therapy, or behavior analysis, are not regulated in every state, and continue to seek licensure in others. As shown in Table 1.2, clinical therapists, who can independently diagnose and treat BH conditions, are the most consistently regulated BH professions nationally. This group includes psychologists, social workers, marriage and family therapists, and professional counselors (i.e., clinical mental health counselors). However, even among these professions, license titles and specific entry requirements still vary significantly from state to state.

Table 1.2 Commonly Regulated Behavioral Health Occupations[52]

Occupational License	# of Jurisdictions Regulating *
Psychologist	52
Clinical Social Worker	52
Professional Counselor	52
Marriage & Family Therapist	51
Social Worker (Non-clinical)	47
Peer Recovery Support Specialist	43
Prevention Specialist	43
Drug and Alcohol Addictions Counselor	42

** Includes 50 U.S. States, plus Washington D.C. & Puerto Rico*

Across the U.S., these occupations are regulated by licensing boards, which are generally composed of licensed practitioners and public members. Some boards are independent, taking direct responsibility for the day-to-day administration of licensing functions such as processing

[51] United States Census Bureau (2022). *Week 45 Household Pulse Survey: April 27 - May 9*. [online] Available at: https://www.census.gov/data/tables/2022/demo/hhp/hhp45.html.
[52] The Knee Center for the Study of Occupational Regulation (n.d.). *CSOR Occupational Regulation Database.* [online] Available at: https://csorwvu.com/find-occupations/; OPLR National Review of Regulation

applications, issuing and renewing licenses, conducting investigations, and carrying out disciplinary actions. Others function in an advisory capacity to a regulatory agency (as with DOPL in Utah), and ultimate regulatory authority is held by state officials who have "no financial interest in the occupation that is being regulated."[53] The administrative functions of licensing are usually funded by fees paid by licensees at initial licensure and renewal. Utah has low fees relative to other states, with master's-level clinical therapists fees around $210 on average in other states, and $120 in Utah.[54]

Licensure Background & Context

One of the difficulties of licensure reform is the complexity of the policy area itself. Terms like licensing, certification, and registration all indicate occupational regulation, but they are often used differently across (and even within) jurisdictions. To add to the complexity, multiple constituents have an interest in licensure policies (e.g., licensees, industry associations, employers, consumers), and seek different benefits from licensure policy. Consequently, these different constituents focus on different aspects of licensure. Below, we present OPLR's view of occupational regulation and reform as context for the findings and recommendations that follow.

Theories of Occupational Regulation

Researchers have developed several theories to explain the emergence of licensing in the context of any particular occupation.[55] The consumer protection theory, which states that licensing protects the public from incompetent or unethical practitioners, most closely reflects the primary aims and ideals of OPLR and of regulators more generally. Licensing serves as a signal of safety and quality in cases where the harm done by an incompetent practitioner would be severe and permanent (e.g., a doctor, a pilot), or where consumers may find it difficult to accurately assess practitioners' competence. Minimum training requirements, standards of practice, penalties for misconduct, and recourse for harmed consumers all contribute to this function.

However, public safety is not the only factor that drives occupational regulation—licensing policy can also emerge from the interests of the regulated professions themselves. For example, public choice theory posits that "practitioners seek licensing in order to reduce competition and drive up their own wages at the expense of the general public."[56] Another theory is professionalization, in which licensing is viewed as the final step in an occupation's effort to organize, gain influence, and raise the status of the occupation. Finally, the theory of occupational arms races applies to professions that share overlapping functions and that may

[53] Federal Trade Commission (2015). *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants **. [online] *www.ftc.gov*. Available at: https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf
[54] OPLR National Review of Regulation
[55] Scheffler, G. and Nunn, R. (2019). *Occupational Licensing and the Limits of Public Choice Theory Occupational Licensing and the Limits of Public Choice Theory Repository Citation Repository Citation*. [online] Available at: https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=3074&context=faculty_scholarship
[56] See pg. 26 Ibid.

be competing amongst themselves to defend their ability to work, obtain a wider scope of practice, or maximize earnings and employment at the expense of the others.[57]

Licensing Policy Reform

Likely driven by a combination of the factors described above, the share of the U.S. workforce affected by occupational regulation has grown dramatically in recent decades. While only about 5% of U.S. workers held state licenses in the early 1950s, that proportion had jumped to 25% as of 2008.[58] OPLR's recent internal census of Utah's executive branch agencies shows that between 32 and 38% of the Utah labor force is regulated in some way in the practice of their occupation.[59] Due to the substantial social and economic burdens that may result from over-licensing, the movement for licensing reform enjoys broad political support. The consensus among many groups is that the common goals of economic and social wellbeing can be advanced through the regular review and careful tailoring of licensing regulations, including reducing licensing restrictions and burdens when possible.

This political consensus is the result of several converging motivations. Progressives' focus on reducing employment barriers for socioeconomically disadvantaged populations was highlighted in the Obama White House's 2015 report, "Occupational Licensing: A Framework for Policymakers." This report emphasized reducing licensing barriers to employment and carefully tailoring regulations to avoid "overly broad or burdensome" requirements.[60] Separately, the conservative push for deregulation in general is apparent in the regular reports and research published by the Institute for Justice,[61] and other conservative groups that support significant reductions in occupational regulation. The White House report provided policymakers and regulators with a three-part framework for best practices in licensing policy reform:[62]

- Ensure that licensing restrictions are **closely targeted to protecting public health and safety**, and are not overly broad or burdensome
- Facilitate a careful consideration of licensure's **costs and benefits**
- Work to **reduce licensing's barriers** to **mobility**

[57] See pg. 32-33 Ibid.
[58] The Department of the Treasury Office of Economic Policy, The Council of Economic Advisers, and The Department of Labor (2015). *Occupational Licensing: A Framework for Policymakers*. Available at: https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf
[59] OPLR Licensing Census
[60] The Department of the Treasury Office of Economic Policy, The Council of Economic Advisers, and The Department of Labor (2015). *Occupational Licensing: A Framework for Policymakers*. Available at: https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf
[61] Institute for Justice, Knepper, L., Deyo, D., Sweetland, K., Tiezzi, J. and Mena, A. (2022). *License to Work 3*. [online] ij.org. Available at: https://ij.org/report/license-to-work-3/.
[62] The Department of the Treasury Office of Economic Policy, The Council of Economic Advisers, and The Department of Labor (2015). *Occupational Licensing: A Framework for Policymakers*. Available at: https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf

Framework for Occupational Regulation

After reviewing the existing literature,[63] OPLR created a generalized framework to describe the various policy 'levers' that comprise occupational regulation. These levers fall into one of three categories: 1) structure and governance levers, 2), entry levers, and 3) practice levers.

- **Structure & governance levers** determine the nature and responsibilities of oversight entities (such as licensing divisions and boards), the model of regulation or authorization type (e.g., licensure, certification, or registration), and the parameters of authorization (e.g., scopes of practice, exemptions, or other limits on individuals' authority to practice).
- **Entry levers** establish qualifications for individuals' entry into *a* regulated profession, such as educational, experiential and exam requirements. These levers also include alternate pathways to licensure (e.g., by endorsement, compacts, or other pathways) as well as application procedures (e.g., ID requirements, background checks).
- **Practice levers** address practitioners' conduct after their entry into a regulated profession; examples include standards of professional conduct, procedures for monitoring, investigation, and enforcement, and renewal requirements such as continuing education.

In the findings and recommendations that follow, OPLR has attempted to consider all of these licensure policy levers as options for improving BH access and safety.

For additional background information on the policy levers and on the regulation of BH professionals both in Utah and beyond, please see the Appendix.

[63] Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *Google Books*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.

Findings

Access to Care

Background & Definitions

The Office of Professional Licensure Review (OPLR) is statutorily mandated[64] to consider occupational regulation's effects on the supply of practitioners in a field, on the barriers that practitioners face as they enter into an occupation, on license reciprocity between jurisdictions and its associated impacts on practitioners' mobility, and on reimbursement for health care services. All of these factors may ultimately impact Utahns' **access to care,** through their intended or unintended effects on the size, composition, and structure of the behavioral health (BH) workforce.

Access to care, or in other words, whether individuals are able to receive the care they need, when they need it,[65,66,67,68] can be understood and measured in terms of the "Six A's"—whether services are **available**, **affordable**, **accessible**, **acceptable**, and **adequate**, and whether patients are **aware** of the services and options that are available to them (see Table 2.1).[69,70,71] These dimensions of access are affected by many interconnected factors and systems, including insurance coverage, transportation, facilities' locations and hours of operation, translation service availability, societal and cultural attitudes, and most relevant to the scope of this review, workforce availability.[72] In the context of BH, occupational regulation can have a significant impact on workforce availability, as the majority of BH providers, particularly those providing clinical services such as diagnosis and psychotherapy, are state licensed or certified.

[64] UCA 13-1b-302 - Office of Professional Licensure Review
[65] Ricketts, T.C. and Goldsmith, L.J., (2005). *Access in health services research: the battle of the frameworks*. *Nursing outlook*, *53*(6), pp.274-280. Available at: https://pdf.sciencedirectassets.com/272472
[66] McLaughlin, C. G., & Wyszewianski, L. (2002). *Access to care: remembering old lessons*. *Health services research*, *37*(6), 1441–1443. Available at: https://doi.org/10.1111/1475-6773.12171
[67] Tran, L.D. and Ponce, N.A., (2017). *Who gets needed mental health care? Use of mental health services among adults with mental health need in California*. *Californian journal of health promotion,* 15(1), p.36. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515380/pdf/nihms876512.pdf
[68] Walker, E.R., Cummings, J.R., Hockenberry, J.M. and Druss, B.G. (2015). *Insurance Status, Use of Mental Health Services, and Unmet Need for Mental Health Care in the United States*. *Psychiatric Services*, [online] 66(6), pp.578–584. Available at: doi:https://doi.org/10.1176/appi.ps.201400248.
[69] McLaughlin, C.G. and Wyszewianski, L., (2002). *Access to care: remembering old lessons.* Health services research, 37(6), pp.1441-1443. Available at: doi: https://doi.org/10.1111%2F1475-6773.12171
[70] Penchansky, R. and Thomas, J.W., 1981. *The concept of access: definition and relationship to consumer satisfaction*. Medical care, pp.127-140.
[71] Saurman, E., 2016. *Improving access: modifying Penchansky and Thomas's theory of access. Journal of health services research & policy*, *21*(1), pp.36-39.
[72] Andersen, R. and Aday, L.A., (1978). *Access to medical care in the US: realized and potential*. *Medical care*, pp.533-546. Available at: https://journals.lww.com/lww-medicalcare/_layouts/15/oaks.journals/downloadpdf

Table 2.1 The "Six A's" of Access to Care[73]		
Dimension	Definition	Components & Examples
Availability	Supply & demand	• Workforce size & composition • Consumers' & communities needs
Affordability	Financial & incidental costs	• Costs of services • Insurance coverage, network adequacy, underinsurance
Accessibility	Location & transportation	• Proximity (distance, travel time) • Transportation availability (e.g., infrastructure)
Acceptability	Consumer perception	• Accommodation of consumers' needs & preferences (e.g., service language, cultural factors)
Adequacy	Organization	• Hours of operation • Physical infrastructure • Referral or appointment systems
Awareness	Communication & information	• Public health literacy • Effective communication between system participants (clinicians, patients, etc.)

Access to care can also be measured in terms of **met and unmet need** for care—in other words, whether those who need care actually receive it. Measuring met need met need can help policymakers to understand the current capacity and reach of the healthcare system, by providing insights into how many people are currently being served, which can then be considered in relation to the size of the workforce and to other system resources (e.g., facilities, hospital beds). **Unmet need** can be either clinical (meaning that an individual meets the criteria for a formal diagnosis of a BH disorder) or perceived (meaning that individuals who think they need care are not receiving it).[74,75] There is strong evidence to suggest that many individuals with BH conditions recover on their own, so measures of clinical unmet need may overestimate

[73] Based on Table I. from Saurman, E. (2015). Improving access: modifying Penchansky and Thomas's Theory of Access. *Journal of Health Services Research & Policy*, [online] 21(1), pp.36–39. doi:https://doi.org/10.1177/1355819615600001

[74] Ricketts, T.C. and Goldsmith, L.J., (2005). *Access in health services research: the battle of the frameworks. Nursing outlook*, *53*(6), pp.274-280. Available at: https://pdf.sciencedirectassets.com/272472

[75] Thoits, P.A., (2022). *Clinical Need, Perceived Need, and Treatment Use: Estimating Unmet Need for Mental Health Services in the Adult Population.* Journal of Health and Social Behavior, *63*(4), pp.491-507. doi: https://doi.org/10.1177/00221465221114487

the system capacity needed to provide sufficient amount of care at the population level.[76,77,78,79] In short, "individuals' perceived need for treatment may better predict their service use, which in turn determines the degree to which mental health treatment needs in the population are met versus unmet."[80] In this way, measuring perceived unmet need may help to illustrate how much additional demand for services exists that is not currently being met by the BH care system.

Current Access to Care in Utah

Understanding the magnitude of unmet need for BH care in Utah can help guide policy decisions intended to improve workforce availability and other access factors. The following analysis centers on access to care for both mental illness and substance use disorders, and provides information on access for both adults and children.[81]

Overall Met & Unmet Need for BH Care in Utah. Utah's BH care system is currently serving the needs of approximately ~527,000 individuals, while an additional ~206,000 to ~515,000 individuals have either a perceived or clinically defined unmet need for care. This equates to a total need in the state for services for between 732,000 and 1,042,000 individuals.[82] To provide services to all Utahns with a perceived unmet need for care would thus represent a 39% increase in the reach of the BH care system; to reach all of those with a clinical unmet need for care would represent a 98% increase.

Met & Unmet Need—Adults. An estimated 27% (599,000) of Utah's adult population has any mental illness (AMI), and 6% (141,000) has a serious mental illness (SMI).[83] Both of these were

[76] Roberts, T., Miguel Esponda, G., Krupchanka, D., Shidhaye, R., Patel, V. and Rathod, S. (2018). Factors associated with health service utilisation for common mental disorders: a systematic review. *BMC Psychiatry,* 18(1). doi:https://doi.org/10.1186/s12888-018-1837-1.

[77] Slade, M. and Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC Psychiatry*, 15(1). doi:https://doi.org/10.1186/s12888-015-0678-4.

[78] Thoits, P.A. (2022). Mental Health Treatment Histories, Recovery, and Well-being. *Society and Mental Health*, 12(1), p.215686932110688. doi:https://doi.org/10.1177/21568693211068879

[79] Wang, Y., Henriksen, C. A., ten Have, M., de Graaf, R., Stein, M. B., Enns, M. W., & Sareen, J. (2017). *Common mental disorder diagnosis and need for treatment are not the same: Findings from the NEMESIS study.* Administration and Policy in Mental Health and Mental Health Services Research, *44*(4), 572–581. Available at:https://doi.org/10.1007/s10488-016-0745-2

[80] Page 492, Thoits, P.A., 2022. Clinical Need, Perceived Need, and Treatment Use: Estimating Unmet Need for Mental Health Services in the Adult Population. *Journal of Health and Social Behavior*, *63*(4), pp.491-507. doi: https://doi.org/10.1177/00221465221114487

[81] Because the available data is from 2020-2021 for children and from 2018-2019 for adults, because Utah has experienced substantial population growth during this period, and because the COVID-19 pandemic has increased the prevalence of BH disorders, the figures presented likely represent an underestimate of the number of individuals who might benefit from access to BH care services in the state of Utah. For methods notes, please see the Appendix.

[82] Because the available data is from 2020-2021 for children and from 2018-2019 for adults; because Utah has experienced substantial population growth during this period, and because the COVID-19 pandemic has increased the prevalence of behavioral health disorders, these ranges likely represent an underestimate of the number of individuals who might benefit from access to behavioral health care professionals' services in the state of Utah. Also, please note that these total figures do not attempt to control for the double counting of individuals with both substance use disorder and mental health treatment needs.

[83] See table 27, pg. 55, National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia). (2019). Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf

the highest in the nation at the time of reporting. Of these estimated 599,000 adults with AMI in Utah, only 49.8% received treatment;[84] in other words, approximately 300,000 Utahns are not receiving treatment for clinically diagnosable mental health disorders.[85,86] However, even if only counting those with a perceived unmet need for care for a mental illness, it is estimated that at least 172,000 Utah adults are not receiving the care they need.[87] Utah adults are also experiencing a significant unmet need for substance use disorder treatment. In 2018-19, of 146,000 Utah adults with a substance use disorder in the past year, fewer than one in ten (9.2%) of those individuals received specialty treatment.[88]

Met & Unmet Need—Children. Lack of access to BH care also impacts Utah children. Approximately 23% of children 3-17 are experiencing a mental, emotional, developmental, or behavioral problem, totaling nearly 178,000 children in the state.[89] As of 2021, approximately 58% of these Utah children with a clinical need for BH care did not receive treatment.[90] Further, children's lack of access to substance use disorder treatment closely mirrors that of adults—national survey data found that only 8% of Utah adolescents with a substance use disorder were able to access needed care.[91]

Access to Care & Workforce Capacity

Provider Wait Times. Although workforce capacity may not be the only barrier to access, evidence from provider wait times suggests that it may be a factor. According to Utah providers,[92] the average wait time for BH care services at their primary practice location is approximately 37 days, substantially higher than the Centers for Medicare & Medicaid Services

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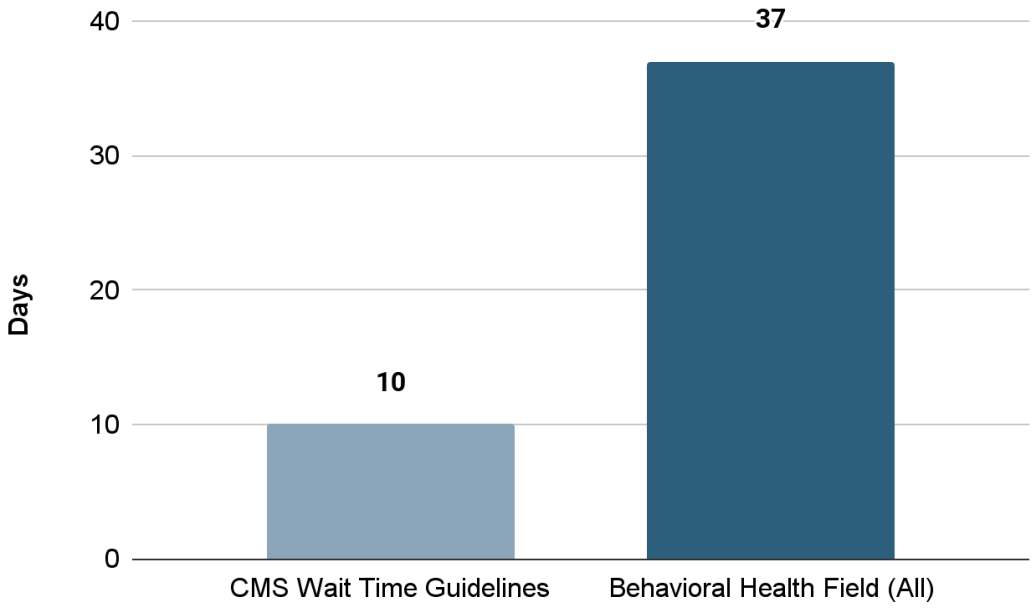
[84] Ibid.
[85] Mental Health America, Reinert, M., Nguyen, T. and Fritze, D. (2022). *The State of Mental Health in America 2022*. [online] mhanational.org. Available at: https://mhanational.org/research-reports/2022-state-mental-health-america-report
[86] See "Adult Mental Health and Service Use" pg. 33, Substance Abuse and Mental Health Services Administration (2020). *Behavioral Health Barometer: Utah, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*. [online] *samhsa.gov*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32861/Utah-BH-Barometer_Volume6.pdf
[87] Mental Health America, Reinert, M., Nguyen, T. and Fritze, D. (2022). *The State of Mental Health in America 2022*. [online] mhanational.org. Available at: https://mhanational.org/research-reports/2022-state-mental-health-america-report
[88] See table 27, pg. 55, National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia). (2019). Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf
[89] Data Resource Center for Child & Adolescent Health (2021). *NSCH 2020 21: Children with mental, emotional, developmental or behavioral problems, All States*. [online] www.childhealthdata.org. Available at: https://www.childhealthdata.org/browse/survey/allstates?q=9353#
[90] Data Resource Center for Child & Adolescent Health (2021). *NSCH 2020 21: NOM 18: Percent of children with a mental/behavioral condition who receive treatment or counseling, Utah*. [online] www.childhealthdata.org. Available at: https://www.childhealthdata.org/browse/survey/results?q=9615&r=1
[91] See table 26, pg. 53, National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia). (2019). Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf
[92] OPLR Behavioral Health Care Workforce Survey (CPMDS)

(CMS) guideline of ten days.[93] This issue may be especially pronounced for certain high-demand occupations and professionals. For example, psychologists and behavior analysts reported wait times at an average of 64 and 131 days, respectively. (see Figure 2.1).

Figure 2.1 Weighted Average BH Provider Wait Times vs. CMS Guidelines (in days)

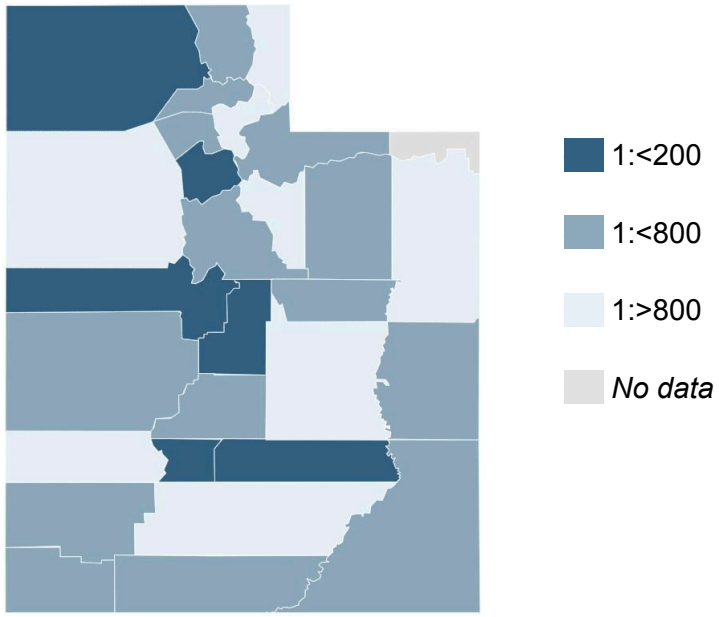


Multi-lingual Providers. Although over 15% of Utah's population speaks a language other than English at home, only 11% of clinical BH care professionals offer services in a language other than English. Similarly, while 10% of Utah's population speaks Spanish at home, only 8% of clinicians provide services in Spanish.[94,95]

Rural Providers. Further, the concentration of mental health providers in more populated areas, particularly along the Wasatch Front, may limit access to care in rural Utah (see Figure 2.2).

[93] Centers for Medicare & Medicaid Services Center for Consumer Information and Insurance Oversight (2022). 2023 Letter to Issuers in the Federally-facilitated Exchanges. [online] U.S. Department of Health and Human Services. Available at: https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf
[94] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[95] American Community Survey, 2017-2021. (2022). [online] United States Census Bureau. Available at: https://www.census.gov/quickfacts/fact/table/UT/.

Figure 2.2 Utah Behavioral Health Provider to Population Ratios, by County[96,97]



The Importance of Access

Individuals with untreated mental illness or with an unmet need for mental health services experience a lower quality of life,[98] lower earnings,[99] have an increased probability of suicidal ideation and suicide attempt,[100] of substance misuse,[101,102,103] and of being killed during a police

[96] County Health Rankings & Roadmaps (2010). Explore Health Rankings | Rankings Data & Documentation. [online] County Health Rankings & Roadmaps. Available at: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation.

[97] Taken from the County Mental Health Rankings county-level numbers of Mental Health Providers, which uses estimates drawn from National Provider Identifiers (NPI). Their estimate includes: Psychiatrists, Psychologists, Licensed Clinical Social Workers, Counselors, Marriage and Family Therapists, Mental Health Providers that treat alcohol and other drug abuse, and Advanced Practice Nurses specializing in mental health

[98] Wang, Y., Henriksen, C. A., ten Have, M., de Graaf, R., Stein, M. B., Enns, M. W., & Sareen, J. (2017). *Common mental disorder diagnosis and need for treatment are not the same: Findings from the NEMESIS study.* Administration and Policy in Mental Health and Mental Health Services Research, *44*(4), 572–581. Available at:https://doi.org/10.1007/s10488-016-0745-2

[99] Biasi, B., Dahl, M.S. and Moser, P., (2021). *Career effects of mental health* (No. w29031). National Bureau of Economic Research. Available at: https://www.nber.org/system/files/working_papers/w29031/w29031.pdf

[100] Ali, M. M., Lackey, S., Mutter, R., & McKeon, R. (2018). *The relationship between perceived unmet mental health care needs and suicidal ideation and attempt.* Administration and Policy in Mental Health and Mental Health Services Research, 45(5), 709–715. Available at: https://doi.org/10.1007/s10488-018-0856-z

[101] Reid, B.E. and Palamar, J.J. (2021). Unmet Need in Relation to Mental Healthcare and Past-Month Drug Use among People with Mental Illness in the United States. *Journal of Psychoactive Drugs*, pp.1–8. doi:https://doi.org/10.1080/02791072.2021.1962577.

[102] Pfeifer, L.R. and Haile, Z.T. (2020). Unmet Mental Health Care Needs and Illicit Drug Use During Pregnancy. *Journal of Addiction Medicine*, 15(3), pp.233–240. doi:https://doi.org/10.1097/adm.0000000000000752.

[103] Cruden, G. and Karmali, R. (2021). Opioid misuse as a coping behavior for unmet mental health needs among U.S. adults. *Drug and Alcohol Dependence*, [online] 225, p.108805. doi:https://doi.org/10.1016/j.drugalcdep.2021.108805.

incident.[104,105,106] For substance use disorders, a lack of treatment is associated with a higher likelihood of persistent and recurrent disorder.[107] Untreated BH disorders may place a significant burden not only on those individuals who are suffering, but also on the relationships and communities in which they are embedded. For instance, those with untreated mental illness are more likely to carry out violent attacks[108] and those with substance use disorders are more likely to perpetrate intimate partner violence.[109]

Ensuring that Utahns have sufficient access to BH care is crucial because unmet need for care leads to serious consequences, including not only the increased societal and economic burdens to the state, but also the tragic and unnecessary loss of human life. In any given year, as many as 23,000 more Utah adults and 10,000 Utah youth[110] will suffer from suicidal ideation because they have an unmet need for BH care,[111,112,113] ultimately resulting in additional attempted and completed suicides that could be prevented by improved access. Unaddressed BH issues also lead to significant increases in healthcare and criminal justice spending, decreased economic productivity, and reduced earnings for individual Utahns.[114,115] A recent analysis determined that every $1 investment in prevention and early intervention for mental illness and addiction programs yields $2 to $10 in savings in health costs, criminal and juvenile justice costs, and low

[104] Alang, S., Rogers, T. B., Williamson, L. D., Green, C., & Bell, A. J. (2021). *Police brutality and unmet need for mental health care.* Health Services Research, 56(6), 1113–1123. Available at: https://doi.org/10.1111/1475-6773.13736

[105] Fuller, D. A., Lamb, H. R., Biasotti, M., & Snook, J. (2015). *Overlooked in the Undercounted: The role of mental illness in fatal law enforcement encounters* (pp. 1–27). Treatment Advocacy Center. Available at: https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted

[106] Rohrer, A. J. (2021). *Law enforcement and persons with mental illness: Responding responsibly. Journal of Police and Criminal Psychology*, *36*(2), 342–349. Available at: https://doi.org/10.1007/s11896-021-09441-2

[107] McCabe, S.E., West, B.T., Strobbe, S. and Boyd, C.J. (2018). *Persistence/recurrence of and remission from DSM-5 substance use disorders in the United States: Substance-specific and substance-aggregated correlates.* Journal of Substance Abuse Treatment, 93, pp.38–48. https://doi.org/10.1016/j.jsat.2018.07.012.

[108] Al Juboori, R., Subramaniam, D. S., & Hinyard, L. (2022). *Understanding the role of adult mental health and substance abuse in perpetrating violent acts: In the presence of unmet needs for mental health services.* International Journal of Mental Health and Addiction. Available at: https://doi.org/10.1007/s11469-022-00778-1

[109] Cafferky, B.M., Mendez, M., Anderson, J.R. and Stith, S.M., (2018). *Substance use and intimate partner violence: a meta-analytic review*. Psychology of Violence, 8(1), p.110. Available at: https://psycnet.apa.org/buy/2016-44359-001

[110] As compared to baseline prevalence rates of suicidal ideation without unmet need for care

[111] Ali, M.M., Lackey, S., Mutter, R. and McKeon, R. (2018). The Relationship Between Perceived Unmet Mental Health Care Needs and Suicidal Ideation and Attempt. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(5), pp.709–715. doi:https://doi.org/10.1007/s10488-018-0856-z

[112] National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia). (2021). [online] Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt39466/2021NSDUHsaeTotals121522/2021NSDUHsaeTotals121522.pdf

[113] Division of Substance Abuse and Mental Health (2021). *2021 SHARP Prevention Needs Assessment Survey: Results for State of Utah*. [online] State of Utah Department of Human Services. Available at: https://dsamh-training.utah.gov/_documents/SHARPreports/2021/StateofUtahProfileReport.pdf.

[114] McDaid, D., Park, A-La. and Wahlbeck, K. (2019). The Economic Case for the Prevention of Mental Illness. *Annual Review of Public Health*, 40(1), pp.373–389. doi:https://doi.org/10.1146/annurev-publhealth-040617-013629.

[115] Kessler, R.C., Heeringa, S., Lakoma, M.D., Petukhova, M., Rupp, A.E., Schoenbaum, M., Wang, P.S. and Zaslavsky, A.M. (2008). Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication. *American Journal of Psychiatry*, 165(6), pp.703–711. doi:https://doi.org/10.1176/appi.ajp.2008.08010126.

productivity.[116,117,118] Put another way, at the population level, an unmet need for BH care services in the present may lead to much much higher costs in the future.

The Role of Occupational Regulation in Access

As described above, Utahns' access to care depends largely on the dimensions of affordability, availability, accessibility, acceptability, accommodation, and awareness. To the degree that occupational regulation can impact these various dimensions, it may also be a useful tool for improving access. Table 2.2 provides examples of the mechanisms through which occupational regulation reform can have an impact on access to care.

Table 2.2 How Occupational Regulation Can Improve Access to Care

Dimension	Related Barriers	Potential Impact of Policy Changes
Availability	• Overall BH workforce shortage • Lack of advanced BH specialists, clinical therapists, and extenders • Misaligned educational and licensure pathways for extenders • Barriers to interstate license portability	• Increase the number of licensed practitioners in the workforce • Increase the labor force participation of licensees • Reduce licensing barriers for out-of-state practitioners • Guide decisions regarding compact participation
Affordability	• Clinicians performing tasks that could be performed by extenders • Difficulties with reimbursement, network adequacy, & coverage	• Authorize licensees to practice at their highest level of competence • Facilitate Medicaid and other reimbursement through changes to licensure and certification
Accessibility	• Advanced BH specialists concentrated in urban areas • Low provider to population ratios in rural counties	• Influence geographical workforce distribution • Design policies conducive to the delivery of telehealth services
Acceptability	• Need for providers proficient in	• Support equitable licensing

[116] Le, L.K.D., Esturas, A.C., Mihalopoulos, C., Chiotelis, O., Bucholc, J., Chatterton, M.L. and Engel, L., (2021). Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. PLoS medicine, 18(5), p.e1003606. Available at: doi:https://doi.org/10.1371%2Fjournal.pmed.1003606

[117] See pg. 241-262, Chapter 9, Benefits and Costs of Prevention. The National Research Council and the Institute of Medicine of the National Academies. Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. Washington, DC: National Academies Press; 2009. Available at: https://nap.nationalacademies.org/catalog/12480/preventing-mental-emotional-and-behavioral-disorders-among-young-people-progress

[118] Steinberg Institute (n.d.). *Fact Sheet: The cost benefits of early intervention in mental illness* [online] steinberginstitute.org. Available at: https://steinberginstitute.org/fact-sheet-cost-benefits-early-intervention-mental-illness/.

	multiple languages and sensitive to cultural concerns and stigmas regarding BH	pathways to attract practitioners from underserved linguistic & cultural backgrounds
Adequacy	*Less related to occupational regulation*	
Awareness	• Varying and inconsistent license titles that confuse consumers • Limited public understanding of when & how to report violations	• Streamline license titles & scopes to provide fewer, more sharply differentiated quality signals • Provide additional information to consumers regarding licensure

While licensure reform can impact these dimensions of access as they relate to the workforce, licensure is only one part of the broader BH system. Reforms must be coordinated with other key sectors, including higher education and insurance, in order to effect the most impactful, lasting, and cohesive changes that can improve access to BH care for all Utahns.[119,120]

Safety of Care

Background & Definitions

The Office of Professional Licensure Review (OPLR) has a statutory mandate[121] to consider 1) whether occupational regulation is necessary to address "present, recognizable, and significant harm" to the public; 2) the potential impacts of that harm; and 3) whether existing or proposed regulation can prevent or diminish that harm. In the context of behavioral health (BH), safety of care can be understood in terms of the risk and incidence of adverse events that result in harm to patients' **health, safety, or welfare**.[122] Harm may be understood in terms of its **probability** (i.e., the likelihood that services rendered will harm the consumer), **severity** (i.e., the magnitude of the harm) and **permanence** (i.e., the duration or recurrence of the harm).

[119] Utah Behavioral Health Assessment & Master Plan. (2023). [online] Salt Lake City, Utah: Ken C. Gardner Policy The University of Utah. Available at: https://gardner.utah.edu/wp-content/uploads/DRAFT_BehaviorHealthPlan-Jul2023_for-review.pdf?x71849
[120] Please see "Key Takeaways" for additional discussion regarding the need for interagency and system-wide cooperation and coordination.
[121] UCA 13-1b-302 Office of Professional Licensure Review
[122] UCA 13-1b-101(5) "'Health, safety, or financial welfare of the public' includes protecting against physical injury, property damage, or financial harm of the public.

Based on a review of the patient safety literature specific to BH, as well as conversations with investigators in the Division of Professional Licensing (DOPL), harms associated with BH care services may arise from a wide variety of adverse patient safety events (see Table 2.3).[123,124,125]

Table 2.3 Adverse Events Related to Patient Safety in Behavioral Health

Adverse Event Type	Examples of Adverse Event
Diagnostic & Assessment Events	Misdiagnosis, underdiagnosis, intentional misdiagnosis for reimbursement/billing, missed diagnosis
Medication Events	Prescription errors, dispensing errors, labeling errors, administration errors, medication side effects [126]
Patient Absence Events	Absconding, wandering, premature discharge
Accident Events	Injury from daily activities & environments in a care setting, injury from therapeutic activities & environments
Restraint Events	Involuntary detainment, seclusion/isolation, physical/mechanical restraint, chemical restraint
Victimization Events	Staff/provider boundary violations, staff/provider threats/harassment/abuse, other patient violence & aggression, suicide & self harm
Administrative Events	Falsified or inaccurate records, missing records, inappropriate releasing or withholding of records, privacy violations, fraudulent billing

There are different types and levels of risks of harm associated with the various activities and services provided by BH professionals—including different risks for assessment and monitoring tasks, care planning and authorization tasks, intervention and treatment tasks, and administration and coordination tasks. Risk also differs according to the care setting where treatment is administered, whether or not a patient was voluntarily or involuntarily admitted, provider characteristics (e.g., license type, career stage, age, gender) and patient

[123] Brickell, T. A., Nicholls, T. L., Procyshyn, R. M., McLean, C., Dempster, R. J., Lavoie, J. A. A., Sahlstrom, K. J., Tomita, T. M., & Wang, E. (2009). Patient safety in mental health. Edmonton, Alberta: Canadian Patient Safety Institute and Ontario Hospital Association. https://www.patientsafetyinstitute.ca/en/toolsResources/Research/commissionedResearch/mentalHealthAndPatientSafety/Documents/Mental%20Health%20Paper.pdf

[124] Averill, P., Vincent, C., Reen, G., Henderson, C. and Sevdalis, N., (2022). Conceptual and practical challenges associated with understanding patient safety within community-based mental health services. *Health Expectations*. https://onlinelibrary.wiley.com/doi/pdf/10.1111/hex.13660

[125] Berzins, K., Baker, J., Brown, M. and Lawton, R. (2018). A cross-sectional survey of mental health service users', carers' and professionals' priorities for patient safety in the United Kingdom. *Health Expectations*, 21(6), pp.1085–1094. doi:https://doi.org/10.1111/hex.12805.

[126] J.K. Aronson, Medication errors: what they are, how they happen, and how to avoid them, *QJM: An International Journal of Medicine*, Volume 102, Issue 8, August 2009, Pages 513–521 doi:https://doi.org/10.1093/qjmed/hcp052

characteristics (e.g., disorder, gender, vulnerable population status).[127,128,129] Risks may even compound depending on the interaction between treatment, setting, and patient/provider characteristics—including the characteristics of multiple patients in care.[130]

Current Safety of Care in Utah

To understand the safety of BH care in Utah, OPLR first turned to data from the National Practitioner Data Bank (NPDB), which highlights how Utah compares to other states in terms of adverse action reports and malpractice claims against BH practitioners. Next, substantiated complaint data from DOPL helps to illuminate consumer complaints and disciplinary actions taken against BH practitioners. This process highlighted the substantial limitations in terms of data collection and measurement related to safety of care in BH not only in Utah, but also nationally. There are few definitive answers regarding safety, and a great deal of work yet to be done to address this data gap.

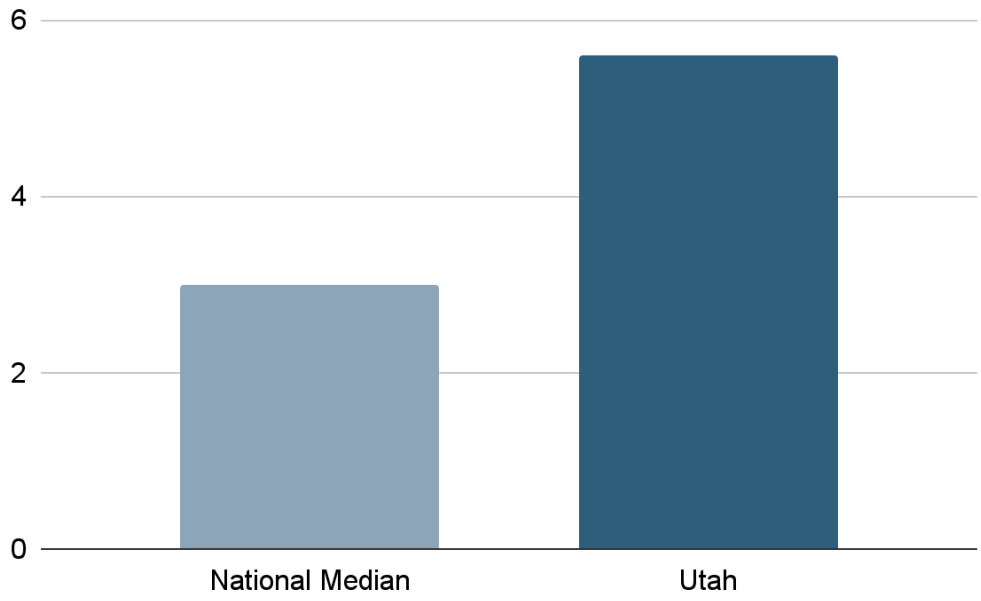
Findings from NPDB Adverse Action & Malpractice Claim Data

To determine whether professionals in Utah pose an above-average risk to the public, OPLR conducted a comparative analysis of adverse actions taken against BH licensees in jurisdictions across the United States. To accomplish this, OPLR utilized the NPDB public use data file, which tracks adverse actions[131] and payments in settlement of medical malpractice judgements against licensed individuals in each state.[132] Analysis of this data indicates that Utah ranks far

[127] Frueh, B.C., Knapp, R.G., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A., Cousins, V.C., Yim, E., Robins, C.S., Monnier, J. and Hiers, T.G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric services* (Washington, D.C.), [online] 56(9), pp.1123–33. doi:https://doi.org/10.1176/appi.ps.56.9.1123.
[128] Pescosolido, B.A. and Olafsdottir, S. (2013). Beyond dichotomies: confronting the complexity of how and why individuals come or do not come to mental health care. *World Psychiatry*, 12(3), pp.269–271. doi:https://doi.org/10.1002/wps.20072.
[129] Further, clients who are females being treated by male providers, who are significantly younger than their providers, and/or who have a previous history of serious mental illness or sexual trauma are at higher risk for sexual victimization in a professional relationship with a BH provider. From: Martin, G.M. and Beaulieu, I. (2023b). Sexual Misconduct: What Does a 20-Year Review of Cases in Quebec Reveal about the Characteristics of Professionals, Victims, and the Disciplinary Process? *Sexual Abuse*, doi:https://doi.org/10.1177/10790632231170818.
[130] Frueh, B.C., Knapp, R.G., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A., Cousins, V.C., Yim, E., Robins, C.S., Monnier, J. and Hiers, T.G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric services* (Washington, D.C.), [online] 56(9), pp.1123–33. doi:https://doi.org/10.1176/appi.ps.56.9.1123. Clients with a previous history of serious mental illness or sexual trauma are at higher risk for experiencing or witnessing additional traumatic events in inpatient psychiatric settings.
[131] Adverse actions reduce, restrict, suspend, or deny clinical privileges or membership in a healthcare organization or program. This includes actions related to: State Licensure/Certification, Clinical Privileges/Panel Membership, Drug Enforcement Administration, HHS OIG Exclusion, and Professional Society Membership
[132] State-level substantiated complaint data, like the above data from DOPL, is not entirely subsumed within the NPDB, as only certain, more intensive disciplinary actions are required to be reported to NPDB. (e.g., revocation of a license), while less intensive actions (e.g., a letter of concern) are not included in this database. Further, the NPDB includes information not available via state licensing agency complaints, including adverse actions related to federal programs, industry associations, and malpractice claims.

above the median annual number of NPDB reports per BH licensee, at the 12th highest (or worst) of 51 states (See Figure 2.3).[133,134]

Figure 2.3 Annual NPDB Reports Per 1,000 BH Providers (2015-2022)



Utah ranks even higher, at 4th out of 51, among US states for the highest proportion of repeat offenders—meaning those with two or more NPDB reports—at 44% of practitioners, versus a national median of only 25%.[135] Overall, this analysis evidences two major points 1) albeit not the worst in the nation, Utah's magnitude of NPDB reports per BH practitioner is relatively

[133] 50 states and D.C

[134] University of Wisconsin Population Health Institute (2023). *2023 County Health Rankings National Findings Report Cultivating Civic Infrastructure and Participation for Healthier Communities*. [online] *www.countyhealthrankings.org*, University of Wisconsin Population Health Institute, pp.1–20. Available at: https://www.countyhealthrankings.org/reports/2023-county-health-rankings-national-findings-report.
To estimate an average annual adverse event rate for each state (i.e. the number of NPDB reports per 1000 licensees), OPLR calculated the total number of NPDB reports against BH practitioners in each state, each year, compared to the total number of BH practitioners working in each state, each year. The number of NPDB reports against BH practitioners was calculated to include: Clinical Social Worker, Psychologist, Mental Health Counselor, Professional Counselor, Addictions Counselor, Marriage and Family Therapist, Prof. Cnslrs. of Family/Marriage and Alcohol. The total number of BH practitioners working in each state, each year was taken from the County Mental Health Rankings state-level number of Mental Health Providers, which uses estimates drawn from National Provider Identifiers (NPI). Their estimate includes: Psychiatrists, Psychologists, Licensed Clinical Social Workers, Counselors, Marriage and Family Therapists, Mental Health Providers that treat alcohol and other drug abuse, and Advanced Practice Nurses specializing in mental health.

[135] OPLR Analysis of NPDB Data

high,[136] and 2) a greater proportion of Utah licensees with a history of violations reoffend compared with the rest of the nation.

Findings from DOPL Substantiated Complaint Data

DOPL's enforcement efforts are largely complaint based. If a person believes that a BH practitioner (licensed or unlicensed) has harmed a consumer, or in some way violated Utah's occupational and professional licensing laws, they may submit a complaint to DOPL. DOPL reviews consumer complaints, investigates those complaints that meet DOPL's criteria,[137,138] and takes disciplinary action[139] against licensees if necessary. Those complaints that result in disciplinary action against a licensee are understood to be "substantiated," or in other words, to reflect actual wrongdoing on the part of a licensed professional, which in some cases may have caused consumer harm.

Over the past 4 years, the most common categories of substantiated complaints against BH licensees were, in order of frequency, 1) ethical standards (e.g., dual relationships, breaches of confidentiality), 2) unauthorized practice (e.g., practicing without a license), 3) other criminal conduct, 4) sexual misconduct, and 5) incompetence/negligence, all of which may constitute instances of patient harm.

Additionally, substantiated complaint rates differ between various licensed BH occupations and practitioners. Complaints range from 3.7 complaints per 1,000 licenses for recreation therapists to 20 complaints per 1,000 licenses for substance use disorder counselors.[140] Further, a review of past DOPL substantiated complaint case notes indicate that safety concerns may be more likely to arise early in a practitioner's career. Early career practitioners were disproportionately represented (by over 16%) in this review of complaints substantiated by the Division,[141] suggesting that a clinician's inexperience is associated with a greater likelihood of engaging in unprofessional or illegal conduct, including behaviors that cause direct harm to their clients.

[136] To determine if Utah's comparatively high number of NPDB reports was simply a result of regulatory vigor or especially active licensing agencies, the analysis was run again, excluding any report that was labeled a licensing-related action; the results were similar, placing Utah 11th worst in the nation. DOPL administrators were also consulted, and reported that Utah's elevated rates of NPDB reports are unlikely to be the result of heightened enforcement activity relative to other states, based on Utah's comparatively limited staffing and resources as compared to other licensing agencies across the nation.
[137] UCA 58-1-106 DOPL is legally responsible to investigate unlicensed practice in regulated professions or occupations, acts or practices inconsistent with generally recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of negligence or incompetence.
[138] Bureau of Investigation, Division of Professional Licensing (n.d.). *Complaint Process: An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing*. [online] Utah.gov. Available at: https://www.utah.gov/pmn/files/438013.pdf.
[139] Disciplinary actions include, but are not limited to, the following: verbal warning, letter of concern, issuing a citation and administrative sanctions
[140] OPLR Analysis of DOPL Substantiated Complaint Data
[141] Ibid.

Data & Measurement Gaps

Analysis of the magnitude and nature of harm to BH consumers is difficult due to the significant limitations of currently available data, including DOPL complaint data and NPDB reports.[142,143] While representative data regarding access to care is collected systematically at the national level, and is widely available for public use, data regarding safety and quality outcomes is comparatively sparse. OPLR's findings are thus necessarily based on incomplete data that significantly limit our ability to make conclusions about the state of BH care safety in Utah. Therefore, it is nearly impossible to quantify the total harm that results from BH care or to draw conclusions about who is harmed and how. The two primary limitations revolve around 1) challenges in data collection and measurement and 2) the fragmentation of existing data.

Because DOPL data is complaint-based, it likely underestimates the true level of safety concerns. For example, incidents of harm to consumers may not result in complaints or reports to regulators. Patients may not be aware of what constitutes appropriate practice, or how and where to submit a formal complaint. Patients may not be willing to report due to power dynamics, safety concerns, or the cost of legal counsel. Further, victims may be unable to provide sufficient evidence of wrongdoing to result in a substantiated complaint against a practitioner. Thus, the experiences of these patients may not be reflected in the data, thereby underreporting the "true" harm occurring in BH care.

When BH patient safety data does exist, those datasets are held separately across siloed state and federal agencies, making the data difficult to access, utilize, and interpret in the aggregate. State-level data on consumer harm in BH is bifurcated between the regulatory agencies that are separately responsible for licensing individual practitioners (DOPL) and health and human services facilities and programs (Department of Health and Human Services [DHHS]). DHHS collects information regarding patient safety incidents that occur within licensed facilities; however, this information does not directly connect to DOPL's substantiated complaint data, and no formal mechanisms exist to ensure that information sharing is taking place across agency lines. The large number of exempted practitioners (e.g., students in training, clergy) and those who provide similar but unregulated services (e.g., life coaches) may complicate this issue even further, making it difficult to ascertain who is being harmed, how much they are being harmed, who is responsible, and how harm may best be prevented. Thus, in practical terms, policymakers and executive branch agencies are operating with a piecemeal understanding of the nature and magnitude of consumer safety issues in BH.

More broadly, there is little consistency in the quality measures that do exist, and a lack of standardized data collection and exchange in BH care.

[142] Specific limitations of the DOPL substantiated complaint and NPDB analyses are detailed in the Appendix.
[143] DHHS's annual report on patient safety incidents likewise cautions against drawing any conclusions about the actual relative frequency of patient safety events in Utah or trends in these events over time.

> *"Standardized data collection and exchange is critical for care coordination and patient-centered, whole-person care, yet there are significant infrastructure challenges in the BH care delivery system…current BH data exchange is limited and stymied by long-standing financial and regulatory barriers that represent a legacy of stigma and systemic bias toward individuals with BH conditions."*[144]

Licensure is predicated on the need to protect consumers, yet assessing the severity, probability, and permanence of harm in BH care is fraught with difficulties. There is very little data from which to form a picture of the risks and sources of harm in BH services; the data that does exist is inconclusive. Until consistent quality measures and reporting standards assessing patient outcomes are established and accessible, the ability to understand, predict, and prevent harm in the BH care field will be severely limited. Impactful quality measures would better orient policymakers and stakeholders to the landscape of BH care in Utah, guiding accurate, data-driven decisions to improve safety and access and better serve the public.

The Importance of Safety

In BH care contexts, patients are often in emotionally, physically, or economically vulnerable circumstances and may place high levels of trust in those providing care. They may be incapable of identifying or protecting themselves from harm perpetrated by BH practitioners, or, in cases of involuntary care, may have no choice in the care they receive. Thus, policies that protect BH care consumers' safety are critical, and are a fundamental purpose of occupational and facility-level regulation for the state.

Unsafe care has serious consequences, including 1) worsening of a patient's existing symptoms, 2) creating additional harms to their health, safety, or welfare and 3) reducing their willingness to access care in the future. Those subjected to unsafe care have reported increased anxiety, depression, substance use, suicidal ideation, and an overall decline in well-being.[145] They may also experience impaired social and occupational functioning,[146] financial exploitation and manipulation, and breaches of confidentiality;[147] in the most severe situations, clients can become the victims of serious crimes such as sexual and physical abuse and suffer from the accompanying trauma and other long-lasting, negative impacts of abuse. BH

[144] See pg. 18 Niles, L. and Olin, S. (2021). *Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care A White Paper*. [online] Available at: https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf

[145] Martin, G.M. and Beaulieu, I. (2023). Sexual Misconduct: What Does a 20-Year Review of Cases in Quebec Reveal about the Characteristics of Professionals, Victims, and the Disciplinary Process? Sexual Abuse, p.107906322311708. doi:https://doi.org/10.1177/10790632231170818.

[146] Frueh, B.C., Dalton, M.E., Johnson, M.R., Hiers, T.G., Gold, P.B., Magruder, K.M. and Santos, A.B. (2000). Trauma Within the Psychiatric Setting: Conceptual Framework, Research Directions, and Policy Implications. Administration and Policy in Mental Health, 28(2), pp.147–154. doi: 10.1023/a:1026611608299

[147] Reamer, F.G. (2003). Boundary Issues in Social Work: Managing Dual Relationships. Social Work, 48(1), pp.121–133. doi:https://doi.org/10.1093/sw/48.1.121

care services even impact legal proceedings, where a biased or inaccurate mental health evaluation could inappropriately or unjustly influence the outcomes of civil, custody, or criminal proceedings.[148,149,150] When practitioners harm clients or are otherwise found to act in ways that are illegal or unprofessional, these incidents fuel public distrust of BH professionals[151,152] and influence perceptions of unfair and disrespectful treatment.[153] In turn, former and prospective users of BH services are potentially disincentivized from seeking help, compounding the already pressing issue of unmet need.

Ultimately, policies that hold BH licensees accountable to provide safe care and support them in doing so are necessary to protect Utahns from a wide range of potential harms at the hands of practitioners, who are entrusted with vulnerable clients' well-being.

The Role of Occupational Regulation in Safety

Occupational regulation may improve safety through regulatory levers related to 1) entry requirements, 2) practice requirements, and 3) structure and governance provisions. In a safe system, entry requirements should ensure that licensees meet a minimum standard for competency to decrease the probability and severity of harm. Effective entry regulations prevent incompetent or unsafe practitioners from becoming licensed in the first place. Practice requirements should set standards for professional conduct and establish monitoring and disciplinary procedures for licensees who fail to meet these standards. These measures may help to dissuade and correct potentially harmful behaviors as well as prevent unsafe practitioners from retaining their licenses. Finally, structure and governance provisions should define the practice authority (i.e., scope) of licensees and determine the oversight bodies that will oversee the investigative and disciplinary processes for BH professionals, creating a regulatory environment that prioritizes public safety and practitioner competence.

Licensure reform alone will not solve the issue of unsafe BH care in Utah. Professional associations and educational institutions provide essential gatekeeping functions, while other state agencies like DHHS regulate the safety of facility level licensing. Improving safety in BH

[148] Patel, S. and Jones, K. (2008). Assessment of Family Custody Issues Using Mental Health Evaluations: Implications for Mental Health Counselors. *Journal of Mental Health Counseling*, 30(3), pp.189–199.
[149] Edens, J.F., Smith, S.T., Magyar, M.S., Mullen, K., Pitta, A. and Petrila, J. (2012). 'Hired guns,' 'charlatans,' and their 'voodoo psychobabble': Case law references to various forms of perceived bias among mental health expert witnesses.. *Psychological Services*, 9(3), pp.259–271. doi:https://doi.org/10.1037/a0028264.
[150] Neal, T.M.S. and Grisso, T. (2014). The cognitive underpinnings of bias in forensic mental health evaluations. *Psychology, Public Policy, and Law*, 20(2), pp.200–211. doi:https://doi.org/10.1037/a0035824.
[151] Martin, G.M. and Beaulieu, I. (2023). Sexual Misconduct: What Does a 20-Year Review of Cases in Quebec Reveal about the Characteristics of Professionals, Victims, and the Disciplinary Process? Sexual Abuse, p.107906322311708. doi:https://doi.org/10.1177/10790632231170818
[152] Feldman-Summers, S. and Jones, G. (1984). Psychological impacts of sexual contact between therapists or other health care practitioners and their clients. Journal of Consulting and Clinical Psychology, 52(6), pp.1054–1061. doi:https://doi.org/10.1037/0022-006x.52.6.1054
[153] Robins, C.S., Sauvageot, J.A., Cusack, K.J., Suffoletta-Maierle, S. and Frueh, B.C. (2005). Special Section on Seclusion and Restraint: Consumers' Perceptions of Negative Experiences and 'Sanctuary Harm' in Psychiatric Settings. Psychiatric Services, 56(9), pp.1134–1138. doi:https://doi.org/10.1176/appi.ps.56.9.1134

care requires interagency and system-wide coordination across a disparate set of stakeholders.[154]

Access & Safety Implications

Taken together, these findings suggest that both in terms of access and in terms of safety, there are many opportunities for Utah to improve the BH care system to better serve constituents. Policymakers should seek solutions that mutually address both access and safety wherever possible.

Policymakers should also bear in mind that improving access to care is, in many ways, about addressing the safety of those who are currently beyond the reach of the system—those who may be silently suffering and unable to get care. In this way, addressing the state's unmet need for care may be just as relevant for promoting public safety as ensuring the safe practice of those who provide care. Utah has a well-documented, widespread access problem that is impacting the lives of hundreds of thousands of Utahns, with tens of thousands more youth and adults suffering from suicidality in any given year because of an unmet need for BH care.[155,156,157,158,159,160] On this basis, policymakers should take immediate steps to improve access to care for Utah consumers through multiple, coordinated solutions including, but not limited to, the proposed changes to occupational regulation contained in this report.

At the same time, the findings of this report suggest that Utah may also be struggling in terms of providing safe care for those who do access the BH care system. The magnitude of safety issues and risks of harm in BH remains largely unknown, but distressing stories of unsafe care rightly raise the question of how to appropriately protect the often-vulnerable consumers of BH care services and better safeguard against risks of harm. Unlike access to care, robust, nationally representative datasets that measure the safety of BH care are not available. Further, state-level data—including patient safety incident reports collected by DHHS as well as complaint data maintained by DOPL—have substantial limitations: 1) these datasets are held

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[154] Please see Key Takeaways for more on this issue.
[155] Data Resource Center for Child & Adolescent Health (2016). *National Survey of Children's Health (2016 - present)*. [online] www.childhealthdata.org. Available at: https://www.childhealthdata.org/browse/survey
[156] Substance Abuse and Mental Health Services Administration (2019). *National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia)*. [online] Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32879/NSDUHsaeTotal2019/2019NSDUHsaeTotal.pdf
[157] Mental Health America, (2022). *The State of Mental Health in America 2022*. [online] mhanational.org. Available at: https://mhanational.org/research-reports/2022-state-mental-health-america-report
[158] Ali, M.M., Lackey, S., Mutter, R. and McKeon, R. (2018). *The Relationship Between Perceived Unmet Mental Health Care Needs and Suicidal Ideation and Attempt.* Administration and Policy in Mental Health and Mental Health Services Research, 45(5), pp.709–715. doi:https://doi.org/10.1007/s10488-018-0856-z.
[159] Substance Abuse and Mental Health Services Administration (2021). *2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)*. [online] Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf
[160] Utah Department of Human Services, Division of Substance Abuse and Mental Health (2021). 2021 Student Health and Risk Prevention: Prevention Needs Assessment Survey. [online] Available at: https://dsamh-training.utah.gov/_documents/SHARPreports/2021/StateofUtahProfileReport.pdf

separately across siloed state agencies, making them difficult to access, utilize, and interpret in the aggregate, 2) instances of harm may not always make it into these datasets , and 3) not every incident or complaint in these datasets reflects actual consumer harm. To address the many unknowns related to safety of care, policymakers should explore avenues for improving what we know about safety, and for improving safety in low-burden ways—including prioritizing policies that enable greater interagency coordination and more targeted, proactive steps to prevent consumer harm. Importantly, the regulation of psychotherapy and counseling should:[161]

> *"....balance its response to high profile but rare 'media spectacles' with its effects on the majority of practitioners' day-to-day practice…. High-impact but low frequency "bad cases" – amplified in the media – have a tendency to drive system-wide escalation of regulation. We would caution against the potential over-proliferation of regulatory and risk management systems, not only given their time and resource consequences, but also because of their unintended consequences for practice."*

Ultimately, safety incidents in *receiving* BH care, and the high profile incidents that drive public perception, may be substantially more rare than the safety issues that result from *not receiving* BH care (which are distressingly common). In short, OPLR's findings reflect the urgent need to improve access to care, while simultaneously addressing the important work of measuring and improving safety. Access improvements take precedence in the focus of OPLR's recommendations, given the clear, severe unmet need for care across the state.

[161] Pg. 4-9, McGivern, G, Fischer, M, Ferlie, E & Exworthy, M (2009), *'Statutory Regulation & the Future of Professional Practice in Psychotherapy & Counseling: Evidence from the Field'*. Unknown Publisher, King's College London. Visit: https://www.listeningtoyou.co.uk/uploads/2/7/0/7/2707581/statutoryregulation1-1.pdf

Recommendations

Overview

In order to improve access to behavioral health (BH) care for Utah consumers, while also improving the safety of care, the Office of Professional Licensure Review (OPLR) recommends that Utah implement the following changes:

1. Train Smarter, Not Harder

Reduce entry barriers & CE burdens by targeting requirements more closely to safety

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

b. ***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.

c. ***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.

2. Expand Pathways and Portability

Attract & retain qualified talent by providing new paths to licensure

a. ***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.

b. ***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.

3. Strengthen Upstream Monitoring

Prevent consumer harm by implementing more proactive monitoring strategies

a. ***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.

b. ***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.

4. Fills Gaps in Career Ladders & Care

Close gaps in care by creating new ways to enter & advance in Utah's BH workforce

a. ***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.

b. ***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.

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

5. Streamline Governance

Improve consistency & consumer focus by streamlining regulatory oversight

a. ***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.

1a. Supervisor Requirements

Summary of Recommendation

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

This recommendation applies only to those licensed to practice under:

- 58-60 Mental Health Professional Practice Act
  - Licensed Clinical Social Worker
  - Marriage and Family Therapist
  - Clinical Mental Health Counselor
- 58-61 Psychologist Licensing Act
  - Psychologist

Status Quo

Utah's master's-level clinicians include Licensed Clinical Social Workers (LCSWs), Marriage & Family Therapists (MFTs), and Clinical Mental Health Counselors (CMHCs). These clinicians are required to complete postgraduate supervised experience hours in order to become licensed to practice independently. Since the passage of HB366, Utah allows cross-supervision, meaning that the supervisors for these clinicians may be licensed as any of the following: LCSW, MFT, CMHC, psychiatrist, psychologist, or registered psychiatric mental health nurse practitioner.

In order to become a clinical supervisor, LCSWs and MFTs are required to have at least two consecutive years of being licensed in good standing. CMHCs must complete 4,000 hours of lawful practice of mental health therapy in the two consecutive years before beginning supervision. MFT supervisors must also be approved as a supervisor by a national marriage and family therapist professional organization or complete specific, approved instruction.[162] CMHC and LCSW supervisors have no required training or accreditation.

No supervisor is permitted to supervise more than six individuals unless otherwise approved by their respective Division of Professional Licensing (DOPL) board, and all must enter into a written supervision contract with each of their supervisees. The rule defining direct supervision for BH clinicians lacks any clarification as to which modalities (e.g., dyadic, triadic, group

[162] Either a Commission on Accreditation for Marriage and Family Therapy Education accredited marriage and family therapy program at an accredited university or 20 clock hours of instruction sponsored by AAMFT or UAMFT. If the supervisor is not AAMFT approved, they must, in each two-year renewal cycle, complete four of the required 40 hours of continuing professional education in topics directly related to marriage and family therapy supervisor training.

supervision) are allowed to count toward these hours.[163] Further, Utah currently has few restrictions on virtual supervision, as direct clinical supervision only needs to occur in real-time, which is possible either remotely or in person. However, as defined by R156-60-302(3)(h)(iii),[164] supervisors must visit the location where their supervisee practices on a quarterly basis if supervision is conducted remotely (unless pre-approved by the board).

Existing Approaches

Many states have training requirements for supervisors of master's-level BH clinicians. The fewest number of states, 22 out of 50, require LCSWs to submit proof of completing supervisory training and/or supervisory CE credits. Many more states require the same of MFTs and CMHCs, 33 and 31 respectively. When specified, this training typically consists of either 3 semester-credit hours of graduate coursework on supervision or 15-40 hours of approved courses. A few states require an additional 3-15 supervision CE hours every renewal period. It should be noted that the training requirements for supervisors differ widely between states, so it is difficult to offer conclusive evidence about the frequency and content of specific types or hours of training.

A vast majority of states require their supervisors to have a number of years (and/or hours) of post-licensure experience prior to conducting supervision. 37 out of 50 states require post-licensure experience for their LCSWs, 40 states require experience for their MFTs, and 40 require experience for their CMHCs. Only Arizona, Connecticut, Maine and New York have no experience requirements for any of their master's level BH clinicians. For states that require post-licensure experience, the experience varies between about 1-5 years, with a mode of 2 years. 3 years is the second most common specification, with 5 years following closely behind.

Hardly any states limit, in law or regulation, the maximum number of supervisees a supervisor can supervise at once. Only 11 out of 50 states (including Utah) specify this for LCSWs, with 15 and 13 states (again, including Utah) requiring the same for MFTs and CMHCs, respectively. For the few states that do, this limit ranges between 3-25 supervisees, with a ceiling of 6 supervisees as the most common requirement. Some states, like Utah and Missouri, include a provision that the board may approve supervisors to extend past the limit.

Rationale

Why change requirements for supervisors?

- Incoming clinicians are struggling to obtain high-quality supervision
- Supervision quality matters for access and safety
- Supervision quality can be improved through training
- Industry insiders support supervisor training, but have capacity concerns
- Revising capacity-constraining policies may help to build supervision capacity

[163] R156-60-102(3)
[164] Ibid.

Incoming BH Clinicians Are Struggling to Obtain High-Quality Supervision

While policy debates around supervision hours tend to focus on quantity, the quality of these hours is more clearly connected to important outcomes for supervisees and the clients they serve. Harmful supervision practices are widespread in the BH field, despite the field's emphasis on supervision as a key component of clinicians' training. A national survey of supervisees from all major BH disciplines found that 93% were receiving inadequate supervision and that 36% were receiving harmful supervision.[165,166] 40% of supervisees reported that "their supervisor did not observe and provide feedback on the supervisee's in-session actions."[167] Another study found that 51% of surveyed beginning- and intern-level supervisees reported that their supervisors had committed at least one ethical violation, including violations of guidelines involving "adequate performance evaluation, confidentiality issues relevant to supervision, and ability to work with alternative perspectives."[168]

These findings are reflected in Utah BH care professionals' comments collected throughout the review process in focus groups, interviews, and survey responses. Members of one focus group estimated that only 20-25% of the supervision that new clinicians are receiving is of value to them or benefits to their clients and others described supervisors "just [signing] off on [supervisees'] paperwork anyway," despite not having regular meetings.[169] Two clinicians gave examples of these poor practices:

> *"In a private practice setting…out of 17 months of me begging every week for supervision, I was given four total supervision [hours]. …I'm a very ethical person. I want to be as practiced as possible, so then I joined another job in [a hospice facility]."*

[165] Ellis, M.V., Berger, L., Hanus, A.E., Ayala, E.E., Swords, B.A. and Siembor, M. (2013). *Inadequate and Harmful Clinical Supervision.* The Counseling Psychologist, [online] 42(4), pp.434–472. Doi: https://doi.org/10.1177/0011000013508656

[166] Ibid. See pg 439-440, Ellis et. al, 2013 define *inadequate supervision* as when "the supervisor is unable, or unwilling, to meet the criteria for minimally adequate supervision, to enhance the professional functioning of the supervisee, to monitor the quality of the professional services offered to the supervisee's clients, or to serve as a gatekeeper to the profession. In addition, inadequate supervision may include, but is not limited to, [failure to provide timely feedback, inattention to the supervisee's concerns or struggle and failure to be open to the supervisee's opinions or feedback]. *Harmful supervision* is defined as "supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee….The two essential components of harmful supervision are (a) that the supervisee was genuinely harmed in some way by the supervisor's inappropriate actions or inactions, or (b) the supervisor's behavior is known to cause harm even though the supervisee may not identify the action as harmful. Thus, harmful supervision may result from the supervisor acting inappropriately or with malice, supervisor negligence, or the supervisor clearly violating accepted ethical standards and standards of practice and care."

[167] Pg. 464, Ibid.

[168] Pg. 443 of Ladany, N., Lehrman-Waterman, D., Molinaro, M. and Wolgast, B. (1999). *Psychotherapy Supervisor Ethical Practices.* The Counseling Psychologist, 27(3), pp.443–475. doi: https://doi.org/10.1177/0011000099273008

[169] OPLR Listening & Vetting Tour

> *"[Of the] 100 hours of supervision, now 75, [supervisees] may get 25% of that face-to-face and the rest is attending a presentation and counting it as supervision or a five-minute chat in the hallway, and that is a problem.….[It's not substantive] because there's no guidelines on it. There's no clarity on it and there's certainly no training."*

These comments reflect the need for clinical supervisors to be "explicitly educated about minimally adequate, inadequate, and harmful supervisory practices".[170] To avoid and minimize harm, clinical supervisors in BH professions need training on the criteria for minimally adequate supervision, on role expectations within the supervisory relationship, and on how to monitor and improve the effectiveness of their own work as a supervisor.[171,172,173]

Supervision Quality Matters for Access and Safety

Poor-quality supervision is associated with increased supervisee burnout and turnover and, by extension, decreases access to safe and competent care for consumers. Evidence suggests that "7% to 10% of clinical-level behavioral health supervisees will leave the field due to harmful supervision."[174,175,176] High-quality supervision, on the other hand, has been associated with decreased turnover intentions and with improved retention of BH workers.[177,178] In other words, taking action to support high-quality supervision for incoming BH clinicians may be an important step in mitigating staffing shortages and increasing the overall capacity of the BH workforce in Utah. These findings are reflected in data from Utah practitioners.[179] One focus group participant emphasized the effects of inadequate supervision, saying,

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[170] See pg. 135-136 of McNamara, M.L., Kangos, K.A., Corp, D.A., Ellis, M.V. and Taylor, E.J. (2017). *Narratives of harmful clinical supervision: Synthesis and recommendations*. The Clinical Supervisor, 36(1), pp.124–144. doi:https://doi.org/10.1080/07325223.2017.1298488

[171] Ibid.

[172] Ellis, M.V., Berger, L., Hanus, A.E., Ayala, E.E., Swords, B.A. and Siembor, M. (2013). *Inadequate and Harmful Clinical Supervision.* The Counseling Psychologist, [online] 42(4), pp.434–472. doi: https://doi.org/10.1177/0011000013508656

[173] Ladany, N., Lehrman-Waterman, D., Molinaro, M. and Wolgast, B. (1999). *Psychotherapy Supervisor Ethical Practices.* The Counseling Psychologist, 27(3), pp.443–475. doi: https://doi.org/10.1177/0011000099273008

[174] See pg. 452 of Ellis, M.V., Berger, L., Hanus, A.E., Ayala, E.E., Swords, B.A. and Siembor, M. (2013). *Inadequate and Harmful Clinical Supervision.* The Counseling Psychologist, [online] 42(4), pp.434–472. doi: https://doi.org/10.1177/0011000013508656

[175] Nelson, M.L. and Friedlander, M.L. (2001). *A close look at conflictual supervisory relationships: The trainee's perspective.* Journal of Counseling Psychology, 48(4), pp.384–395. doi:https://doi.org/10.1037/0022-0167.48.4.384.

[176] Hutman, H., Ellis, M.V., Moore, J.A., Roberson, K.L., McNamara, M.L., Peterson, L.P., Taylor, E.J. and Zhou, S. (2023). Supervisees' Perspectives of Inadequate, Harmful, and Exceptional Clinical Supervision: Are We Listening? *The Counseling Psychologist*, 51(5), pp.719–755. doi:https://doi.org/10.1177/00110000231172504

[177] Knudsen, H.K., Ducharme, L.J. and Roman, P.M. (2008). *Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse*. Journal of Substance Abuse Treatment, 35(4), pp.387–395. doi:10.1016/j.jsat.2008.02.003, visit: https://www.sciencedirect.com/science/article/pii/S0740547208000378

[178] Mor Barak, Michàlle E., Travis, Dnika J., Pyun, H. and Xie, B. (2009). *The Impact of Supervision on Worker Outcomes: A Meta-analysis.* Social Service Review, 83(1), pp.3–32. doi:https://www.journals.uchicago.edu/doi/full/10.1086/599028

[179] OPLR Listening & Vetting Tour

> *"Without [supervisor support], you're going to get a lot of individuals who go into the profession but don't last more than five years, because they're going to burn out and they weren't prepared. We front-load the training so that we have a good workforce for a long period of time."*

A survey respondent similarly reflected how inadequate supervision may be pushing people out of the field: "I have heard stories from clinicians that they never met with their supervisor and felt so lost. This causes some so much distress they don't stay in the field."[180] High turnover can harm consumers' access to care by "[causing] disruption in continuity of care, [diminishing] access to care while a position remains vacant, and [posing] financial hardship on the provider organization through costs related to recruitment, orientation, and training of a new hire."[181] In short, low-quality supervision may push providers out of the workforce, increasing costs and wait times, and reducing continuity of care for a vulnerable public.

Inadequate and non-supportive supervisory relationships may create feelings of frustration, disempowerment, emotional exhaustion, and depersonalization for supervisees [182,183,184]—leading to potential harm not only to the supervisee,[185] but also to the clients they serve.[186,187,188,189,190] Harmful supervision may cause trauma, lessened self-confidence, and "functional impairment in the supervisee's professional life".[191] Low support from supervisors has also been associated with increased supervisee burnout and higher levels of worker anxiety and

[180] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[181] See pg. 519 of Paris, M. and Hoge, M.A. (2009). *Burnout in the Mental Health Workforce: A Review.* The Journal of Behavioral Health Services & Research, 37(4), pp.519–528. doi:https://doi.org/10.1007/s11414-009-9202-2
[182] Vallance, K. (2004). *Exploring counsellor perceptions of the impact of counselling supervision on clients*. British Journal of Guidance & Counselling, 32(4), pp.559–574. doi:https://doi.org/10.1080/03069880412331303330
[183] National Academy of Medicine (2019). *Taking Action Against Clinician Burnout*. [online] Washington, D.C.: National Academies Press. doi:https://doi.org/10.17226/25521.
[184] Prins, J.T., Gazendam-Donofrio, S.M., Tubben, B.J., van der Heijden, F.M.M.A., van de Wiel, H.B.M. and Hoekstra-Weebers, J.E.H.M. (2007). *Burnout in medical residents: a review. Medical Education*, [online] 41(8), pp.788–800. doi:https://doi.org/10.1111/j.1365-2923.2007.02797.x
[185] Ellis, M.V., Berger, L., Hanus, A.E., Ayala, E.E., Swords, B.A. and Siembor, M. (2013). *Inadequate and Harmful Clinical Supervision.* The Counseling Psychologist, [online] 42(4), pp.434–472. doi: https://doi.org/10.1177/0011000013508656
[186] It is important to note that research on the direct relationship between clinical supervision and client outcomes is still in its early stages and has, to this point, produced inconclusive results.
[187] Watkins, C.E. (2020). What do clinical supervision research reviews tell us? Surveying the last 25 years. *Counselling and Psychotherapy Research*, 20(2), pp.190–208. doi:https://doi.org/10.1002/capr.12287
[188] Tugendrajch, S.K., Sheerin, K.M., Andrews, J.H., Reimers, R., Marriott, B.R., Cho, E. and Hawley, K.M. (2021). *What is the evidence for supervision best practices?* The Clinical Supervisor, 40(1), pp.68–87. doi:https://doi.org/10.1080/07325223.2021.1887785.
[189] However, the established links between supervision quality and supervisee competency and wellbeing, as well as the links between supervisee competency and well-being and client outcomes, suggest that high-quality supervision is likely to be associated with overall improvements in care for consumers. We encourage Utah policymakers, regulators, and industry stakeholders to revisit this topic as research on the relationship between supervision and client outcomes in behavioral health continues to advance.
[190] Keum, B.T. and Wang, L. (2020). *Supervision and psychotherapy process and outcome: A meta-analytic review.* Translational Issues in Psychological Science, 7(1), pp.89–108. doi:https://psycnet.apa.org/doi/10.1037/tps0000272
[191] See pg. 441 of Ellis, M.V., Berger, L., Hanus, A.E., Ayala, E.E., Swords, B.A. and Siembor, M. (2013). *Inadequate and Harmful Clinical Supervision.* The Counseling Psychologist, [online] 42(4), pp.434–472. doi: https://doi.org/10.1177/0011000013508656

exhaustion.[192,193,194] When burned-out providers are still working with clients, the safety and quality of care declines as well. One meta-analysis identified statistically significant negative relationships in general health care settings between provider burnout and multiple measures of safety and quality, including medical errors, adverse events, "near misses," and patient satisfaction.[195] High-quality supervision works in the opposite direction and is associated with reduced stress, anxiety, and burnout among supervisees—which likely leads to better and safer care for their patients.[196,197] As one study of BH regulation concluded, "interpersonal processes within clinical supervision, rather than distant…regulation, are the key to protecting the public and ensuring the safety and efficacy of practice."[198]

Supervision Quality Can Be Improved Through Training

Training clinical supervisors on effective supervision practices may be an important step in promoting high-quality supervision in Utah, and thereby improving consumers' access to safe BH care. Training clinical supervisors helps to increase their confidence in their ability to practice and to properly assist in the growth of new supervisees. Multiple studies show that training increases self-rated supervisory competency,[199,200] with some participants explaining that training enabled them to better reflect upon their strengths and weaknesses as supervisors, thus positively impacting their later supervision practices.[201] In terms of specific competencies, training increases supervisors' perception of their job performance, supportiveness, ability to manage supervisory relationships, assist students in goal setting, and promote professional

[192] Mor Barak, Michàlle E., Travis, Dnika J., Pyun, H. and Xie, B. (2009). *The Impact of Supervision on Worker Outcomes: A Meta-analysis.* Social Service Review, 83(1), pp.3–32. doi:https://www.journals.uchicago.edu/doi/full/10.1086/599028

[193] Knudsen, H.K., Ducharme, L.J. and Roman, P.M. (2008). *Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse*. Journal of Substance Abuse Treatment, 35(4), pp.387–395. doi:https://doi.org/10.1016/j.jsat.2008.02.003,

[194] Iosim, I., Runcan, P., Dan, V., Nadolu, B., Runcan, R. and Petrescu, M. (2021). *The Role of Supervision in Preventing Burnout among Professionals Working with People in Difficulty.* International Journal of Environmental Research and Public Health, 19(1), p.160. doi:https://doi.org/10.3390/ijerph19010160.

[195] Salyers, M.P., Bonfils, K.A., Luther, L., Firmin, R.L., White, D.A., Adams, E.L. and Rollins, A.L. (2016). *The Relationship between Professional Burnout and Quality and Safety in healthcare: a meta-analysis.* Journal of General Internal Medicine, 32(4), pp.475–482. doi:https://doi.org/10.1007/s11606-016-3886-9

[196] Mor Barak, Michàlle E., Travis, Dnika J., Pyun, H. and Xie, B. (2009). *The Impact of Supervision on Worker Outcomes: A Meta-analysis.* Social Service Review, 83(1), pp.3–32. doi:https://www.journals.uchicago.edu/doi/full/10.1086/599028

[197] Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A. and Coyle, D. (2006). *Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses.* Journal of Clinical Nursing, 15(8), pp.1007–1015. doi:https://doi.org/10.1111/j.1365-2702.2006.01370.x

[198] See pg. 9 of McGivern, G, Fischer, M, Ferlie, E & Exworthy, M (2009), *'Statutory Regulation & the Future of Professional Practice in Psychotherapy & Counselling: Evidence from the Field'*. Unknown Publisher, King's College London. Visit: https://www.listeningtoyou.co.uk/uploads/2/7/0/7/2707581/statutoryregulation1-1.pdf

[199] Taylor, K.N., Gordon, K., Grist, S. and Olding, C. (2012). *Developing supervisory competence: preliminary data on the impact of CBT supervision training.* The Cognitive Behaviour Therapist, 5(4), pp.83–92. doi:https://doi.org/10.1017/s1754470x13000056.

[200] Harris, N., Case, E. and Sheppard, H. (2018). *Predoctoral internship training: Psychology intern perspectives on an internship rotation targeting supervision competency development.* The Clinical Supervisor, 37(2), pp.278–297. doi https://doi.org/10.1080/07325223.2017.1421110

[201] Ibid.

development.[202,203] More successfully managing supervisory relationships increases supervisor satisfaction and management of stress, providing evidence that training indirectly causes other positive outcomes as well.[204] One novel study assigned supervisors to two groups, one of which received supervision training while the other did not, then randomly assigned counselors to each group to better analyze the effects of supervision training. The researchers found that supervisors who received training saw improvements in their self-perceived clinical supervision behavior, knowledge, self-efficacy, and working alliance relative to those who did not receive training.

This study also established that the positive outcomes of training extend to supervisees as well. Those supervisees who were randomly assigned to trained supervisors reported much lower levels of dissatisfaction with their experience than their peers in the control group.[205] In essence, the strict, hierarchical nature of the supervisor-supervisee relationship softens with a trained supervisor. Trained supervisors depend less on utilizing a "superior-subordinate relationship," thus enabling supervisees to verbalize their needs more.[206] Counselors within agencies that provide inservice training on supervision also experience their supervision as more supportive and enabling of their professional development.[207] Supervisees benefit when their supervisors are trained, specifically through improvements to the supervisor-supervisee relationship.

Emerging evidence suggests that the training a supervisor receives may even have an impact on their supervisee's clients. One study found that "approximately 16% of variance in [client] outcomes" could be attributed to the treating therapist's supervisor.[208] Additionally, clients receiving supervised therapy, with a trained supervisor, claimed a greater reduction in Beck Depression Inventory scores and a higher rate of satisfaction with their therapist than clients receiving unsupervised therapy.[209] An increased emphasis on supervision education for psychologists has positively impacted clients of psychotherapy, as one study found that better client outcomes were associated with supervisors who had recently graduated, likely due to that

[202] Kraemer Tebes, J., Matlin, S.L., Migdole, S.J., Farkas, M.S., Money, R.W., Shulman, L. and Hoge, M.A. (2010). *Providing Competency Training to Clinical Supervisors Through an Interactional Supervision Approach.* Research on Social Work Practice, [online] 21(2), pp.190–199. doi:https://doi.org/10.1177/1049731510385827
[203] Barrow, M. and Domingo, R.A. (1997). *The Effectiveness of Training Clinical Supervisors in Conducting the Supervisory Conference.* The Clinical Supervisor, 16(1), pp.55–78. doi:https://doi.org/10.1300/J001v16n01_04
[204] Kraemer Tebes, J., Matlin, S.L., Migdole, S.J., Farkas, M.S., Money, R.W., Shulman, L. and Hoge, M.A. (2010). Providing Competency Training to Clinical Supervisors Through an Interactional Supervision Approach. *Research on Social Work Practice*, [online] 21(2), pp.190–199. doi:https://doi.org/10.1177/1049731510385827
[205] Herbert, J.T., Schultz, J.C., Lei, P. and Aydemir-Döke, D. (2017). *Effectiveness of a Training Program to Enhance Clinical Supervision of State Vocational Rehabilitation Personnel.* Rehabilitation Counseling Bulletin, 62(1), pp.3–17. doi:https://doi.org/10.1177/0034355217725721
[206] Barrow, M. and Domingo, R.A. (1997). *The Effectiveness of Training Clinical Supervisors in Conducting the Supervisory Conference.* The Clinical Supervisor, 16(1), pp.55–78. doi:https://doi.org/10.1300/J001v16n01_04
[207] Greenspan, R., Hanfling, S., Parker, E., Primm, S. and Waldfogel, D. (1992). *Supervision of Experienced Agency Workers*. The Clinical Supervisor, 9(2), pp.31–42. doi:https://di.org/10.1300/J001v09n02_04
[208] See pg. 75 of Callahan, J.L., Almstrom, C.M., Swift, J.K., Borja, S.E. and Heath, C.J. (2009). Exploring the contribution of supervisors to intervention outcomes. *Training and Education in Professional Psychology*, 3(2), pp.72–77. doi: https://psycnet.apa.org/doi/10.1037/a0014294
[209] Bambling, M., King, R., Raue, P., Schweitzer, R. and Lambert, W. (2006). *Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression.* Psychotherapy Research, 16(3), pp.317–331. doi:https://doi.org/10.1080/10503300500268524

supervisory training.[210] Supervisory quality clearly matters, and supervision training is an effective tool in combating the consequences of poor quality supervision that arise in every stage of BH treatment.

Industry Insiders Support Supervisor Training, But Have Capacity Concerns

Based on feedback provided to OPLR throughout the review process, Utah's BH workforce strongly supports the idea of creating a training requirement for clinical supervisors, provided that this does not reduce the already limited supervision capacity within the state.

In OPLR's behavioral health workforce survey, many participants left comments detailing the importance of supervision in creating quality clinicians, while expressing deep frustration at the current state of supervision.[211] Participants in OPLR focus groups were similarly disheartened by the highly variable supervision quality plaguing their fields and expressed their desire for supervision training and CE hours to combat this, with statements like, "There needs to be training for supervisors," and "[Ensuring] that supervisors receive continuing education… that's where we're really impacting our future clinicians".[212] In short, many Utah practitioners expressed a belief that education and training for supervisors should be used to protect against potential both harm to supervisees and to the public at large. Drawing a comparison to the less than sufficient supervision they experienced, many BH practitioners praised the training MFTs received in supervision, expressing interest in a similar program.

> *"It's great training. Something like that is appropriate to ask social workers to do— have criteria for meeting supervision objectives and actually help grow the profession in a competent manner"*

Others seconded this, with one participant explaining a similar program she went through.

> *"[Another state] had a requirement that one had to take a supervision course and complete it successfully to be a supervisor. I took that course and it was very helpful in the work I went on to do with students and new practitioners."*

Effective supervision training allows therapists to grow their field while honing their skills and strengthening their confidence as clinicians. As one therapist succinctly stated, "As a good supervisor, you're becoming a better clinician." Utah BH industry associations also support the implementation of supervision training. The UMHCA, UAMFT, NASW-UT came together to lobby

[210] Wrape, E.R., Callahan, J.L., Ruggero, C.J. and C. Edward Watkins (2015). An exploration of faculty supervisor variables and their impact on client outcomes. *Training and Education in Professional Psychology*, 9(1), pp.35–43. doi:https://psycnet.apa.org/doi/10.1037/tep0000014
[211] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[212] OPLR Listening & Vetting Tour

for high quality supervision, and among their primary recommendations was 28 hours of supervision courses.[213]

Despite widespread support for implementing a supervisor training requirement, many stakeholders also have concerns regarding any changes that might further constrain the already-limited supply of supervisors in the state.[214]

> *"I agree with supervision training in principle, but preceptors are a big issue as we are understaffed there as well."*

> *"Having clinical supervisors be trained is a good idea, but there are a lot of people who need to be supervised and this may limit the number of people who can supervise."*

In short, anything that may further limit the pool of potential clinical supervisors in Utah should be implemented only in conjunction with counter-balancing measures to ensure sufficient supervision capacity for the state's ongoing training needs.

Revising Capacity-Constraining Policies May Help to Build Supervision Capacity

Policymakers should include, alongside the new training requirement for supervisors, one or more capacity-building measures, such as 1) eliminating or relaxing the maximum limit on number of supervisees, 2) clarifying that triadic and group supervision may substitute for one-to-one (i.e., dyadic) supervision, 3) removing restrictions on tele-supervision, and 4) removing or revising the requirement that a clinician must hold their license for two years before becoming a clinical supervisor.

Maximum Number of Supervisees. While the new training requirements will help supervisors to provide high-quality supervision, eliminating Utah's current limit of 6 supervisees would provide greater flexibility for BH facilities and employers to independently determine how best to allocate time and workforce capacity to provide supervision for incoming clinicians. Further, eliminating or revising this upper limit may help to bring retirees and seasoned professionals back into the workforce by providing a pathway for them to focus on mentoring the next generation of professionals. Unlike Utah, most states do not specify an upper limit on the number of supervisees that a clinical supervisor may concurrently supervise. Those that do set a limit range from 3 (Missouri) to 25 (Florida). During OPLR's review, industry leaders supported

[213] Utah Mental Health Counselors Association, Utah Association for Marriage & Family Therapy and National Association of Social Workers, Utah (2022). *Official Statement Regarding HB366 and need for increased qualified supervision training.* [online] umhca.org. Available at: https://umhca.org/resources/Documents/Unified%20Statement%20in%20support%20of%20qualified%20supervision%20standards.pdf

[214] OPLR Listening & Vetting Tour

the idea of removing this limit altogether, and clarified that doing so may help to counteract any potential loss in the supervisor workforce due to the new training requirements.[215] Clinicians are also frustrated with this rule; an administrator from DOPL shared that people frequently petition their respective boards for permission to oversee more than six supervisees, but exceptions are rarely granted. If completely eliminating this upper bound proves problematic, Utah policymakers may wish to borrow from Florida or Idaho by introducing a caveat that eliminates this limit only for those whose primary work role is as a clinical supervisor, or that simply raises this limit substantively across the board (e.g., from 6 to 30).[216] Another alternative may be to remove or revise this limit for only those supervisors who are employed at certain Department of Health and Human Services (DHHS) facilities, for example, those that are already subject to additional oversight and safety checks.

Triadic & Group Supervision. Next, the state's overall clinical supervision capacity may also be improved by specifying that triadic and group supervision are allowed to count toward a supervisee's required direct clinical supervision hours. Currently, there appears to be a lack of clarity and some confusion in the field as to whether or under what circumstances group supervision is allowed. The stereotypical direct clinical supervision hour is dyadic—it involves one supervisor and one supervisee getting together to do case consultation, where they discuss questions, concerns, and issues directly related to the supervisee's work with clients. Other beneficial forms of supervision may include meeting in triads (i.e., one supervisor and two supervisees) and meeting in larger groups (i.e., one supervisor and three or more supervisees). "Each supervision modality makes important, unique, and yet complementary contributions to supervisee growth".[217] Triadic supervision encourages supervisees to learn from each other in a more intimate and involved setting than in a larger group, where supervisees may accept peer feedback even more readily than that from a supervisor.[218,219] Group supervision exposes supervisees to a broad range of client interactions and counselor styles where participants learn from a range of experiences.[220,221] These modes of supervision, which bring together peers in addition to the more traditional supervisee-supervisor dyads, "decrease professional isolation, increase professional support and networking, normalize the stress of clinical work, and [are] intellectually stimulating".[222] Supervisees benefit heavily from receiving a mix of supervision

[215] OPLR Listening & Vetting Tour
[216] R24.15.01 – Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists; Idaho rules for Marriage and Family Therapists and Licensed Clinical Mental Health Counselors supervisors specify that the maximum number of supervisees is 6, unless the supervisor's primary work role is as a clinical supervisor.
[217] See pg. 293 of Borders, L.D., Welfare, L.E., Greason, P.B., Paladino, D.A., Mobley, A.K., Villalba, J.A. and Wester, K.L. (2012). *Individual and Triadic and Group: Supervisee and Supervisor Perceptions of Each Modality.* Counselor Education and Supervision, 51(4), pp.281–295. doi:https://doi.org/10.1002/j.1556-6978.2012.00021.x.
[218] Ibid.
[219] Borders, L. and Drury, S. (1992). *Comprehensive school counseling programs: A review for policymakers and practitioners. J*ournal of Counseling & Development, [online] 70(4), pp.487–498. doi:https://doi.org/10.1002/j.1556-.
[220] Borders, L.D., Welfare, L.E., Greason, P.B., Paladino, D.A., Mobley, A.K., Villalba, J.A. and Wester, K.L. (2012). *Individual and Triadic and Group: Supervisee and Supervisor Perceptions of Each Modality.* Counselor Education and Supervision, 51(4), pp.281–295. doi:https://doi.org/10.1002/j.1556-6978.2012.00021.x.
[221] Henggeler, S.W. and Schoenwald, S.K. (1998). Multisystemic Therapy Supervisory Manual: Promoting Quality Assurance at the Clinical Level. [online] pp.1–55. Available at: https://www.ojp.gov/pdffiles1/Digitization/181299NCJRS.pdf
[222] See pg. 42 of Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Clinical Supervision and Professional Development of the Substance Abuse Counselor A Treatment Improvement Protocol TIP 52*. [online] Available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4435.pdf

modalities, as do supervisors. Explicitly allowing for these types of supervision in rule may help establish the precedent for engaging in these methods and clear up any confusion as to what is allowed. Further, utilizing triadic and/or group supervision formats will help to decrease the total time required by supervisors to provide high-quality direct clinical supervision. For example, instead of conducting one-hour sessions with each of their supervisees each week, a supervisor may alternate between dyadic, triadic, and group supervision formats, effectively cutting down the time needed to provide direct clinical supervision hours. This alteration requires no substantive change in supervision rule, yet it encourages better supervision practice and increases supervisor capacity. Policymakers may want to define how many hours of direct supervision can occur in triadic and group settings and determine limits on proper group size to maintain a complimentary mix of modalities.

Remote Supervision Requirements. Another potential solution for increasing supervision capacity, in conjunction with promoting high-quality supervision through supervisor training, would be to eliminate the current requirement that supervisors visit a supervisee's practice location on an at-least quarterly basis. This is an issue as supervisees in Utah's rural and frontier areas may struggle to find supervisors and supervisors from other regions may be either unwilling or unable to travel to provide supervision to these providers. Eliminating this requirement could help to increase the availability of high-quality supervision for those working in these comparatively underserved areas of Utah. DOPL personnel note that despite being petitioned, boards rarely grant an exception to this rule,[223] and those wishing to provide or to receive remote supervision without this additional burden are often left without a clear understanding as to why their request has been denied. Given that the current rule does not specify the nature or duration of the mandated quarterly visit, there may be little substantive difference in supervision quality between a supervision schedule that includes this brief, intermittent face-to-face interaction and one that does not. Either way, the substance of supervision occurs remotely. As it is written, this rule may be sacrificing access for no discernable improvement in quality or safety. Research even suggests that telesupervision is typically perceived as equivalent in quality to in-person supervision, particularly when the telesupervision is conducted live with audiovisual components.[224,225,226,227,228] Although telesupervision does come with unique challenges, like maintaining confidentiality in an online environment and properly utilizing potentially unfamiliar technology, it uniquely transcends obstacles in supervision access while maintaining the traditional supervisee-supervisor

[223] The MFT board is the only one reported to have ever done so.
[224] It should be noted that research on the comparative efficacy of telesupervision is currently limited.
[225] Martin, P., Lizarondo, L. and Kumar, S. (2017). *A systematic review of the factors that influence the quality and effectiveness of telesupervision for health professionals. J*ournal of Telemedicine and Telecare, 24(4), pp.271–281. doi:https://doi.org/10.1177/1357633X17698868.
[226] Phillips, L.A., Logan, J.N. and Mather, D.B. (2021). *COVID-19 and beyond: Telesupervision training within the supervision competency*. Training and Education in Professional Psychology, 15(4), pp.284–289. doi:https://doi.org/10.1037/tep0000362.
[227] Inman, A.G., Bashian, H., Pendse, A.C. and Luu, L.P. (2018). *Publication trends in telesupervision: A content analysis study*. The Clinical Supervisor, 38(1), pp.97–115. doi:https://doi.org/10.1080/07325223.2018.1528194.
[228] Jordan, S.E. and Shearer, E.M. (2019). *An exploration of supervision delivered via clinical video telehealth (CVT).* Training and Education in Professional Psychology, 13(4), pp.323–330. doi:https://doi.org/10.1037/tep0000245.

relationship.[229] Utah policymakers should consider removing this barrier to remote supervision, or at least providing a caveat for those working in rural areas of the state.

Minimum Time with License. Finally, to improve supervision capacity, policymakers may consider eliminating or creating an alternative path around the current requirement that licensees must hold their clinical license for 2 years before becoming a supervisor. Some BH clinicians may be adequately prepared to provide supervision before they have been fully licensed for two years. For example, an individual who has been working at the associate level for many years, but who was unable to become fully licensed as a clinician (e.g.., due to not passing the exam, or struggling to obtain general experience hours while working part time), may have significantly more experience working with clients than someone who has been fully licensed for two years, but who accrued less experience either at the associate level or after becoming fully licensed. In this way, clinicians who are held up by the exam or by meeting the general experience hours requirement may be just as prepared or even more prepared to supervise than those who meet this requirement. As one recently-licensed clinician shared with OPLR, "There is a severe lack of qualified supervisors in rural Utah. Even though I am a fully licensed LCSW with 10 years practice in the social work field, I'm not allowed to provide supervision for another year. Those who are allowed to supervise are so overwhelmed that very little supervision is occurring." Removing or creating an alternative to the current two-year requirement could help to increase capacity specifically in areas already facing a shortage of supervisors. The addition of a supervisor training requirement may provide enough assurance of supervisor competence to reduce the need for a time-with-license requirement as well.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- What content, duration, & format of supervisor training will be required?
- Who will be authorized to conduct training for supervisors?
- How will existing supervisors be impacted & included in the changes?

What Content, Duration, & Format of Supervisor Training Will Be Required?

When determining the substance and length of supervisors' training, policymakers should establish high standards for quality without creating overly-burdensome requirements. For example, this could include requiring a certain number of hours of training,[230,231] which might be accomplished through both informal and formal instruction. Initial and CE supervisor training

[229] Wood, J.A.V., Miller, T.W. and Hargrove, D.S. (2005). *Clinical Supervision in Rural Settings: A Telehealth Model*. Professional Psychology: Research and Practice, 36(2), pp.173–179. doi:https://doi.org/10.1037/0735-7028.36.2.173.
[230] Utah industry organizations recently suggested 20 hours of supervision training for MFTs and 8 hours for LCSWs and CMHCs.
[231] Utah Mental Health Counselors Association, Utah Association for Marriage & Family Therapy and National Association of Social Workers, Utah (2022). *Official Statement Regarding HB366 and need for increased qualified supervision training,*. [online] umhca.org. Available at: https://umhca.org/resources/Documents/Unified%20Statement%20in%20support%20of%20qualified%20supervision%20standards.pdf.

requirements might incorporate both 1) didactic instruction on the fundamentals of supervision and 2) informal learning through mentorship activities. In terms of substance, many high-quality training programs for supervisors have already been created, reflecting the ever-increasing knowledge base of what constitutes best practice in supervision.[232] Formal training on essentials of supervision might beneficially include instruction related to:[233,234,235]

1. Role/responsibilities of clinical supervisors
    a. Supervisory relationships
    b. Evaluation/gatekeeping
2. Methods/techniques for clinical supervision
    a. Using client feedback & outcomes
    b. Leading group supervision
    c. Technology & telesupervision
3. Legal/ethical issues in clinical supervision

Mentorship activities might include the supervisor-in-training observing others' supervision practices, engaging in peer consultation regarding the practice of supervision, or having others directly observe their own supervision practices. Creating a requirement that relies on informal as well as formal learning strategies may help to prevent undue burden and prove even more beneficial in promoting high-quality supervision among practitioners. Alternatively, policymakers could opt for a competency- rather than duration-based requirement for supervisor training. Rather than requiring that a certain number of hours be completed, this could be accomplished by requiring the supervisor-in-training to procure recommendations or evaluations from already-qualified supervisors, other clinicians, or their own supervisees.

Who Will Be Authorized to Conduct Training for Supervisors?

To avoid limiting supervision capacity any further, authorization to provide both formal and informal elements of supervisor training should be extended as broadly as possible. This might include authorizing industry associations, universities, online course providers, or existing supervisors to provide such training. Current supervision licensing rules for MFTs allow the American Association for Marriage and Family Therapy (AAMFT), Utah Association for Marriage and Family (UAMFT), Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), or an accredited university to provide supervision training.[236] Associations related to LCSWs and CMHCs should also be authorized to provide training, including National

[232] Tugendrajch, S.K., Sheerin, K.M., Andrews, J.H., Reimers, R., Marriott, B.R., Cho, E. and Hawley, K.M. (2021b). *What is the evidence for supervision best practices?* The Clinical Supervisor, 40(1), pp.68–87. doi:https://doi.org/10.1080/07325223.2021.1887785.
[233] Bernard, J.M. and Goodyear, R.K. (2019). *Fundamentals of Clinical Supervision*. [online] pp.5–18. Available at: https://www.pearsonhighered.com/assets/preface/0/1/3/4/0134752511.pdf.
[234] Center for Credentialing & Education (2021). *APPROVED CLINICAL SUPERVISOR CREDENTIAL ELIGIBILITY POLICY*. [online] *cce-global.org*. Available at: https://www.cce-global.org/Assets/ACS/ACS_Eligibility_Policy.pdf
[235] Grus, C. and Morris, J.-S. (2014). *Guidelines for Clinical Supervision in Health Service Psychology Board of Educational Affairs Task Force on Supervision Guidelines 1*. [online] Available at: https://www.apa.org/about/policy/guidelines-supervision.pdf
[236] R156-60b-302d. Qualifications to be a Marriage and Family Therapist Training Supervisor.

Association of Social Workers (NASW), NASW-UT, American Mental Health Counselors Association (AMHCA), and Utah Mental Health Counselors Association (UMHCA). Other credentials, like the Approved Clinical Supervisor (ACS) credential from the Center for Credentialing & Education (CCE)[237], could be included as well. Insofar as mentorship activities with peers and already-licensed supervisors may count towards training hours, these individuals should be authorized to sign-off on these informal training hours as well.

How Will Existing Supervisors Be Impacted & Included in the Changes?

For current supervisors, there needs to be a specified timeline within which to complete supervision training. It may be appropriate to specify that anyone providing supervision before the date of passage be given two years[238] to comply with the new requirements. Training should not be required for some practicing supervisors, for instance those with substantial experience and expertise in supervision, itself. As it stands in current rule, AAMFT approved supervisors should continue to be exempt from these training and continuing education requirements, as AAMFT certification is incredibly rigorous. If it is determined that the ACS credential, or other similar designations from authorized organizations, are comparably rigorous and meet the standards of quality, then they should be similarly exempt. Therefore, it should be written into rule that earning and subsequently maintaining these designations are equivalent to meeting the state's supervisor training and continuing education requirements. Other alternatives to demonstrating competency should be allowed as well, for example, observations and evaluations by experts, documentation of supervision contracts, etc.[239]

To ensure that all affected licensees quickly understand and adopt changes to supervision requirements, administrators should (1) provide timely notifications to licensees and (2) publish clear summaries of the new requirements. These actions may also serve to reduce the volume of questions or requests for clarification about supervision requirements that DOPL staff receive. When changes to supervision requirements come into effect, send timely notifications (e.g., via email or postcard) to all master's-level BH clinicians licensed by DOPL, summarizing the changes and directing licensees to the DOPL website. Sending an email to all license holders and posting a notice on each profession's webpage would be relatively low burden, straightforward methods for communicating this information. Training programs (e.g., institutes of higher education and other training institutions) should also receive timely notification of changes so that current and incoming students can be made aware of updated requirements.

Additional Ideas

Utah policymakers may wish to consider alternative approaches instead of or in addition to requiring training for supervisors and modifying existing capacity-constraining policies.

[237] Center for Credentialing & Education (2022). *Approved Clinical Supervisor | ACS*. [online] www.cce-global.org. Available at: https://www.cce-global.org/credentialing/acs.
[238] Actual number should be determined by the boards
[239] Similar to the APPEL program, where candidates may demonstrate competency in a variety of ways. https://www.schools.utah.gov/file/84d3b8f6-241a-4e1c-ab8a-56ce4dddc0fa.

- **Provide supervisees with information regarding appropriate supervision practices**. This could include a "supervisee bill of rights" that individuals receive while in graduate school and/or when issued an initial associate-level clinician license. Information could include a clear explanation of state supervision requirements, how to identify poor-quality supervision practices, and how to address or report poor supervision. Regulators might also consider requiring supervisees to complete a supervisory experience survey at multiple points during supervision to uncover potentially inadequate or harmful supervisory practices they may be experiencing.[240]
- **Require supervision contracts to address** how **measurement-based care** will be implemented throughout the period of supervision. BH practitioners and academic researchers alike consistently identify the use of client feedback and outcomes (i.e., measurement-based care) as a best practice for providing high-quality clinical supervision.[241,242] Client feedback provides "a source of standardized performance feedback that is critical for training purposes"[243] and that can "enhance clinical decision-making, improve accountability, drive program planning, and inform treatment effectiveness."[244] For example, client feedback is effective in helping therapists identify and intervene with clients who are deteriorating or likely to deteriorate.[245] Several clinical trials and a replication study showed that when therapists (including both supervisees and fully licensed therapists) received client feedback, "not-on-track" (NOT) clients' deterioration rates were reduced significantly from the baseline, a clear demonstration of client feedback's effects on quality of care.[246,247,248,249,250]

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[240] Ellis, M.V., Berger, L., Hanus, A.E., Ayala, E.E., Swords, B.A. and Siembor, M. (2013). *Inadequate and Harmful Clinical Supervision.* The Counseling Psychologist, [online] 42(4), pp.434–472. doi:https://doi.org/10.1177/0011000013508656 - Provides a relevant survey instrument.

[241] Choy-Brown, M. and Stanhope, V. (2018). The Availability of Supervision in Routine Mental Health Care. *Clinical Social Work Journal*, 46(4), pp.271–280. doi:https://doi.org/10.1007/s10615-018-0687-0.

[242] Milne, D.L. and Reiser, R.P. (2011). Observing competence in CBT supervision: a systematic review of the available instruments. *The Cognitive Behaviour Therapist*, 4(3), pp.89–100. doi:https://doi.org/10.1017/s1754470x11000067.

[243] Worthen, V.E. and Lambert, M.J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling and Psychotherapy Research*, 7(1), pp.48–53. doi:https://doi.org/10.1080/14733140601140873.

[244] Garland, A.F., Bickman, L. and Chorpita, B.F. (2010). Change What? Identifying Quality Improvement Targets by Investigating Usual Mental Health Care. *Administration and Policy in Mental Health and Mental Health Services Research*, 37(1-2), pp.15–26. doi:https://doi.org/10.1007/s10488-010-0279-y.

[245] Lambert, M.J., Whipple, J.L., Hawkins, E.J., Vermeersch, D.A., Nielsen, S.L. and Smart, D.W. (2006). Is It Time for Clinicians to Routinely Track Patient Outcome? A Meta-Analysis. *Clinical Psychology: Science and Practice*, [online] 10(3), pp.288–301. doi:https://doi.org/10.1093/clipsy.bpg025.

[246] Worthen, V.E. and Lambert, M.J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling and Psychotherapy Research*, 7(1), pp.48–53. doi:https://doi.org/10.1080/14733140601140873.

[247] Lambert, M.J., Whipple, J.L., Smart, D.W., Vermeersch, D.A., Nielsen, S.L. and Hawkins, E.J. (2001). The Effects of Providing Therapists With Feedback on Patient Progress During Psychotherapy: Are Outcomes Enhanced? *Psychotherapy Research*, 11(1), pp.49–68. doi:https://doi.org/10.1080/713663852.

[248] Lambert, M.J., Whipple, J.L., Vermeersch, D.A., Smart, D.W., Hawkins, E.J., Nielsen, S.L. and Goates, M. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: a replication. *Clinical Psychology & Psychotherapy*, [online] 9(2), pp.91–103. doi:https://doi.org/10.1002/cpp.324.

[249] Hawkins, E.J. (2004). The Therapeutic Effects of Providing Patient Progress Information to Therapists and Patients. *Psychotherapy Research*, 14(3), pp.308–327. doi:https://doi.org/10.1093/ptr/kph027.

[250] Whipple, J.L., Lambert, M.J., Vermeersch, D.A., Smart, D.W., Nielsen, S.L. and Hawkins, E.J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology*, 50(1), pp.59–68. doi:https://doi.org/10.1037/0022-0167.50.1.59.

1b. Supervision Hours

Summary of Recommendation

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.[251]

This recommendation applies only to those seeking licensure to practice under:

- 58-60 Mental Health Professional Practice Act
  - Licensed Clinical Social Worker
  - Marriage and Family Therapist
  - Clinical Mental Health Counselor

Status Quo

Utah's master's-level clinicians include Licensed Clinical Social Workers (LCSWs), Clinical Mental Health Counselors (CMHCs), and Marriage & Family Therapists (MFTs). These clinicians are required to complete 3,000 total hours of postgraduate supervised experience for licensure. This includes a requirement for 1,000 hours delivering mental health therapy and other direct interventions, referred to here as "direct client contact hours." Of these 1,000 direct client contact hours, 75 hours must consist of "direct clinical supervision," in which a supervisor and supervisee meet together to conduct activities such as case consultation, observation, and feedback. The remaining 2,000 hours—which we will refer to here as "general experience hours"—may be fulfilled by completing non-client-facing tasks such as research, professional development, and administrative work.

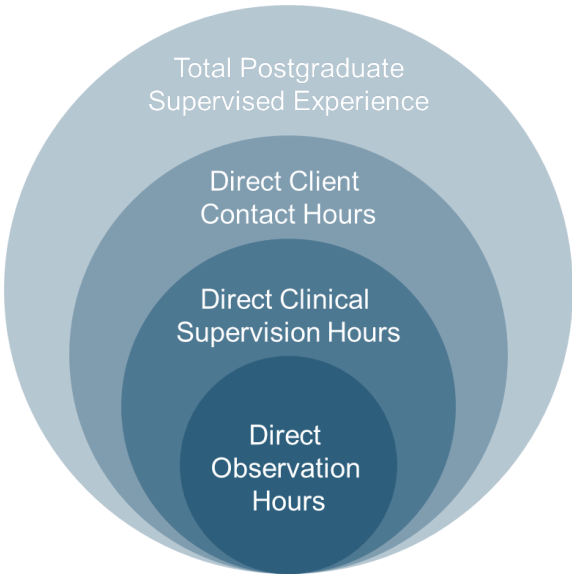
Existing Approaches

Across the United States, master's-level clinicians in BH (e.g., LCSWs, MFTs, and CMHCs)[252] are required on average[253] to complete 2,300 **total hours of postgraduate supervised experience** before they are authorized to practice independently. (Figure 3.1 illustrates the relationships between the types of hours commonly included in these totals.) Average requirements for LCSWs are highest at 3,000 hours, followed by CMHCs (2,650) and MFTs (2,250).

[251] These recommendations focus on the type and quantity of supervision hours required. For additional recommendations on improving the quality of supervision practices, including the introduction of required training for clinical supervisors, Please refer to 1a. Supervisor Requirements
[252] Also referred to as "licensed professional counselors" in many jurisdictions.
[253] All average hour figures are rounded to the nearest 50.

Requirements for **direct client contact hours**[254] average 1,600 hours for LCSWs, 1,350 hours for MFTs, and 1,300 hours for CMHCs. Utah's direct client contact hour requirements fall close to the national median for MFTs and LCSWs, and slightly lower than the national median for CMHCs. Utah's requirements for direct client contact hours are lower than the national medians for LCSWs (1,000 in Utah vs. 1,500 national median), CMHCs (1,000 vs. 1,500) and MFTs (1,000 vs. 1,200).

Figure 3.1 Types of Postgraduate Supervised Experience Hours



Many states have eliminated requirements for **general experience hours** to be completed in addition to direct client contact hours, a policy that is more common for MFTs and CMHCs, but that has also appeared in social work regulation in some jurisdictions. In these states, the number of required direct client contact hours tends to be higher than national averages. For example, New York and Florida do not require LCSWs to complete any additional general experience hours above their direct client contact hour requirements of 2,000 hours and 1,500 hours, respectively—or an average of 1750 direct client contact hours. The 16 states with no general experience hour requirements for MFTs require an average of 1,250 direct client contact hours; the 8 states with no general experience hour requirements for CMHCs require an average of 1,800 direct client contact hours.

Direct clinical supervision hour requirements vary more widely, ranging from an average of 150 hours for MFTs, to 100 hours for LCSWs and CMHCs. Many states set requirements for the frequency of direct clinical supervision hours, for example, by requiring that direct clinical supervision occur weekly, that a minimum number of direct clinical supervision hours be

[254] In Utah's Mental Health Professionals Practice Act (Title 58-60), the term "mental health therapy hours" is used to refer to the hours in which supervisees are in direct contact with clients, providing clinical mental health services such as psychotherapy and other interventions. Terminology for these hours varies between states and includes "direct client contact hours," "clinical hours," etc. In this document, the most commonly used term across U.S. jurisdictions, "direct client contact hours," will be used.

completed each month, or that an hour of direct clinical supervision occur at regular intervals throughout the process of accruing direct client contact hours (e.g., after every 40 direct client contact hours).[255] All but four U.S. states and territories require MFTs to complete at least 100 direct clinical supervision hours, and all but 11 require at least 100 direct clinical supervision hours for LCSWs and CMHCs.

Some jurisdictions also require that direct clinical supervision hours include a minimum amount of **direct observation hours**, in which the supervisor observes the supervisee's therapy sessions (either live or asynchronously) and gives feedback on those sessions. For example, Montana requires that 10 hours of LCSWs' 100 direct clinical supervision hours be spent conducting direct observation, defined as "participation in the service delivery, observation through a two-way mirror, observation of a video or audiotape of the service delivery, or observation through an interactive video link of the service delivery."[256,257] Idaho,[258] Nebraska,[259] and North Dakota[260] all require that MFTs' supervision involve direct observation (sometimes referred to as "raw data"), and Iowa[261] requires CMHCs to complete 24 hours of live or recorded observation. Utah does not currently mandate direct observation as part of the direct clinical supervision hours requirement.

Rationale

Why change supervision hours?

- General experience hours don't meaningfully improve safety
- General experience hour requirements are burdensome
- Direct client contact & direct clinical supervision hours are more beneficial
- Direct observation is critical for high-quality supervision

Utah's current supervision hour requirements largely consist of general experience hours, which do not involve direct contact with clients, are not as relevant to building clinicians' competence as direct client contact hours, and create unnecessary burdens and barriers for many clinicians. By eliminating requirements for general experience hours, strengthening requirements for more effective direct client contact and direct clinical supervision hours, and introducing requirements for direct observation, the state can focus its regulations on those activities that are most effective for building clinicians' competence and that will likewise help to promote greater access to care and safety for Utah consumers.

[255] OPLR National Review of Regulation
[256] MCA 24.219.504
[257] MCA 24.219.301
[258] IDAPA 24.15.01
[259] Neb. Rev. Stat. §38-2133
[260] NDAC 111-02-02-03
[261] IAC 645—31.7(154D)

General Experience Hours May Not Meaningfully Improve Safety

As currently defined, the content of general experience hours encompasses a wide variety of activities outside of direct client services, including research and study time, fulfilling reporting and billing requirements, and other operational tasks. While these activities may be important for supervisees' general professional development, they are less directly related to ensuring minimum competency in clinical practice, for example in delivering individual psychotherapy, where there is a greater risk of harm to clients. In discussions with industry leaders and regulators, including Division of Professional Licensing (DOPL) board members, proposals to eliminate these hours have been well-received, and we find no compelling research to support that more general experience hours are associated with better outcomes for clients. In fact, one preliminary analysis suggests that higher general experience hour requirements may even be associated with a slight increase in ethical violations and disciplinary actions.[262]

General Experience Hour Requirements Are Burdensome

General experience hour requirements can also become an unnecessary barrier, particularly for individuals who work part time or take a career break as they are in the process of pursuing full licensure—for instance, those raising families or those with illnesses or disabilities. The number of general experience hours that individuals can complete during the same period of time may also vary significantly between employment settings, resulting in some providers being able to obtain their license much more quickly than others.This may include those who are training in settings such as public mental health agencies, where additional time is spent on administrative tasks such as complying with the higher reporting requirements that are often associated with public funding, or in residential settings, where more opportunities for general experience hours may be available throughout the workday. As one practitioner described,[263]

> *"I worked in residential treatment and everything I did, from playing basketball with [residents], to crisis intervention, to attending meetings, all counted towards that 4,000 hours….Periodically we run into professionals raising families and they're doing 10 to 15 hours of work per week, which is almost completely clinical. They're not engaged in those other miscellaneous tasks that may or may not contribute to their professional development."*

Another BH practitioner described how individuals working part time may turn to less effective activities to complete the general experience hours they need, even while accruing substantially more direct client contact hours as compared to their peers:

[262] Doolan, K. (2018). *Ethical Accountability of Licensed Professional Counselors: A Ethical Accountability of Licensed Professional Counselors: A Comparative Study of State Regulations and the Effects on Ethical Comparative Study of State Regulations and the Effects on Ethical Behavior Behavior*. Old Dominion University, School of Public Service. [online] doi:https://doi.org/10.25777/fmx9-8q69.
[263] OPLR Listening & Vetting Tour

> *"[Associates say], 'I've got 1,150 therapy hours; I got everything done other than this 3,000. What books should I read, or what conferences should I attend?' …Especially the young mothers that are in their 20s and have young children [say], 'I work two evenings a week, and…to try to get these 3,000 hours, well, I'm holding my baby all day—I've got a podcast [about therapy] on.' You don't know if that's useful or not."*

General experience hour requirements may unnecessarily hold back or even push out entirely those professionals who are looking for additional flexibility while beginning their careers. By removing these requirements, Utah can open the door for more individuals to join the workforce and provide much-needed clinical services.

Direct Client Contact Hours and Direct Clinical Supervision Hours Are More Beneficial & Less Burdensome

Direct client contact hours (when supervisees provide mental health therapy and other interventions directly) and direct clinical supervision hours (when supervisors and supervisees meet face-to-face) are highly beneficial in terms of developing competence. By eliminating the general experience hours requirement, increasing required direct client contact hours, and increasing required direct clinical supervision hours, Utah can lower the overall burden of licensure, while potentially increasing licensees' preparation and safety.

As a training strategy, direct client contact hours have been shown to produce greater skill increases compared to other strategies. For example, clinicians who applied new skills during direct client contact hours showed significantly improved scores on delivering cognitive behavioral therapy (CBT) than their peers who only reviewed the manual or used a CBT training website.[264] Direct clinical supervision hours are also among those most consistently associated with improved practitioner competence. During direct clinical supervision hours, supervisors meet with supervisees to discuss their client cases, observe therapy sessions, give feedback on skills, and help them navigate ethical dilemmas. Direct clinical supervision is shown to produce skill increases superior to those of less interactive training techniques (e.g., attending seminars or studying from manuals).[265,266,267,268]

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[264] Sholomskas, D.E., Syracuse-Siewert, G., Rounsaville, B.J., Ball, S.A., Nuro, K.F. and Carroll, K.M. (2005). *We Don't Train in Vain: A Dissemination Trial of Three Strategies of Training Clinicians in Cognitive-Behavioral Therapy*. Journal of Consulting and Clinical Psychology, 73(1), pp.106–115. doi:https://doi.org/10.1037/0022-006X.73.1.106

[265] Holloway, E.L. and Neufeldt, S.A. (1995). *Supervision: Its contributions to treatment efficacy.* Journal of Consulting and Clinical Psychology, 63(2), pp.207–213. doi:https://doi.org/10.1037/0022-006X.63.2.207

[266] Weck, F., Kaufmann, Y.M. and Witthöft, M. (2017). Topics and techniques in clinical supervision in psychotherapy training. *The Cognitive Behaviour Therapist*, 10(e3), pp.1–17. doi:https://doi.org/10.1017/S1754470X17000046

[267] Lohani, G., & Sharma, P. (2023). *Effect of clinical supervision on self-awareness and self-efficacy of psychotherapists and counselors: A systematic review.* Psychological Services, 20(2), 291–299. https://doi.org/10.1037/ser0000693

[268] Bearman, S.K., Schneiderman, R.L. and Zoloth, E. (2016). *Building an Evidence Base for Effective Supervision Practices: An Analogue Experiment of Supervision to Increase EBT Fidelity.* Administration and Policy in Mental Health and Mental Health Services Research, 44(2), pp.293–307. doi:https://doi.org/10.1007/s10488-016-0723-8.

An analysis of sampled DOPL complaint data also supports strengthened requirements for direct client contact hours and direct clinical supervision hours from a client safety perspective. Early career practitioners are disproportionately represented (by over 16%) in complaints substantiated by the Division,[269] suggesting that a clinician's inexperience is associated with a greater likelihood of engaging in unprofessional or illegal conduct, including behaviors that cause direct harm to their clients.

In interviews, industry focus groups, and survey responses, DOPL board chairs, industry association leaders, and Utah practitioners expressed an overwhelming consensus that direct client contact hours are the best time for new clinicians to develop their skills and learn how to practice safely and ethically.[270,271] As one focus group participant shared,

> *"Students and early career practitioners tell me how important supervision is. That's where they really feel like they're learning how to be a social worker, where they can see social workers in action, and where they see us engage in ethical decision making."*

Direct Observation is Critical for High-Quality Supervision

BH practitioners and academic researchers alike consistently identify the use of direct observation ("directly observing clinicians' practice in sessions or reviewing audio or video recorded [sessions]")[272] as a best practice for providing high-quality supervision.[273,274] Evidence-based supervision guidelines developed by multiple BH professions emphasize the importance of incorporating direct observation into supervision.[275,276,277] In addition to building overall competency and teaching complex decision-making skills,[278] direct observation enables supervisors to quickly intervene when they identify issues that may result in negative client

[269] OPLR Analysis of DOPL Substantiated Complaint Data - Individuals licensed for 0-5 years.
[270] OPLR Listening & Vetting Tour
[271] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[272] See pg. 12 of Martino, S., Paris, M., Añez, L., Nich, C., Canning-Ball, M., Hunkele, K., Olmstead, T.A. and Carroll, K.M. (2016). *The Effectiveness and Cost of Clinical Supervision for Motivational Interviewing: A Randomized Controlled Trial*. Journal of Substance Abuse Treatment, 68, pp.11–23. doi:https://doi.org/10.1016/j.jsat.2016.04.005
[273] Choy-Brown, M. and Stanhope, V. (2018). *The Availability of Supervision in Routine Mental Health Care.* Clinical Social Work Journal, 46(4), pp.271–280. doi:https://doi.org/10.1007/s10615-018-0687-0.
[274] Milne, D.L. and Reiser, R.P. (2011). *Observing competence in CBT supervision: a systematic review of the available instruments.* The Cognitive Behaviour Therapist, 4(3), pp.89–100. doi:https://psycnet.apa.org/doi/10.1017/S1754470X11000067
[275] Tugendrajch, S.K., Sheerin, K.M., Andrews, J.H., Reimers, R., Marriott, B.R., Cho, E. and Hawley, K.M. (2021). *What is the evidence for supervision best practices?* The Clinical Supervisor, 40(1), pp.68–87. doi:https://doi.org/10.1080/07325223.2021.1887785
[276] Borders, L.D., Glosoff, H.L., Welfare, L.E., Hays, D.G., DeKruyf, L., Fernando, D.M. and Page, B. (2014). Best Practices in Clinical Supervision: Evolution of a Counseling Specialty. *The Clinical Supervisor*, [online] 33(1), pp.26–44. doi:https://doi.org/10.1080/07325223.2014.905225
[277] Choy-Brown, M. and Stanhope, V. (2018). *The Availability of Supervision in Routine Mental Health Care.* Clinical Social Work Journal, 46(4), pp.271–280. doi:https://doi.org/10.1007/s10615-018-0687-0.
[278] Holloway, E.L. and Neufeldt, S.A. (1995). *Supervision: Its contributions to treatment efficacy.* Journal of Consulting and Clinical Psychology, 63(2), pp.207–213. doi:https://doi.org/10.1037/0022-006X.63.2.207

outcomes, particularly issues that new clinicians may be unable to self-identify.[279] Observation can happen either synchronously or asynchronously, and can occur in person or via technological means, including video/audio feeds or recordings.[280] The benefits of direct observation were supported in interviews and focus groups conducted by OPLR:[281]

> *"The most effective supervision requires direct observation, because otherwise you're relying on the supervisee to self-identify a skill deficit, which is hard for someone who's new to the mental health field."*

> *"I have some associates who are not where they should be in their training, and either because they are inexperienced or because there are concerns, we absolutely have to be recording video and continuing feedback and training."*

By creating a new requirement for direct observation, described as an "essential part of successful learning"[282] for new clinicians, Utah can both strengthen new clinicians' training by increasing their opportunities to receive constructive feedback[283] and bring the state's supervision standards more in line with evidence-based training practices.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- How many hours will be required?
- How will we label & define different types of supervised hours?
- How will we ensure that practitioners know about the updated hour requirements?

How Many Hours Will Be Required?

As described above, the number and type of required supervision hours varies widely across states. Our recommendation is that Utah eliminate general supervision hours, while increasing direct client contact hours and direct clinical supervision hours, and adding a requirement for direct observation hours. In order to be consistent with national patterns, we recommend that the required amount of each type of supervision hours fall within the following ranges:

[279] Mor Barak, Michàlle E., Travis, Dnika J., Pyun, H. and Xie, B. (2009). *The Impact of Supervision on Worker Outcomes: A Meta-analysis.* Social Service Review, 83(1), pp.3–32. doi:https://www.journals.uchicago.edu/doi/full/10.1086/599028
[280] Weck, F., Kaufmann, Y.M. and Witthöft, M. (2017). Topics and techniques in clinical supervision in psychotherapy training. *The Cognitive Behaviour Therapist*, 10(e3), pp.1–17. doi:https://doi.org/10.1017/S1754470X17000046
[281] OPLR Listening & Vetting Tour
[282] Milne, D. (2009). Evidence-based clinical supervision : principles and practice. 1st ed. Chichester, West Sussex, UK: John Wiley & Sons Ltd.
[283] Choy-Brown, M. and Stanhope, V. (2018). *The Availability of Supervision in Routine Mental Health Care.* Clinical Social Work Journal, 46(4), pp.271–280. doi:https://doi.org/10.1007/s10615-018-0687-0.

Type	Recommended Range
Direct client contact hours	1,200-1,500 hours
Direct clinical supervision hours	85-150 hours
Direct observation hours	Minimum of 5-25 hours

When setting the exact number of required hours within these ranges, policymakers should consider (1) who is allowed to conduct direct observation, when, and how (2) what proportion and frequency of direct clinical supervision hours are required and (3) whether hour requirements are nested or stacked.

Who will be allowed to provide direct observation, when and how? First, policymakers should consider who will be authorized to conduct direct observation hours, when they can be completed, and in what formats. OPLR's recommendation is that any fully licensed clinician be allowed to provide direct observation, including during practicum (i.e., before graduation), either synchronously or asynchronously, using in situ or video observation. Allowing observation by any licensed clinician will allow incoming clinicians to benefit from the observations and feedback of multiple licensed professionals, rather than their direct supervisor alone. If, as recommended, direct observation hours can be conducted by any fully licensed clinician, supervisor capacity constraints may be less of a concern and therefore the minimum number of direct observation hours may be set higher (e.g., 15-25). However, if only clinical supervisors are allowed to provide direct observation, and especially if the individuals' own direct supervisor is the only one allowed to provide direct observation, the required number of direct observation hours should be set lower (e.g., 5-10) to minimize the impact on supervisors' time and capacity.

What proportion/frequency of direct clinical supervision hours will be required? Policymakers may also wish to consider whether to set requirements regarding the regularity and frequency of direct clinical supervision hours, in relation to direct client contact hours. For example, if a greater number of direct client contact hours are required, the number of direct clinical supervision hours might increase accordingly. Provisions may also be made in statute or rule to determine the frequency of these hours—to ensure that they are earned regularly throughout the course of supervision, rather than all at once. This could include requiring that a certain number of direct clinical supervision hours be completed each month (e.g., 4 hours per month) or that only a certain number of direct client contact hours may be completed before a direct clinical supervision hour must occur (e.g., 1 hour for every 40 direct client contact hours). The latter approach may provide additional flexibility for part-time workers, which may be beneficial given the high rate of part-time work among BH professionals in Utah.[284]

Will postgraduate supervised experience hour requirements be nested or stacked? Finally, policymakers should address whether postgraduate supervised experience hour

[284] Data from OPLR's 2023 Behavioral Health Care Workforce Survey shows that ~38% of actively licensed and currently employed BH professionals in Utah work part time at their primary practice location.

requirements are stacked or nested. If requirements are stacked, all types of required hours are accrued and counted separately. If requirements are nested, then both direct observation hours and direct clinical supervision hours could be allowed to count toward the requirements for direct client contact hours. Utah's current supervision hour requirements follow a nested format, which is fairly common across states. If hour requirements are nested, the number of required hours in each category might be set toward the higher end of the recommended range. Conversely, if hour requirements are separate or "stacked" and all types of hours are accrued and counted separately, the number of required hours in each category may be set closer to the lower end of the recommended ranges.[285]

How Will We Label & Define Different Types of Supervised Hours?

In updating postgraduate supervision requirements for clinicians, it will also be important for policymakers to standardize terminology and definitions for the various types of required hours. OPLR's review of the current terminology for supervision hours found significant inconsistency across Utah statute, administrative rules, and DOPL application forms. Twenty-four unique terms are used to refer to general experience hours, direct client contact hours, and direct clinical supervision hours, ten of which only appear once, and only three of which are defined in either the Mental Health Professional Practice Act (58-60) or the associated administrative rule. Terminology also differs both by profession and between statutes, rules, and applications, despite referring to the same requirements. The language used on DOPL application forms is also inconsistent with terminology used in statute and rule.

To improve internal consistency and clarity, avoid confusion, and bring Utah's use of terminology more in line with commonly used statutory language across the country, policymakers should uniformly define and use standard terms in all relevant statutes, administrative rules, and DOPL resources. The terms and definitions used in this report may be of benefit in doing so:

- **Postgraduate supervised experience** is the total amount of time spent in supervision, including *all* types of supervision hours.
- **Direct client contact hours** are those in which supervisees are providing services directly to clients, including psychotherapy/mental health therapy, assessment, diagnosis, and other direct interventions.
- **Direct clinical supervision hours** are those in which supervisors and supervisees meet to engage in case consultation, observation and feedback sessions, and to discuss other items related to the supervisee's professional development and client care.

[285] An example of a *nested structure* is as follows (all numbers for illustration purposes only): 1,500 total postgraduate supervised experience hours, including 1,500 direct client contact hours, 150 of which must be direct clinical supervision hours, and 15 of which must be direct observation hours.An example of a *stacked structure* is as follows: 1,500 total postgraduate supervised experience hours, including 1,350 direct client contact hours, 135 direct clinical supervision hours, and 15 direct observation hours.

- **Direct observation hours** involve clinicians observing supervisees' direct client contact hours (via in person observation, live video or audio feed, or video or audio recording) and providing constructive feedback and coaching.

How Will We Ensure that Practitioners Know About the Changes?

Further, to ensure that all affected licensees quickly understand and uniformly adopt changes to supervision requirements, administrators should establish a plan to (1) provide timely notifications (e.g., via email) to licensees of these changes and (2) create clear summaries of the new requirements. These actions may also serve to reduce the volume of questions or requests for clarification about supervision requirements that DOPL staff receive. Training programs (e.g., higher education) should also receive timely notification of changes in requirements so that current and incoming students are aware of supervision requirements.

Summaries of the supervision requirements for each profession and an explanation of all changes should be written in plain language in notifications and also summarized publicly on the DOPL website. These summaries should include information such as definitions, the type and amount of hours required, and links to relevant statutes and administrative rules.[286,287]

Additional Ideas

Utah policymakers may want to explore alternative approaches instead of or in addition to changing the requirements for postgraduate supervised experience hours as outlined above.

- **Consider making similar changes to supervision hour requirements for other BH licensees** beyond the core clinical therapist occupations (e.g., psychologists, substance use disorder counselors, social service workers, vocational rehabilitation counselors, behavior analysts, recreational therapists).
- **Provide reimbursement to supervisors for providing direct clinical supervision.** Under current Utah law, Utah supervisees cannot pay their supervisors, and supervisors cannot bill public or private payers (including Medicaid) for hours spent conducting direct clinical supervision activities. By exploring avenues to enable reimbursement for this type of work (e.g., by creating associated reimbursement codes), supervisors can be more appropriately compensated for their time, and the additional economic burden of taking on supervisees may be reduced. It may be beneficial for both public payers and private insurance providers to explore ways to reimburse for supervision services.

[286] Pennsylvania Department of State (n.d.). *Clinical Social Worker Licensure Requirements Snapshot*. [online] Pennsylvania Department of State. Available at: https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/SocialWorkersMarriageanFamilyTherapistsandProfessionalCounselors/Pages/Clinical-Social-Worker-Licensure-Requirements-Snapshot.aspx An example of a board website that clearly summarize licensing requirements.

[287] North Carolina Social Work Certification and Licensure Board (2018). *Levels and Eligibility Requirements - North Carolina Social Work Certification and Licensure Board*. [online] North Carolina Social Work Certification and Licensure Board. Available at: https://ncswboard.gov/levels-and-eligibility-requirements/.

1c. Continuing Education

Summary of Recommendation

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.

This recommendation applies to all of those with required continuing education, who are licensed or certified to practice under:

- 58-60 Mental Health Professional Practice Act
- 58-61 Psychologist Licensing Act
- 58-40 Recreational Therapy Practice Act
- 58-78 Vocational Rehabilitation Counselors Licensing Act
- 26B-5-610 Crisis Worker and Certified Peer Support Specialist Qualification
- R523-7-4 (9) Certified Case Manager Certification

Status Quo

In order to retain their state license or certification, members of Utah's behavioral health (BH) care workforce are required to annually complete between 8-24 hours of continuing education (CE). Utah does not currently count many forms of informal learning (e.g., study groups, self-directed readings) toward the required CE of most of the BH workforce, including social workers, marriage and family therapists, and clinical mental health counselors. The exception is that case consultation—which refers to meetings between BH professionals where they discuss client care and issues directly related to the practice of BH together—may count for up to six hours of psychologists' required CE during each two-year renewal period.[288,289] Direct observation, which involves a licensee being observed and given feedback by another licensed BH professional, does not currently count toward the CE requirement for any of Utah's BH care professionals. Licensees attest to completion of CE requirements during the biennial renewal, with the provision that the Division of Professional Licensing (DOPL) may audit them to verify completion of these hours.

Existing Approaches

Across the U.S. and in other common-law jurisdictions around the world, BH care workers are typically required to complete some form of ongoing professional development or CE in order to

[288] R156-60-105 Mental Health Professional Practice Act Rule
[289] R156-61-302h Psychologist Licensing Act Rule

maintain their licensure.[290,291] The specifics of what is required and of what counts toward fulfilling this requirement vary significantly by jurisdiction as well as by applicant occupation, career stage, and license type.

Number of Hours Required

A review of BH occupational regulation in other U.S. states and territories indicates that BH clinicians (including psychologists, licensed clinical social workers [LCSWs], marriage and family therapists [MFTs], and clinical mental health counselors [CMHCs]) are typically required to complete 15-20 CE hours per year.[292] For psychologists and LCSWs, Utah's annual requirements are slightly higher than the median value for other U.S. jurisdictions—20 hours vs. 15 for LCSWs, and 24 hours vs. 20 for psychologists. Annual requirements for Utah MFTs and CMHCs are both equal to the national median value, at 20 hours. Interestingly, several jurisdictions do not require CE hours for certain BH clinicians—Mississippi does not require CE hours for LCSWs, Michigan and Hawaii do not require CE hours for MFTs, and Hawaii does not require CE hours for CMHCs. Utah's requirements for clinical social workers (CSWs) and social service workers (SSWs) are slightly lower than the national median of 15 hours, at 10 hours required annually. Unlike most other states, however, Utah requires associate-level licensees to complete CE hours while they are still in the process of pursuing full licensure as MFTs or CMHCs.[293]

What Counts

Across the country, activities that can be counted toward BH professions' CE requirement include both formal and informal learning experiences[294]—for example, conferences, courses, lectures, workshops, seminars, symposia, in-service training, roundtable discussions, study groups, self-directed readings, and peer case consultation. Serving in field leadership positions, conducting and publishing research, teaching courses, providing supervision to others, and volunteering are also often accepted toward a BH professional's CE hours. Further, many jurisdictions allow CE hours to be earned in either live or asynchronous formats, and either in-person or remotely. Many jurisdictions specify the proportion of CE hours that may be earned via these various activities and formats. For instance, a somewhat common policy is to specify that only a certain number of CE hours may be fulfilled through informal or self-directed learning activities, while the rest must be earned through more formal training.[295] Similarly, some states

[290] Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *Google Books*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.
[291] Knee Center for the Study of Occupational Regulation, West Virginia University. https://csorwvu.com/find-occupations/
[292] OPLR National Review of Regulation
[293] Of the 56 U.S. states and territories OPLR analyzed, only 13 require continuing education for associate-level MFTs and only 16 require continuing education for associate-level CMHCs.
[294] Association of Social Work Boards (n.d.). *Laws and regulations database*. [online] Association of Social Work Boards. Available at: https://www.aswb.org/regulation/laws-and-regulations-database/.
[295] E.g., Missouri 20 CSR 2095-1.064, "(6) A licensee may obtain no more than twenty (20) hours of self study continuing education."; Massachusetts 258 CMR 31.04 (4), "A licensed social worker may obtain credit… for an individual continuing education activity… as long as… (e) The number of continuing education hours awarded… does not exceed 50% of the total number of continuing education hours required for renewal"

(including Utah)[296,297] restrict the total number of hours that can be earned in asynchronous and/or remote learning formats.[298]

Case consultation is an accepted form of CE for BH clinicians in many other U.S. jurisdictions and in other common law nations.[299] Direct observation or coaching may also count toward fulfilling CE requirements in some jurisdictions. For example, California allows up to half of psychologists' required CE hours to be completed via peer consultation—including case consultation, reading groups, or research groups.[300,301] Social workers, MFTs, mental health counselors, and addiction counselors in Indiana may earn up to half of their required CE hours through self-directed learning activities, including "providing peer review of another licensee's therapy and skills, which includes consultation, conference, and critique."[302] These forms of ongoing professional development are not only accepted but also required in some jurisdictions. For instance, the Psychology Board of Australia requires that psychologists complete 10 hours of peer consultation activities annually as part of their continuing professional development.[303]

Rationale

Why allow continuing education via case consultation and direct observation?

- Current CE requirements may not meaningfully improve safety
- Utah practitioners support CE requirements, but want less burdensome alternatives
- Case consultation & direct observation are more beneficial & less burdensome

[296] R156-60-105 Mental Health Professional Practice Act Rule "(7) A licensee may recognize CE credit… (c) for distance learning courses that are not real-time and interactive, one hour of CE for each hour, up to a maximum of:(i) 15 CE hours for an LCSW;(ii) eight hours for an SSW or CSW;(iii) 15 CE hours for an MFT;(iv) ten CE hours for a CMHC; and(v) 15 CE hours for a SUDC"
[297] R156-61-302h Psychologist Licensing Act Rule "(5) Credit for continuing education shall be recognized [for]... (e) A maximum of 18 hours per two year period may be recognized for Internet or distance learning courses that includes an examination, a completion certificate and recognized by the American Psychological Association or a state or province psychological association.
[298] E.g., New Jersey and Washington D.C. require that 50% of Marriage and Family Therapists' continuing education hours be fulfilled in face-to-face instruction.
[299] Association of Social Work Boards (n.d.). *Laws and regulations database*. [online] Association of Social Work Boards. Available at: https://www.aswb.org/regulation/laws-and-regulations-database/.
[300] Department of Consumer Affairs, Board of Psychology (n.d.). *Continuing Education Information - California Board of Psychology*. [online] www.psychology.ca.gov. Available at: https://www.psychology.ca.gov/laws_regs/2023lawsregs.pdf
[301] State of California Department of Consumer Affairs (2023). *CALIFORNIA BOARD OF PSYCHOLOGY LAWS AND REGULATIONS*. [online] Available at: https://www.psychology.ca.gov/laws_regs/2023lawsregs.pdf § 1397.60.1(a)(1)
[302] Indiana Professional Licensing Agency (2023). *Behavioral Health and Human Services Licensing Information*. [online] PLA. Available at: https://www.in.gov/pla/professions/behavioral-health-and-human-services/behavioral-health-and-human-services-licensing-information/#Continuing_Education_Categories.
[303] Psychology Board of Australia (2015). *REGISTRATION STANDARD: CONTINUING PROFESSIONAL DEVELOPMENT*. [online] pp.1–3. Available at: https://www.psychologyboard.gov.au/Registration/Continuing-Professional-Development.aspx; and https://www.psychologyboard.gov.au/documents/default.aspx?record=WD15%2f18517&dbid=AP&chksum=YgBfRLolyJvwRt0cAHZaFA%3d%3d

Research suggests that many forms of CE have limited efficacy, while placing significant burdens on practitioners. Members of Utah's BH care workforce agree that CE is often tremendously burdensome and not especially beneficial for improving safety and competence. Importantly, this burden includes taking time away from direct patient care, which may further reduce access to care for Utah consumers. While many of Utah's BH professionals seem interested in maintaining some form of CE requirement, they are also eager for reforms that will ease the burden of fulfilling these hours and that will ensure that these hours are relevant and impactful both for themselves and for the clients they serve. Research suggests that ongoing case consultation and direct observation are more beneficial and less burdensome than other forms of training.

Current CE Requirements May Not Meaningfully Improve Safety

Academic and policy researchers have expressed significant concerns about the efficacy and relevance of CE requirements.[304,305,306] Their work has highlighted the minimal impact of many CE units, particularly insofar as they tend to be didactic only rather than interactive. As one review article concluded, "Most [studies report] almost no relationship between participation in traditional CE courses and improved patient outcomes."[307] An overview of research on professional behavior change interventions found robust evidence that single-exposure training models and didactic instruction alone are "ineffective methods of producing practitioner behavior change."[308] Rather, didactic instruction needs to be accompanied by ongoing, interactive learning that is grounded in practical experience in order to build proficiency.[309,310]

Utah practitioners share these concerns regarding the efficacy of CE in terms of enabling BH professionals' safety and competence. For example, survey respondents commented that CE requirements have "only marginal relevance to actual competence" and that "there should be alternative ways to get these hours without sitting in usually ineffective trainings." Another respondent shared how completing CE hour requirements seem ill-suited to actually improving

[304] Daniels, A.S. and Walter, D.A. (2002). *Current Issues in Continuing Education for Contemporary Behavioral Health Practice.* Administration and Policy in Mental Health, 29(4/5), pp.359–376. doi:https://doi.org/10.1023/A:1019653123285
[305] Young, L.J. and Willie, R. (1984). *Effectiveness of Continuing Education for Health Professionals: A Literature Review.* Journal of Allied Health, [online] 13(2), pp.112–123. Available at: https://www.jstor.org/stable/45441324
[306] Hoge, M.A., Huey, L.Y. and O'Connell, M.J. (2004). *Best Practices in Behavioral Health Workforce Education and Training*. Administration and Policy in Mental Health, 32(2), pp.91–106. doi:https://doi.org/10.1023/B:APIH.0000042742.45076.66
[307] Vaughn, H.T., Rogers, J.L. and Freeman, J.K. (2006). Does Requiring Continuing Education Units for Professional Licensing Renewal Assure Quality Patient Care? *The Health Care Manager*, [online] 25(1), p.78. Available at: https://journals.lww.com/healthcaremanagerjournal/abstract/2006/01000/does_requiring_continuing_education_units_for.11.aspx
[308] Grimshaw, J.M., Shirran, L., Thomas, R., Mowatt, G., Fraser, C., Bero, L., Grilli, R., Harvey, E., Oxman, A. and O'Brien, M.A. (2001). *Changing Provider Behavior: An Overview of Systematic Reviews of Interventions. Medical Care*, [online] 39(8), pp.II2–II45. Available at: https://www.jstor.org/stable/3767642.
[309] Daniels, A.S. and Walter, D.A. (2002). *Current Issues in Continuing Education for Contemporary Behavioral Health Practice.* Administration and Policy in Mental Health, 29(4/5), pp.359–376. doi:https://doi.org/10.1023/A:1019653123285
[310] Lyon, A.R., Stirman, S.W., Kerns, S.E.U. and Bruns, E.J. (2010). *Developing the Mental Health Workforce: Review and Application of Training Approaches from Multiple Disciplines.* Administration and Policy in Mental Health and Mental Health Services Research, [online] 38(4), pp.238–253. doi:https://doi.org/10.1007/s10488-010-0331-y.

their competency as a professional: “I do not find this beneficial and/or helpful. It is more of checking off the box without really understanding or caring about the subject matter.”

Utah Practitioners Support CE Requirements, But Want Less Burdensome Alternatives

Given the limited efficacy of the current CE requirements, the natural question may be whether to simply eliminate CE requirements altogether. However, evidence from OPLR’s focus groups, interviews, and survey responses suggests that many of Utah’s BH practitioners appreciate and value CE requirements.[311,312] For instance, many respondents shared how they like the motivation that these requirements provide, with statements such as, “I appreciate the CEUs required to maintain licensure as it motivates me to stay up to date in my field and continue to hone my skills,” and, “I recommend continuing high CE standards, as that is where therapists can learn together and keep updated on new skills.” Others shared how they appreciated the specific requirements for suicide and ethics training laid out in the current regulation. As one survey commenter shared, “Decreasing the amount of CEUs doesn’t help anyone. Not requiring specific continuing education hours in areas such as ethics, supervision, suicide prevention doesn't help anyone.” Or as another professional shared,

> *“I'm all in favor of continuing education because it keeps the mind open and keeps the individual looking and learning and trying to develop themselves… [but] I do think we need to focus on those that are most important.”*

Throughout OPLR’s review, however, the burden of CE requirements was also a consistent theme. Of the ~1100 comments collected during OPLR’s BH workforce survey, 131 specifically mentioned CE requirements. As one respondent summarized, “It is a large barrier to entry and adds additional stress and burnout to an already exhausting and demanding field with a massive shortage of mental health professionals.” Expressing the difficult nature of the current situation, one commenter stated: “Things need to change… The state of Utah is regulating people right out of work… CEUs are a good idea, but there needs to be reform.” Policy researchers agree that, “The process and content of continuing education require review and change. This is true for all professional disciplines that serve the behavioral health needs of consumers.”[313]

Many comments from Utah’s BH workforce point to the significant burden that these requirements create in terms of time and travel—with professionals describing them as “hard to attend,” “difficult to obtain,” and “hard to come by.” The burden of obtaining CE hours may be especially pronounced for those working in rural areas. As several commenters pointed out, CE

[311] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[312] OPLR Listening & Vetting Tour
[313] See pg. 373 of Daniels, A.S. and Walter, D.A. (2002). *Current Issues in Continuing Education for Contemporary Behavioral Health Practice.* Administration and Policy in Mental Health, 29(4/5), pp.359–376. doi:https://doi.org/10.1023/A:1019653123285

requirements are “hard to fulfill in rural areas,” “very challenging for clinicians that live rural,” and “getting to them is near to impossible.” One respondent summarized the issue with the statement: “Finding continuing education classes in a state the size of Utah is difficult or out right none exist for license holders working [in certain areas of the state].”

BH professionals in Utah also shared how current CE requirements can create a substantial financial burden, which is reflected in comments describing these requirements as “a large strain on our time and resources,” “very expensive,” and “a huge financial burden.” For those taking a step away from full-time work (e.g., retirees, part-time workers), this burden may be felt even more acutely. As one retiree highlighted, “When you are retired, the cost of the training is very expensive… it costs a lot of money. I could not get my hours of training because of the money. So I will not recertify this year.” Or, as one professional who had taken a career break noted “[With] the continuing education requirement… it almost isn't worth maintaining the license. I have many friends who choose not to renew due to this.” Academic research corroborates the idea that while BH clinicians want to learn advanced skills that reflect the needs of their clients, they may be unable to invest the time and money needed to do so.[314] Providing free or low-cost options for fulfilling state CE requirements may be an important part of ensuring that qualified BH care professionals are not being pushed out of the workforce.

Many individuals also pointed to the apparent discrepancy between their own CE hour requirements and those of their colleagues working in the broader healthcare field. While many Utah healthcare professionals (e.g., pharmacists, APRNs, dentists) are required to complete only 30 CE hours every two years, Utah’s BH care providers are typically required to complete 40.[315] Further, many healthcare professionals are given easy access to CE hours through their employers’ training and development programs, while BH professionals often do not have this same access available. As one respondent told us,[316]

> *“My partner works in healthcare, and they get monthly free continuing education opportunities… that makes it more accessible… finding ways to support people in being able to meet their professional development goals would be nice.”*

While CE requirements create a variety of burdens for practitioners themselves (e.g., travel time and expenses, lodging expenses, fees for training itself), by requiring licensees to take time away from practice, including unpaid time off, CE requirements may also be exacerbating access issues for Utah consumers. As one rural practitioner pointed out, “Trainings are often hard to attend due to having a lot of patients to see and not enough time to see them.”[317] Another respondent shared that these requirements are “taking [them] away from patient care

[314] Powell, B.J., McMillen, J.C., Hawley, K.M. and Proctor, E.K. (2013). Mental Health Clinicians’ Motivation to Invest in Training: Results From a Practice-Based Research Network Survey. *Psychiatric Services*, 64(8), pp.816–818. https://doi.org/10.1176/appi.ps.003602012.
[315] Utah Division of Professional Licensing (2023). *Licenses*. [online] Available at: https://dopl.utah.gov/licenses/.
[316] OPLR Listening & Vetting TOur
[317] OPLR Behavioral Health Care Workforce Survey (CPMDS)

due to staff shortages" and that more flexibility in what counts toward fulfilling CE requirements could help to address this issue.

In short, although Utah BH practitioners appear reluctant to eliminate CE requirements altogether, they seem keen to expand what counts. In particular, they are looking for more affordable, convenient, and flexible options that allow them to use their best judgment regarding what will be most beneficial for their development as a professional and for the clients they serve in their current role or setting. As one licensee shared:

> *"I still volunteer actively which requires a license, even though I receive no income. I think the CE requirements… should be maintained, but I do like the ability to do this via remote learning, etc. that is more convenient and affordable."*

Or as one professional pointed out, "I pay out of my own pocket for my continuing education and would like to be able to get it anywhere that fits my current needs." Interestingly, several commenters also pointed out how Utah's current CE requirements (which include the need for live, in-person training) may actually hinder them from accessing higher-quality, specialized trainings that are more readily available in remote and/or asynchronous formats.

> *"There are many pre-recorded trainings that I would like to participate in… These courses are often presented by some of the best in the business and are excellent trainings. Because of this licensing restriction, I am not able to take the classes that I would like to take and the classes that would be most applicable to my current setting."*

Several commenters expressed deep appreciation for free or easily available CE opportunities that they had accessed through their professional association or employer. As one respondent shared, "I am extremely grateful to the CEU's made available the past 20 years …which have allowed me to economically maintain my licensure and knowledge in the field." In other words, Utah's BH professionals seem to support retaining a CE requirement, as long as they are provided with additional support, autonomy, and flexibility in how they fulfill this requirement.

Case Consultation and Direct Observation Are More Beneficial & Less Burdensome

Given Utah practitioners' support for retaining CE requirements, in addition to the desire for less burdensome alternatives, OPLR recommends allowing both 1) case consultation and 2) direct observation to count toward fulfilling these requirements. Research suggests that ongoing case consultation and direct observation are more beneficial than traditional, didactic training approaches in building practitioners' competence and adherence to evidence-based methods.

Plus, they are less burdensome for practitioners to obtain and may help to create significantly more flexibility and affordability in fulfilling CE hour requirements.

Case consultation involves a meeting between two or more BH professionals, where they discuss issues directly related to client care or other aspects of professional practice. Case consultation is a core part of the direct supervision hours that clinicians obtain during their early careers. Direct observation involves a practitioner receiving feedback from another professional based on that professionals' observation of their actual practice—for example, through live observation or recordings of their work.[318] Direct observation allows providers to practice and receive feedback on their work as a form of post-training coaching.
Case consultation and direct observation have been shown to more effectively increase skills than less interactive training techniques.[319,320,321,322,323,324,325,326] As researchers highlight:[327]

> *"It is important that psychotherapists and counsellors have what we describe as 'formative spaces', such as supervision or reflective practice groups, in which to discuss difficult issues… [they] are crucial to safe and effective practice. Where these formative spaces exist, they combine support and challenge in a high trust environment… backed by a strong professional ethos. "*

In other words, the ongoing case discussions, practice feedback, and coaching that occur among professionals may be even more important than initial training in promoting skill

[318] Milne, D.L. and Reiser, R.P. (2011). *Observing competence in CBT supervision: a systematic review of the available instruments*. The Cognitive Behaviour Therapist, 4(3), pp.89–100. doi:https://psycnet.apa.org/doi/10.1017/S1754470X11000067
[319] Choy-Brown, M. and Stanhope, V. (2018). *The Availability of Supervision in Routine Mental Health Care.* Clinical Social Work Journal, 46(4), pp.271–280. doi:https://doi.org/10.1007/s10615-018-0687-0.
[320] Schoenwald, S.K., Mehta, T.G., Frazier, S.L. and Shernoff, E.S. (2013b). *Clinical Supervision in Effectiveness and Implementation Research*. Clinical Psychology: Science and Practice, 20(1), pp.44–59. doi:https://doi.org/10.1111/cpsp.12022
[321] Holloway, E.L. and Neufeldt, S.A. (1995). *Supervision: Its contributions to treatment efficacy.* Journal of Consulting and Clinical Psychology, 63(2), pp.207–213. doi:https://doi.org/10.1037/0022-006X.63.2.207
[322] Sholomskas, D.E., Syracuse-Siewert, G., Rounsaville, B.J., Ball, S.A., Nuro, K.F. and Carroll, K.M. (2005). *We Don't Train in Vain: A Dissemination Trial of Three Strategies of Training Clinicians in Cognitive-Behavioral Therapy.* Journal of Consulting and Clinical Psychology, 73(1), pp.106–115. doi:https://doi.org/10.1037/0022-006x.73.1.106.
[323] Weck, F., Kaufmann, Y.M. and Witthöft, M. (2017). Topics and techniques in clinical supervision in psychotherapy training. *The Cognitive Behaviour Therapist*, 10(e3), pp.1–17. doi:https://doi.org/10.1017/S1754470X17000046
[324] Lohani, G., & Sharma, P. (2023). *Effect of clinical supervision on self-awareness and self-efficacy of psychotherapists and counselors: A systematic review.* Psychological Services, 20(2), 291–299. https://doi.org/10.1037/ser0000693
[325] Bearman, S.K., Schneiderman, R.L. and Zoloth, E. (2016). *Building an Evidence Base for Effective Supervision Practices: An Analogue Experiment of Supervision to Increase EBT Fidelity.* Administration and Policy in Mental Health and Mental Health Services Research, 44(2), pp.293–307. doi:https://doi.org/10.1007/s10488-016-0723-8
[326] Salas, E., Kraiger, K. and Smith-Jentsch, K.A. (2012). The Science of Training and Development in Organizations: What Matters in Practice. *Psychological Science in the Public Interest*, 12(2), pp.74–101. doi:https://doi.org/10.1177/1529100612436661
[327] McGivern, G, Fischer, M, Ferlie, E & Exworthy, M (2009), *'Statutory Regulation & the Future of Professional Practice in Psychotherapy & Counselling: Evidence from the Field'*. Unknown Publisher, King's College London. [online] Available at: https://www.listeningtoyou.co.uk/uploads/2/7/0/7/2707581/statutoryregulation1-1.pdf

development and practitioner competence and safety.[328,329] While educational lectures and workshops can serve as an initial source of information, they should be supplemented by ongoing case consultation and direct observation by professional peers and mentors.[330] These training experiences focus on the "mastery of action"[331] and can be directly applied to practitioners' daily experiences.[332] As one review of CE requirements in the field of BH outlined, "To be effective, continuing education must become more grounded in practical experience and promote the development of an experience base that guides future behavior."[333] Another review of research on mental health education programs found that the most effective forms of training incorporate "interactive methodological approaches; a curriculum based on challenges in the trainees' daily routines;...interdisciplinary group work; flexible timing; the use of e-learning resources; and optimizing the implementation of knowledge into the participants' routine work practices."[334] In other words, in order for CE to be effective, it must be more closely linked to the daily challenges, routines, and realities that clinicians face. Case consultation and direct observation are both compelling alternatives to formal, didactic approaches to CE, given that they are closely linked to professionals' everyday work, and may be obtained more flexibly and affordably through professional relationships among BH practitioners.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- Which BH practitioners will be eligible?
- How many case consultation and/or direct observation hours will be accepted?

[328] Beidas, R.S., Edmunds, J.M., Marcus, S.C. and Kendall, P.C. (2012). Training and Consultation to Promote Implementation of an Empirically Supported Treatment: A Randomized Trial. *Psychiatric Services*, 63(7), pp.660–665. doi:https://doi.org/10.1176/appi.ps.201100401.

[329] Beverly Funderburk, Mark Chaffin, Elizabeth Bard, Jenelle Shanley, David Bard & Lucy Berliner (2015) Comparing Client Outcomes for Two Evidence-Based Treatment Consultation Strategies, Journal of Clinical Child & Adolescent Psychology, 44:5, 730-741, doi: 10.1080/15374416.2014.910790

[330] Hoge, M.A., Huey, L.Y. and O'Connell, M.J. (2004). *Best Practices in Behavioral Health Workforce Education and Training*. Administration and Policy in Mental Health, 32(2), pp.91–106. doi:https://doi.org/10.1023/B:APIH.0000042742.45076.66

[331] See pg. 2 of Lyon, A.R., Stirman, S.W., Kerns, S.E.U. and Bruns, E.J. (2010). *Developing the Mental Health Workforce: Review and Application of Training Approaches from Multiple Disciplines.* Administration and Policy in Mental Health and Mental Health Services Research, [online] 38(4), pp.238–253. doi:https://doi.org/10.1007/s10488-010-0331-y.

[332] Ibid.

[333] See pg. 369 of Daniels, A.S. and Walter, D.A. (2002). *Current Issues in Continuing Education for Contemporary Behavioral Health Practice.* Administration and Policy in Mental Health, 29(4/5), pp.359–376. doi:https://doi.org/10.1023/A:1019653123285

[334] Blanco-Vieira, T., Augusto, F., Lauridsen-Ribeiro, E., Marcos V.V. Ribeiro, Elisa Andrade Meireles, Brunno Araújo Nóbrega, Maria, S., Maria, Caetano, S.C., Wagner Silva Ribeiro and Conceição, M. (2018). A Guide for Planning and Implementing Successful Mental Health Educational Programs. *Journal of Continuing Education in The Health Professions*, 38(2), pp.126. doi:https://doi.org/10.1097/ceh.0000000000000197.

Which BH Practitioners Will Be Eligible?

Policymakers will need to address which practitioners in the BH workforce will be eligible to count case consultation and/or direct observation hours toward their CE requirements. This change may be especially helpful and relevant for clinical providers.

How Many Case Consultation and/or Direct Observation Hours Will Be Accepted?

One issue policymakers may wish to address is how many case consultation and/or direct observation hours will be allowed to count toward fulfilling CE requirements. An appropriate approach may be to set an upper limit on the percent of CE hours that may be fulfilled in these ways (e.g., 50%, 75%).

Additional Ideas

Utah policymakers may wish to consider alternative approaches instead of or in addition to allowing case consultation and direct observation hours to count toward CE.

- **Expand the list of activities that count toward CE hours**, for instance by removing the upper limit on asynchronous and/or remote hours, by allowing for self-directed/small group study, by removing the need for board/industry association sign-off on hours providers, by allowing for volunteerism beyond service in professional organizations' leadership roles,[335] by including supervisor certification/training, etc.
- **Reduce the number of CE hours required** of BH practitioners. For example, policymakers may wish to consider reducing the overall number of hours required, particularly for lower-risk licensees (e.g., those without no previous disciplinary actions, those working for larger organizations or state agencies where additional oversight measures are in place, or those who have been licensed for more than 5-10 years).
- **Require all BH clinicians to engage in case consultation and/or direct observation,** for instance by stipulating that no fewer than 10 CE hours must be obtained via these methods, by requiring licensees to report the names/license numbers of those with whom they conduct case consultation and/or direct observation activities, or by requiring them to submit a plan for how they will conduct ongoing case consultation and/or direct observation. This could be done at initial licensure and/or renewal.

[335] Virginia: 18VAC140-20-105 "Up to two continuing education hours required for renewal may be satisfied through delivery of social work services, without compensation, to low-income individuals."

2a. Exam Alternate Path

Summary of Recommendation

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.

This recommendation applies only to those seeking licensure to practice under:

- 58-60 Mental Health Professional Practice Act
  - Licensed Clinical Social Worker
  - Marriage and Family Therapist
  - Clinical Mental Health Counselor

Status Quo

All master's level clinicians, which include clinical social workers (LCSWs), marriage and family therapists (MFTs), and clinical mental health counselors (CMHCs) are required to pass a licensing exam in Utah. No alternate pathways exist to allow these clinicians to substitute other measures of competency, experience, or education for the exam requirement.

Utah currently requires the following examinations for master's-level clinical licensure:

- LCSW: Association of Social Work Boards (ASWB) Clinical Examination
- MFT: National Marriage & Family Therapy Examination (NMFTE)
- CMHC: National Clinical Mental Health Counseling Examination (NCMHCE) and National Counselor Examination (NCE)

Associate-level clinicians, which include certified social workers (CSWs), associate MFTs (AMFTs), and associate CMHCs (ACMHCs), are not required to take a licensing exam to receive their associate license and to work under supervision. While CSWs may retain their license into perpetuity, AMFTS and ACMHCS have a maximum time limit of 2 years[336] to pass the exam after completing their postgraduate supervised training hours. In other words, although AMFTS and ACMHCS are initially permitted to practice under supervision, if they do not pass their respective licensing exam(s), this authorization is revoked.

Existing Approaches

Social Work. The ASWB Clinical exam is accepted in all U.S. states and territories for clinical social work licensure. A few states accept a passing score on the ASWB Advanced Generalist exam in place of the Clinical exam for licensure as an independent clinical social worker

[336] May be extended to 4 years with board approval.

(Colorado and Ohio) and the U.S. Virgin Islands has no exam requirement. California previously accepted a California-specific clinical examination, but that option has been discontinued in favor of the ASWB Clinical exam. New York's statutes include a provision to accept other exams that are determined to be equivalent by the licensing board.

Marriage & Family Therapy. Most U.S. states and territories require licensees to pass the NMFTE, administered by the Association of Marital & Family Therapy Regulatory Boards. A few states also require licensees to pass a state jurisprudence exam. California has developed its own LMFT Clinical Examination, which can be used to earn an in-state MFT license, which is generally not accepted in other jurisdictions, although a few jurisdictions (Oregon, Texas, and the Northern Mariana Islands) also recognize the California LMFT exam.

Clinical Mental Health Counseling. Most jurisdictions require either the NCE or the NCMHCE. Utah requires both exams, which is relatively common in other states as well. The NCE is the most commonly required examination. Some states also require a state-specific jurisprudence exam. A few jurisdictions, including Pennsylvania, Arizona, and Oregon, will accept alternative exams such as the Certified Rehabilitation Counselor (CRC) exam or the Art Therapist Certification Board exam.

Rationale

Why create an alternate path around licensing exams for BH clinicians?

- A supervision-based alternative may maintain safety, while improving access to care
- Exams may hold back qualified practitioners, unnecessarily limiting access to care
- Utah stakeholders are supportive of a supervision-based alternate pathway

A Supervision-Based Alternative May Maintain Safety, While Improving Access to Care

Although licensure exams are a common requirement for master's-level clinicians, there is a paucity of evidence on the connection between exam performance and practitioners' future safety and competence. By contrast, substantial evidence links high-quality supervision and practitioners' future safety and competence.[337] As one study of behavioral health (BH) regulation concluded, "interpersonal processes within clinical supervision… are the key to protecting the public and ensuring the safety and efficacy of practice."[338] Leaders from across Utah's BH system, as well as the academic literature, are in agreement that direct client contact hours, direct clinical supervision, and direct observation are better targeted to ensuring competence and safety. A master's-level clinical therapist with over 10 years of experience, who currently

[337] For additional discussion of the evidence for correlations between supervision and practitioners' safety and competence, please see 1b. Supervision Hours

[338] See pg. 9 of McGivern, G, Fischer, M, Ferlie, E & Exworthy, M (2009), *'Statutory Regulation & the Future of Professional Practice in Psychotherapy & Counselling: Evidence from the Field'*. Unknown Publisher, King's College London. [online] Available at: https://www.listeningtoyou.co.uk/uploads/2/7/0/7/2707581/statutoryregulation1-1.pdf

runs a Utah practicum site for students in training, explained how supervision serves as an important mechanism for promoting safety:[339]

> *"Testing is one measure, but [to have supervisees] in the field working with experienced professionals who can assess their ability, do co-therapy, assess their assessment skills, and look at their interaction skills—to me that's far more valuable than people who can test well and have no personal skills whatsoever….If we're going to take away testing [requirements], add time for supervision…to really promote people's success."*

In the absence of evidence that clinical licensing exams are reliable predictors of safety, and in the presence of evidence that supervision *is* predictive of safety, introducing a supervision-based alternate path is a reasonable course of action that may increase access to care without compromising, and perhaps even improving, safety and quality of care.

States that have eliminated examination requirements for associate-level clinical licenses have seen dramatic increases in the volume of licenses issued in the months and years following those changes. In January of 2022, Illinois removed the requirement for licensed social workers (equivalent to Utah's CSW license) to pass the ASWB Master's exam, and by December had issued 3,826 new licenses, a 337% increase over 2021.[340] After this influx of talent, Illinois had 7,369 total active licensees—meaning that in the first year of enacting this policy change, the state doubled its pool of licensed social workers. In June of 2022, Rhode Island also removed the ASWB Master's exam requirement for clinical social workers (equivalent to Utah CSWs), and as of the end of 2022, the state had licensed a total of 358 new clinical social workers, a 145% increase from the 146 licenses issued in 2021. As of August of 2023, RI had licensed a further 355 new CSWs, representing a 425% increase in monthly issuance volume since legislation was passed.[341]

Following the passage of Utah legislation removing examination requirements for SSWs and CSWs, Division of Professional Licensing (DOPL) administrators and employers have likewise reported a significant uptick in issued licenses and in the number of CSWs available to fill open positions in BH organizations.[342] As of August 2023, the state had already issued 772 new CSW licenses and 351 new SSW licenses since the beginning of the year, representing 41% and 139% increases respectively over the total number of licenses issued in all of 2022.

[339] OPLR Listening & Vetting Tour
[340] Correspondence with Illinois Department of Financial and Professional Regulation personnel
[341] Correspondence with Rhode Island Department of Health, Center for Professional Regulations personnel
[342] OPLR Listening & Vetting Tour

Exams May Hold Back Qualified Practitioners, Unnecessarily Limiting Access to Care

During the course of OPLR's review, many BH stakeholders shared multiple examples of how the current clinical exam requirements may be keeping competent practitioners out of the workforce, thereby restricting access to care, particularly in Utah's high-need areas.

Employers in the BH field, as well as DOPL board members, told OPLR that examination requirements are having noticeable effects on the state's ability to license and hire competent practitioners.[343] For example, one administrator at a large BH agency shared the following:

> *"As an employer, I am feeling the workforce crunch…. I have concerns about the board examination and test. I went to school with two brilliant individuals. English was their fifth, maybe even more language. They finally passed the clinical exam, but after years of trying. They are just brilliant individuals who should not have had those issues."*

A DOPL board member also explained how exam requirements can sometimes restrict access by preventing competent therapists from becoming fully licensed:

> *"It's not unusual for people to come before the board for the third or fourth time [having failed the exam]. Their clinical supervisor might come to the meeting and say, 'She's a wonderful therapist…but taking written tests is not her strength. She studies, she buys all the guides [for exam preparation], but she just can't do it.' Unfortunately, a few people have left the field just because they couldn't pass the exam. As we're speaking to access, I think that's relevant."*

One individual who spoke with OPLR described taking the ASWB Clinical exam multiple times after completing a master's degree in social work. Despite being unable to pass the exam, this individual went on to complete a doctorate degree in social work and to become a professor of social work, illustrating that exam performance is not necessarily an accurate reflection of knowledge, skill, or competence, or of an individual's potential to develop such expertise.

Retaking licensing examinations can also pose a significant financial burden to practitioners. Current exam fees for master's-level clinicians range from $260 for the ASWB Clinical exam,[344]

[343] OPLR Listening & Vetting Tour
[344] Association of Social Work Boards (2023). *Online Exam Registration*. [online] examregistration.aswb.org. Available at: https://examregistration.aswb.org/.

to $275 for the NCMHCE[345] (required for CMHC licensure), to $365 for the AMFTRB[346] (required for MFT licensure). A focus group participant shared, “I’ve seen colleagues of mine who could not pass the [CMHC] test and dropped out of the field after taking it four or five times, to the tune of well over $1,000.” Those in rural areas must also travel long distances to take exams, some of which are only administered in person or on certain days of the year. One rural local mental health authority (LMHA) administrator shared that these factors are sometimes barriers for practitioners from rural Utah, including Native American practitioners: “Several of our Native American providers have had difficulty passing the clinical exam…. Many have never left the county, and five hours up to [the testing center in] Draper is a big deal. It’s difficult.”

Utah’s current examination requirements may also be unnecessarily limiting access to effective care for Utahns whose primary language is not English. A meta-analysis of culturally congruent mental health interventions[347] found that when services were delivered in non-native English speaking clients’ preferred languages, interventions were twice as effective as services delivered in English.[348] However, in the case of the ASWB Clinical exam (which is only offered in English), licensure candidates who are non-native English speakers are much less likely to pass the exam on their first attempt. According to data released by ASWB in 2022, the first-time pass rate for test-takers whose primary language was not English was 59.1%, compared to 76.2% for native English speakers (a 17.1% difference).[349] Without an alternative to licensure exams, competent, non-native English speaking practitioners may be less likely to achieve full licensure—thereby limiting their ability to enter and advance in their chosen profession, and limiting the number of clinicians who can provide effective multilingual services.

OPLR survey data has found that there may in fact be a gap between the proportion of BH providers who can deliver multilingual services and the proportion of Utah’s population who may need these services.[350] While 15.4% of Utah’s population speak languages other than English at home,[351] only 10.8% of clinicians report delivering non-English language services. In 2021, 17,000 new residents immigrated to Utah from outside of the US, and of the total 119,000

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[345] edX (2020). *LMHC Licensure Guide for Mental Health Counselors*. [online] Teach.com. Available at: https://teach.com/careers/counseling/mental-health-counselor/lmhc-license/.
[346] Association of Marital & Family Therapy Regulatory Board (2023). *Your Exam Roadmap – AMFTRB*. [online] amftrb.org. Available at: https://amftrb.org/your-exam-roadmap/.
[347] “*Culturally congruent practices in mental health interventions”* are defined as those practices that are “consistent with clients’ conceptualization of the problems, means for solving problems, and goals regarding outcomes…[including] providing services in clients’ preferred language, modifying the length/frequency of sessions, utilizing culturally congruent terminology and concepts, involving family members or friends, consulting with persons familiar with a client’s culture to facilitate accurate understanding, etc.” Smith, T.B. (2013). *Culturally congruent practices in counseling and psychotherapy: A review of research.* [online] BYU ScholarsArchive. Available at: https://scholarsarchive.byu.edu/facpub/2003/?utm_source=scholarsarchive.byu.edu%2Ffacpub%2F2003&utm_medium=PDF&utm_campaign=PDFCoverPages
[348] Griner, D. and Smith, T.B. (2006). *Culturally adapted mental health intervention: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training*, 43(4), pp.531–548. doi:https://doi.org/10.1037/0033-3204.43.4.531
[349] Association of Social Work Boards (2022). *2022 ASWB Exam Pass Rate Analysis - Final Report*. [online] *aswb.org*. Association of Social Work Boards. Available at: https://www.aswb.org/wp-content/uploads/2022/07/2022-ASWB-Exam-Pass-Rate-Analysis.pdf
[350] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[351] US Census Bureau (2021). *Why We Ask About...Language Spoken at Home*. [online] www.census.gov. Available at: https://www.census.gov/acs/www/about/why-we-ask-each-question/language/.

in-migrants to Utah, 31% were Hispanic, Black, Native American/Indigenous, Asian, Native Hawaiian/Pacific Islander, multiracial, or part of another racial or ethnic group.[352]

Utah Stakeholders Are Supportive of a Supervision-Based Alternate Pathway

Throughout the course of OPLR's review, many Utah stakeholders have expressed their willingness to support an alternate pathway to licensure in place of the current clinical exam requirement, including key BH organizations and employers from around the state.[353] Leaders in these organizations expressed that an alternate pathway excluding clinical exams would improve access by providing a way for competent providers to become fully licensed. They specifically mentioned communities with less access: Utah's immigrant and refugee communities, non-native English speakers, Native American communities, and those living in Utah's rural areas. Large employers also reported a noticeable increase in the number of CSWs hired at their organizations after recent legislation eliminated the requirement to pass the ASWB Masters exam. Safety and competency were not a significant concern—these stakeholders expressed that they would be comfortable with removing exam requirements if, as recommended, those requirements were substituted with strengthened supervision requirements, such as additional hours and supervisor sign-offs.

Importantly, allowing added supervision hours to substitute for the existing clinical exam requirement will also not place an undue burden on practitioners or regulators, as compared to other alternate pathways that have been attempted in other states.[354] Additional supervision hours can be accrued and reported in the same way as the existing hour requirements. While some additional documentation from supervisors and supervisees will be necessary, DOPL will not need to make significant changes to its current processes, nor will it be required to design or conduct time-intensive and costly competency assessments, or to go through the process of developing a state-specific alternative to the national licensing exams.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- Who will be allowed to participate in this alternate pathway?
- How many and what type(s) of additional supervised hours will be required?

[352] Kem C. Gardner Policy Institute (2023). *Characteristics of Utah's Migrants: A 2021 Update Fact Sheet*. [online] Available at: https://gardner.utah.edu/wp-content/uploads/Migrant-Charac-FS-Jun2023.pdf?x71849.
[353] OPLR Listening & Vetting Tour
[354] When Texas introduced a competency-assessment based pathway (AMEC), it proved to be time-intensive and costly to conduct assessments and evaluate candidates' portfolios; the program resulted in the issuance of no more than 70 clinical licenses in the final three years of the program, before it closed. California's Board of Behavioral Sciences developed its own clinical exams for LCSWs, CMHCs, and MFTs, but this required the resources of an entire office dedicated to examination development and administration, and in 2008, the estimated yearly cost to maintain these programs was estimated at $1 million (Alexander and Johnston, 2008. "Final Report on Alternative Paths to Licensure for the Minnesota Board of Social Work). In 2016, California returned to using the ASWB Clinical exam for social work licensing, and as of 2023 also uses the NCMHCE to license CMHCs. A state-developed clinical MFT examination is still available as of 2023.

- How many and what types(s) of additional recommendations will be required?
- How will we ensure that practitioners understand both the opportunities and limitations associated with pursuing an alternate path to licensure?

Who Will Be Allowed to Participate in this Alternate Pathway?

Policymakers may choose whether to set conditions for who may opt-in to the supervision-based alternate path. If no conditions are set, any candidate for licensure would be able to choose either the traditional exam pathway or the supervision-based alternate path. This would create the most flexibility for incoming candidates, and would require the least administrative burden for regulators. If, however, concerns arise in the course of ongoing discussions with BH system stakeholders, legislators may wish to consider setting eligibility criteria for participating in the alternate path. This could be done in consultation with DOPL boards. Eligibility criteria for using the alternate path might include one or more of the following:

- The individual has completed a minimum number of exam attempts (e.g., 1-2 attempts)
- The individual has scored within a certain threshold below the passing score on a previous exam attempt (for example, no more than 5-10 points below the passing score, or no less than 80-90% of the passing score)
- The individual is employed by and completing supervision at a state agency and/or other approved facility

How Many and What Type(s) of Additional Supervised Hours Will Be Required?

Policymakers will also need to decide how many and what type of additional supervision hours will be required. Given OPLR's recommendation to substantially change required post-graduate supervised experience hours for incoming clinicians in BH, the number and type of hours required for the alternate path should be set in harmony with these broader changes to supervised hour requirements.

Based on OPLR's recommendation,[355] supervision requirements for incoming clinicians include:

- Direct Client Contact Hours (1200-1500 hours)
- Direct Clinical Supervision Hours (85-150 hours)
- Direct Observation Hours (2-25 hours)

Thus, an alternate pathway might proportionally add to each of these hour requirements. For example, those qualifying for licensure using the alternate path might be required to complete 10-25% more of each type of required supervised hours. On the other hand, the requirements might be set in a more targeted way to emphasize those hours that give supervisors the best

[355] 1b. Supervision Hours

chance to observe and assess the skills and competence of their supervisees. In this case, those using the alternate path might be required to complete twice as much direct observation, or more direct clinical supervision hours (e.g., 25-50%).

How Many and What Types(s) of Additional Recommendations Will Be Required?

Recommendations from supervisor(s) and/or other qualified clinicians are an important component of this supervision-based alternate pathway. These recommendations should be provided by licensed clinicians who have directly observed the supervisee's practice and who can speak to the supervisee's competence and safety in client contact situations. Policymakers should consider the following:

- How many recommendations will be required, and from whom (e.g., direct clinical supervisor, line manager, other supervisors, other clinicians)?
- What recommendation format will be required? Will recommenders complete a standardized recommendation form, submit a letter of recommendation, or provide some other form of recommendation? Who will accept and process these recommendations?

How Will We Ensure that Practitioners Understand Both the Opportunities and Limitations Associated with Pursuing an Alternate Path to Licensure?

Participation in this proposed alternate path would come with both opportunities and limitations for practitioners. The alternate path would provide a way for individuals to obtain Utah-only licensure, but practitioners who choose this option may be ineligible for multi-state licensure through interstate compacts. If practitioners who have obtained licensure through the alternate path wish to participate in compacts or otherwise become licensed in other jurisdictions, they may be required to pass the traditional clinical exams. This will need to be communicated clearly to applicants pursuing this path, both by educators and by regulators.

Additional Ideas

Utah policymakers may wish to consider alternative approaches instead of or in addition to creating an alternate pathway around clinical licensing exams for LCSWs, MFTs, and CMHCs.

- **Remove maximum time limits for passing clinical exams.** Currently, AMFTS and ACMHCs are given two years after completing their postgraduate supervised experience hours to pass the relevant licensing exam(s). Eliminating this upper limit would enable individuals to continue working while under the supervision of a licensed clinician, rather than forcing them up or out of the BH workforce. This change would also decrease the administrative burden for licensing boards, who currently must approve extensions beyond the two year limit.
- **Expand access to exam preparation resources and courses**, such as courses on test-anxiety reduction and study skills. For example, the Counseling Exam Test Anxiety Intervention (CETAI) has been shown to have significant effects on exam pass

rates—one study showed that after participating in this intervention, 75% of individuals who had previously failed the NCMHCE were able to pass on their next exam attempt.[356] These resources could be offered through multiple channels:
    - Utah System of Higher Education (USHE) training programs could be required to offer test preparation courses, for example as elective courses.
    - Industry associations and non-USHE training programs could also be encouraged to offer test preparation courses and resources, and to subsidize all or part of the expense for some candidates.
- **Establish a grant program to cover exam fees** for certain licensure candidates, such as those who have a demonstrated financial need or who have already paid for an initial exam attempt. Practitioners have reported that exam fees, rather than a candidate's preparation, can sometimes be the primary barrier to individuals attempting the exam. This approach has already been implemented in Minnesota.[357]
- **Establish a program to award supervision grants to employers** who hire additional associate-level clinicians, or specifically those who are completing additional hours as part of an alternate pathway. A similar program was implemented in Minnesota, where grant funding was used to pay for supervisors' time spent with supervisees. This funding provided a "financial buffer to insulate the supervision system" from external demands such as billable hour expectations, thereby "allowing supervisors more leeway in budgets, and therefore more time with supervisees."[358]
- **Create supervision-based alternate pathways for other BH licenses**, beyond master's-level clinical therapists.

[356] Carr, A.M. (2016). *An Exploratory Study of Test Anxiety As It Relates To The National Clinical Mental Health Counseling Examination.* [Doctoral Dissertation] Available at: https://www.proquest.com/openview/8c1affa696cf268aef94804ca66b7388/1?cbl=18750&pq-origsite=gscholar.
[357] Aby, M. and Gonzalez Benson, O. (2021). *Funding Diversity: A Case Study of A State-initiated, Funding-driven Program to Diversify Mental Health Service Provision in Minnesota. Human Service Organizations: Management, Leadership & Governance*, 45(3), pp.1–16. doi:https://doi.org/10.1080/23303131.2021.1894293
[358] See pg. 8 Ibid.

2b. Interstate Compacts

Summary of Recommendation

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.

This recommendation applies to all current and future behavioral health interstate compacts. Current relevant compacts include:

- 58-60a Counseling Compact
- 58-61-b PsyPact
- Social Work Interstate Compact

To the best of our knowledge, no other compact initiatives currently exist for behavioral health professions, but this may change as new compacts are proposed and developed.

Status Quo

Licensure compacts are formal agreements between member states to establish "uniform standards to lower barriers to multi-state practice," allowing eligible licenses from one state to be automatically recognized by all other member states.[359] Utah is currently a member of two interstate licensing compacts for behavioral health (BH) professions: the Psychology Interjurisdictional Compact (PsyPact)[360] and the Counseling Compact[361] (for Clinical Mental Health Counselors). Utah enacted legislation to join PsyPact in 2017, and the state's membership in the Psypact became effective in 2020.[362] Utah enacted legislation to join the Counseling Compact in 2022.

While compacts are a form of multilateral licensure recognition between a group of states, Utah (and other states) have taken unilateral steps to recognize professional licenses from out of state. SB 23 (2020) created 'universal licensure' or 'licensure by endorsement' in Utah, where most professionals licensed and in good standing in another state can be licensed in Utah with minimal burden. Licensure by endorsement changes the dynamic for compacts, in that the State already has a simple path for out-of-state professionals to practice in Utah. Licensure by endorsement cannot, however, provide Utah practitioners with a multi-state license to practice outside Utah thus practitioners do benefit additionally from compacts.

[359] National Center for Interstate Compacts (n.d.). *What are Interstate Compacts? – National Center for Interstate Compacts | The Council of State Governments*. [online] compacts.csg.org. Available at: https://compacts.csg.org/compacts/.
[360] UCA 58-61b Psychology Interjurisdictional Compact
[361] UCA 58-60a Counseling Compact
[362] The Psychology Interjurisdictional Compact (2020). *PSYPACTMap - Psychology Interjurisdictional Compact (PSYPACT)*. [online] psypact.org. Available at: https://psypact.org/mpage/psypactmap

Existing Approaches

Licensing compacts for BH professions are fairly new on the regulatory scene—PsyPact was approved in 2015 by the Association of State and Provincial Psychology Boards (ASPPB) and the first group of member states (including Utah) enacted legislation in 2017, taking effect in 2020.[363] PsyPact currently has 39 active member states, and legislation has been recently enacted in Vermont but is not yet effective. The Counseling Compact, developed by the Council of State Governments (CSG) was first introduced in states' 2021 legislative sessions. The Counseling Compact has been adopted by 29 member states, with legislation pending in 7 other states. The compact has not yet taken effect for member states but applications are expected to open in early 2024.[364]

In addition to PsyPact and the Counseling Compact, the new Social Work Compact has recently joined the BH compact landscape. As of 2023, only Missouri has enacted legislation to join the Social Work Compact, and a few other states (including Wisconsin, Ohio, New Jersey, North Carolina, South Carolina, and Georgia) have legislation pending. Social Work Compact legislation was introduced in the last days of the 2023 General Session but did not advance.

While compact initiatives do not currently exist for the other BH professions included in this review, interstate portability is still a frequently-discussed topic within the field. For instance, as of 2023 the American Association of Marriage & Family Therapists (AAMFT) has launched a strategic portability effort with the goal of "[identifying and mitigating] barriers to license portability."[365] However, AAMFT's current focus is on updating model licensure language across states, rather than pursuing the development of a compact.

Rationale

Why adopt BH licensing compacts as long as single-state licensure is preserved?

- Compacts promote consumer access to BH services
- Including single- and multi-state paths enables participation & preserves sovereignty
- Compact membership improves practitioners' professional portability

Compacts Promote Consumer Access to BH Services

The greatest advantage of compact membership is increased access to BH services for Utah consumers. Compacts contribute to these aims by 1) enabling more BH practitioners to begin practicing in Utah, 2) allowing more Utahns who travel or live out of state to maintain continuity

[363] Ibid.
[364] Counseling Compact (2023). *FAQ for Counselors – Counseling Compact*. [online] counselingcompact.org. Available at: https://counselingcompact.org/faq/.
[365] American Association for Marriage and Family Therapy (2023). *Strategic Portability Effort*. [online] www.aamft.org. Available at: https://www.aamft.org/AAMFT/ADVANCE_the_Profession/Strategic_Portability_Effort/SP_Effort/SP_Effort.aspx

of care with their Utah-based BH providers, 3) broadening consumers' access to specialty services, and 4) attracting and retaining students in Utah's training programs for BH professionals.

When compacts or other types of interstate reciprocity arrangements are in place, the reduced financial and procedural burdens of gaining licensure in one or more new states may attract more practitioners who would like to move or expand their practice to other geographic areas. While these burdens are already low for many out-of-state BH practitioners who would like to practice in Utah (due to Utah's licensure by endorsement program), complete removal of these barriers via compact could further access for Utah consumers. Many practitioners nationwide are still unaware of Utah's endorsement pathway, and this lack of information can become a small yet meaningful impediment to more widespread participation in the pathway and improved access for Utahns. Compact membership closes this information gap by making Utah's participation known to eligible practitioners in all compact member states, and removes the need for Utah to expend resources advertising its licensure by endorsement program.

Compact membership can also improve continuity of care for many Utahns. Continuity of care, which includes the timely delivery of services and a consistent relationship between service users and providers,[366] has been associated with many key outcomes of BH care, including improved quality of life, health,[367] and even reduced mortality rates.[368] Utahns likely to experience licensing-related disruptions in continuity of care include those who travel often for work, are military members, attend college in another state, live near state borders, or are among the large number of those who travel out-of-state for missionary service or other volunteer opportunities. For example, a clinician based in rural Utah shared that it is difficult to provide consistent care for his clients who work as long-distance truck drivers—these clients may be on the road for weeks at a time, and he is unable to provide telehealth services for them unless he is licensed in all of the states through which they travel.[369]

Compact membership also benefits consumers through access to a broader market for BH services. Utah clients are better able to access services from practitioners with expertise in specialized areas of BH care that are not readily available within Utah, and clients in other states are likewise able to seek out services from Utah practitioners with areas of expertise that may not be available in their own home state. Research and economic theory also support the general benefits of licensure mobility—as early as Adam Smith in the 1770s, economists have recognized "the ability of workers to move to different labor markets without restriction as being

[366] Biringer, E., Hartveit, M., Sundfør, B., Ruud, T. and Borg, M. (2017). Continuity of care as experienced by mental health service users - a qualitative study. *BMC Health Services Research*, [online] 17(1). doi:https://doi.org/10.1186/s12913-017-2719-9.
[367] Adair, C.E., McDougall, G.M., Mitton, C.R., Joyce, A.S., Wild, T.C., Gordon, A., Costigan, N., Kowalsky, L., Pasmeny, G. and Beckie, A. (2005). Continuity of Care and Health Outcomes Among Persons With Severe Mental Illness. *Psychiatric Services*, 56(9), pp.1061–1069. doi:https://doi.org/10.1176/appi.ps.56.9.1061
[368] Hoertel, N., Limosin, F. and Leleu, H. (2014). Poor longitudinal continuity of care is associated with an increased mortality rate among patients with mental disorders: Results from the French National Health Insurance Reimbursement Database. *European Psychiatry*, 29(6), pp.358–364. doi:https://doi.org/10.1016/j.eurpsy.2013.12.001.
[369] OPLR Listening & Vetting Tour

fundamental to the efficient functioning of those markets."[370] Licensure mobility is also a key component of efficient economic growth and recovery—"in the aftermath of a recession, work movements across regions speed economic recovery. Even during normal times, worker migration facilitates better matches between workers and firms."[371]

Joining interstate compacts can also support consumer access by improving Utah's ability to attract students to BH professional training programs. Some practitioners have expressed concerns that if Utah's BH licenses are no longer recognized by compacts due to differences in licensing requirements, the state will struggle to persuade both Utah residents and those from other states to attend training programs and begin their careers here. One clinician shared, "We want to bring in quality students and providers [to attend school and get licensed in Utah], but they're not going to want to come out here and go to school here, because they're not going to be able to transfer back home when they want to."[372] By offering both multi-state, compact-eligible licenses and single-state, Utah-specific licenses, the state will be able to attract and retain students in its training programs, because they will be confident in their ability to get high-quality education and training in Utah without limiting their licenses' future portability.

Including Single- and Multi-State Paths Enables Participation & Preserves Sovereignty

By ensuring that pathways to both single-state and multi-state licensure are preserved when joining compacts, Utah practitioners and consumers will be able to enjoy the benefits of compacts, while Utah retains sovereignty to develop creative licensing policies and pathways that increase access in the state. For instance, the proposed supervision-based alternate pathway[373] that would allow master's-level clinicians to achieve Utah-specific licensure without taking national licensing exams could increase workforce availability in the state, while not affecting other practitioners' ability to complete multi-state licensing requirements and participate in compacts if they choose.

While licensing compacts are associated with many benefits, they are also associated with some burdens and costs to the state (for example, initial licensing requirements may be higher than existing state requirements, and there may be related data-collection and reporting requirements). Not every compact will align with Utah's needs, and the decision to join a compact should be based on that compact's ability to improve access and mobility for critical, high-need professions. Utah's licensure by endorsement policies already provide a high degree of portability for in-bound professionals,[374] and some compacts may only provide minimal additional benefits in terms of access and portability. When it is determined that compact membership will substantially help the state's access and mobility goals, simultaneously

[370] See pg. 1 of Johnson, J.E. and Kleiner, M.M. (2017). *Is Occupational Licensing a Barrier to Interstate Migration?* [online] National Bureau of Economic Research. doi:https://doi.org/10.3386/w24107.
[371] See pg. 6 of Nunn, R. (2016). *Occupational Licensing and American Workers*. [online] The Hamilton Project. Available at: https://www.hamiltonproject.org/publication/paper/occupational-licensing-and-american-workers/
[372] OPLR Listening & Vetting Tour
[373] 2a. Exam Alternate Path
[374] UCA 58-1-302. License by endorsement

preserving single-state licensing pathways will allow Utah to continue innovating internally without losing the benefits of compact membership.

Compact Membership Improves Practitioners' Professional Portability

Finally, compact membership has benefits for participating practitioners, including the reduced financial and logistical barriers to interstate licensure as described above, the ability to provide continuous care to clients traveling and living out of state, and improved market matching for providers and consumers. Many industry leaders and practitioners expressed their support for compact membership in interviews, focus groups, and survey responses.[375,376] The following quotes highlight practitioners' support for compacts:

> *"I'm super excited about the counseling compact. I love that that's happening. I think that's another way that we can kind of support clients and consumers, and support mental health practitioners by reducing some of those barriers."*

> *"I am strongly hopeful that reciprocity will soon happen so our licenses can be honored in other states to offer specialized care that is not available to the client in their region or state. I hope this can be rigorously sought with success."*

> *"The [social work] interstate license compact is something I have hoped would come to fruition for years…This compact agreement would increase access for mental health services by social workers in Utah and across the country. I fully support this act and strongly encourage Utah to join this compact to increase access for individuals seeking help, and allow social workers to help those across state lines."*

Key Considerations

What key decisions will policymakers need to make to implement this change?

- How will policymakers decide whether to join specific compacts?
- How will we clearly communicate the entry requirements and privileges associated with multi-state and single-state licenses to current and prospective licensees?

[375] OPLR Listening & Vetting Tour
[376] OPLR Behavioral Health Care Workforce Survey (CPMDS)

How Will Policymakers Decide Whether to Join Specific Compacts?

OPLR's recommendation to consider the preservation of both multi-state and single-state licensure paths should be applied during the process of evaluating the merits of specific proposed compacts, both in BH and more broadly. Decisions to join multi-state compacts should also carefully weigh benefits and drawbacks including data collection and reporting burdens and critical workforce needs. In other words, even if proposed compacts allow for both multi-state and single-state licensure paths, some still may not be well-suited to Utah's needs and priorities.

How Will Multi-state and Single-state Licensing Information Be Communicated?

The requirements and implications of taking either a multi-state or single-state licensing pathway must be clearly communicated to licensees. This is particularly crucial for prospective licensees who are still in school or deciding whether to attend school in Utah, and whether to pursue licensure in the state after completing their studies. These individuals need access to comprehensive, accurate information to make decisions regarding training, education, and future licensing. Poor communication of licensing pathways could result in some practitioners inadvertently spending extra time and money completing education and training that fulfills compact requirements, despite not having plans to practice outside of Utah; or, vice versa, students may complete Utah-specific educational and experience requirements, expecting to be able to move out of state, only to learn their license is only valid in Utah. To avoid these situations, we recommend that policymakers and executive branch agencies develop a comprehensive plan for communicating this information to licensees and prospective licensees, which may include:

- Posting a clear explanation of licensing pathways on the Division of Professional Licensing (DOPL) website for each license with an associated compact. Materials should include information on each pathway's training requirements (education, exam, and experience) and implications for interstate mobility and could include easily understandable graphics such as flowcharts to illustrate the different options available for potential licensees.
- Issuing information to newly licensed individuals clarifying the portability of the license they have just obtained (i.e., whether it is a single or multi-state license).
- Requiring training programs to explain multi-state and single-state licensing pathways to students at the beginning of their degree or training program, and to distribute explanatory materials and DOPL contact information to students.
- Conducting proactive outreach to industry associations, faculty members and guidance counselors who lead training programs associated with impacted licenses. This could take the form of a webinar or asynchronous training, with accompanying written materials.

3a. Recovery Assistance (UPHP)

Summary of Recommendation

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.

This recommendation applies to all of those licensed or certified to practice under:

- 58-60 Mental Health Professional Practice Act
- 58-61 Psychologist Licensing Act

Status Quo

The Utah Professionals Health Program (UPHP) is a recovery assistance program that provides an alternative to public disciplinary action for licensed healthcare professionals who have substance use disorders. It enables individuals to confidentially get help. UPHP services are not currently available to behavioral health (BH) providers. UPHP offers services to those licensed to practice under the Podiatric Physician Licensing Act, Pharmacy Practice Act, Veterinary Practice Act, Nurse Practice Act, Utah Medical Practice Act, Utah Osteopathic Medical Practice Act, Dentist and Dental Hygienist Practice Act, and Utah Physician Assistant Act. Utah lawyers also have a program similar to UPHP.[377] UPHP also currently assists only those whose ability to practice is impaired due to a substance use disorder. It does not assist professionals whose ability to practice is impaired for any other reason, including other BH conditions.

Existing Approaches

Jurisdictions with Licensee Recovery Assistance for BH Care Providers[378]

- Alabama
- Arizona
- Connecticut
- Delaware
- Florida
- Hawaii
- Illinois
- Louisiana
- Michigan
- Minnesota
- New Jersey
- Ohio
- Oklahoma
- South Carolina
- Virginia

Forty-seven US jurisdictions offer license recovery programs (excluding California, Maine, Nebraska, and Wisconsin). The number of people served by each program is not available to

[377] OPLR Listening & Vetting Tour
[378] Ibid.

the public. The range of professions covered by these programs varies across jurisdictions, but fifteen states extend license recovery assistance to BH care providers as well. Depending on the jurisdiction, this may include psychologists, social workers, marriage and family therapists, clinical mental health counselors, and addiction/substance use disorder counselors.

The range of assistance provided by each program also varies, but Utah is the only state with a license recovery assistance program that does not provide assistance for disorders other than substance use (e.g., mental health). All other programs monitor a broader set of BH conditions, including both mental health and substance use disorders. For example, many states offer recovery assistance to licensees struggling with a variety of mental health concerns, cognitive impairments or neurologic disorders, stress, and burnout.

Rationale

Why Provide Recovery Assistance for BH?

- BH professionals experience substance use/mental health disorders
- Working in BH may put professionals at risk for developing disorders
- Suffering BH professionals who remain untreated may pose a risk to consumers
- UPHP effectively assists recovering professionals, promoting access to care
- Effective recovery assistance should address both substance use & mental health

BH Professionals Experience Substance Use & Mental Health Disorders

BH providers may be impacted by mental health and substance use disorders at rates similar to or greater than those observed in the general population.[379] A study of clinical psychology doctoral students found that 12.2% were at risk for alcohol abuse and that 12.4% were at moderate-to-severe risk of drug abuse.[380] In one study, researchers found that 43% of psychologists were aware of a male psychologist with a substance use problem, and 28% knew of a female psychologist with a substance use problem.[381] Related research found that 11% of surveyed therapists had experienced problems with substance use[382] and that nearly 6% of surveyed psychologists had conducted therapy while under the influence of alcohol.[383] In short, BH providers are not immune to the same disorders that they are trained to diagnose and treat

[379] Victor, S.E., Devendorf, A.R., Lewis, S.P., Rottenberg, J., Muehlenkamp, J.J., Stage, D.L. and Miller, R.H. (2022). *Only Human: Mental-Health Difficulties Among Clinical, Counseling, and School Psychology Faculty and Trainees.* Perspectives on Psychological Science, 17(6), pp.1576–1590. doi:https://doi.org/10.1177/17456916211071079.
[380] Hobaica, S., Szkody, E., Owens, S.A., Boland, J.K., Washburn, J.J. and Bell, D.J. (2021). Mental health concerns and barriers to care among future clinical psychologists. *Journal of Clinical Psychology*, 77(11), pp.2473–2490. doi:https://doi.org/10.1002/jclp.23198
[381] Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice,* 16(1), 1–15. https://doi.org/10.1111/j.1468-2850.2009.01137.x
[382] Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16*(2), 305–315. https://doi.org/10.1037/0735-7028.16.2.305
[383] Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). *Ethics of practice: The beliefs and behaviors of psychologists as therapists. American Psychologist, 42*(11), 993–1006. https://doi.org/10.1037/0003-066X.42.11.993

in others. For instance, the Division of Professional Licensing (DOPL) received a total of 35 substantiated substance use complaints against BH providers between 2013-2022, with the majority of these complaints directed toward clinicians (22) (e.g., LCSWs, MFTs, CMHCs, Psychologists). This data indicates that substance-use related complaints account for an average of 3.6% of all substantiated complaints against BH providers in any given year. In other words, substance use issues exist among BH workers in Utah, including those with independent authority to diagnose and treat patients.

Working in BH May Put Professionals at Risk for Developing These Disorders

In fact, BH providers may be exposed to workplace conditions that put them at risk for developing BH disorders. Providing BH care to others may impose significant stressors on professionals—from the intense demands of therapeutic relationships, to heavy caseloads and the heightened sense of responsibility that often come along with working in healthcare settings, to the sometimes very real risk of patients harming themselves or others.[384,385,386] Given the nature of their roles, many BH care providers are routinely exposed to traumatic and challenging situations at work, which may put them at risk for developing BH challenges of their own. Exposure to traumatic situations in the workplace has been linked to drug and alcohol abuse.[387]

Further, BH providers have been shown to experience moderate to high rates of burnout.[388] As researchers highlight,

> *"The unique occupational challenges that exist… within human services professions, including intense personal contact and an asymmetrical relationship with a 'receiving' individual has long been thought to place these professionals at increased risk for burnout."* [389]

[384] O'Connor, K., Muller Neff, D. and Pitman, S. (2018). *Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. European Psychiatry*, 53(53), pp.74–99. doi:https://doi.org/10.1016/j.eurpsy.2018.06.003
[385] Leiter, M.P. and Harvie, P.L. (1996). Burnout Among Mental Health Workers: a Review and a Research Agenda. *International Journal of Social Psychiatry*, 42(2), pp.90–101. doi:https://doi.org/10.1177/002076409604200203.
[386] Lent, J. and Schwartz, R. (2012). *The Impact of Work Setting, Demographic Characteristics, and Personality Factors Related to Burnout Among Professional Counselors*. *Journal of Mental Health Counseling*, 34(4), pp.355–372. doi:https://doi.org/10.17744/mehc.34.4.e3k8u2k552515166
[387] Fatima Fernandes, M.N. de and Silva Gherardi-Donato, E.C. da (2017). Is It Workplace Stress a Trigger for Alcohol and Drug Abuse? *Open Journal of Nursing*, 07(03), pp.435–448. doi:https://doi.org/10.4236/ojn.2017.73034.
[388] Singh, J., Karanika-Murray, M., Baguley, T. and Hudson, J. (2020). *A Systematic Review of Job Demands and Resources Associated with Compassion Fatigue in Mental Health Professionals.* International Journal of Environmental Research and Public Health, [online] 17(19), p.6987. doi:https://doi.org/10.3390/ijerph17196987
[389] See pg. 635 of Collins, M.H. and Cassill, C.K. (2021). Psychological wellness and self-care: an ethical and professional imperative. *Ethics & Behavior*, 32(7), pp.1–13. doi:https://doi.org/10.1080/10508422.2021.1971526

Working in BH may also lead to compassion fatigue, which is described as the "cost of caring" for others who are in emotional and physical pain.[390,391] One study found that 43% of psychologists reported irritability and emotional exhaustion, both symptoms of burnout and compassion fatigue, in the previous year.[392] Systematic reviews of the academic literature suggest that the prevalence of burnout among mental health service providers may be as high as 55-67%.[393,394,395] As one author describes it, "Burnout is a recognized occupational hazard among psychotherapists."[396] Burnout and compassion fatigue often lead to or exacerbate mental health problems. Research indicates that psychotherapists experiencing burnout and compassion fatigue are at increased risk of developing anxiety and depressive disorders and suffering secondary traumatic stress.[397]

BH Professionals Who Remain Untreated May Pose a Risk to Consumers

If left untreated, these difficulties may lead to many negative effects for BH care professionals as well as the clients they serve. Burnout may result in diminished quality of life for clinicians, as well as lower quality care for their patients.[398,399] In one study, 85% of psychotherapists surveyed believed that working when too distressed to be effective is unethical. However, the study also found that 60% of them had done so. Similarly, 36.7% of distressed psychologists surveyed believed that their distress decreased the quality of care they provided to their clients.[400] As Pope and colleagues point out, "Although rare, some of these practices such as… doing therapy while under the influence of alcohol so clearly undermine the rights and welfare of patients that

[390] Mathieu, F. (2007). *Running on Empty: Compassion Fatigue in Health Professionals*. [online] Rehab & Community Care Medicine. Available at: https://compassionfatigue.org/pages/RunningOnEmpty.pdf.
[391] Singh, J., Karanika-Murray, M., Baguley, T. and Hudson, J. (2020). *A Systematic Review of Job Demands and Resources Associated with Compassion Fatigue in Mental Health Professionals.* International Journal of Environmental Research and Public Health, [online] 17(19), p.6987. doi:https://doi.org/10.3390/ijerph17196987
[392] Smith, P. L., & Moss, S. B. (2009). *Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? Clinical Psychology: Science and Practice, 16*(1), 1–15. https://doi.org/10.1111/j.1468-2850.2009.01137.x
[393] Simionato, G.K. and Simpson, S. (2018). *Personal risk factors associated with burnout among psychotherapists: A systematic review of the literature. Journal of Clinical Psychology*, 74(9), pp.1431–1456. doi: https://doi.org/10.1002/jclp.22615
[394] Morse, G., Salyers, M.P., Rollins, A.L., Monroe-DeVita, M. and Pfahler, C. (2012). *Burnout in Mental Health Services: A Review of the Problem and Its Remediation. Administration and Policy in Mental Health and Mental Health Services Research*, [online] 39(5), pp.341–352. doi:https://doi.org/10.1007/s10488-011-0352-1
[395] Collins, M.H. and Cassill, C.K. (2021). Psychological wellness and self-care: an ethical and professional imperative. *Ethics & Behavior*, 32(7), pp.1–13. doi:https://doi.org/10.1080/10508422.2021.1971526
[396] See pg. 44 of Finan, S., McMahon, A. and Russell, S. (2021). *At What Cost Am I Doing This?' An Interpretative Phenomenological Analysis of the Experience of Burnout among Private Practitioner Psychotherapists*. *Counselling and Psychotherapy Research*, 22(1). doi:https://doi.org/10.1002/capr.12483.
[397] Yang, Y., & Hayes, J. A. (2020). *Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. Psychotherapy, 57*(3), 426–436. https://doi.org/10.1037/pst0000317
[398] Canfield, J. (2005). Secondary Traumatization, Burnout, and Vicarious Traumatization. *Smith College Studies in Social Work*, 75(2), pp.81–101. doi:https://doi.org/10.1300/j497v75n02_06.
[399] See pg. 44 of Finan, S., McMahon, A. and Russell, S. (2021). *At What Cost Am I Doing This?' An Interpretative Phenomenological Analysis of the Experience of Burnout among Private Practitioner Psychotherapists*. *Counselling and Psychotherapy Research*, 22(1). doi:https://doi.org/10.1002/capr.12483.
[400] Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice, 16*(1), 1–15. https://doi.org/10.1111/j.1468-2850.2009.01137.x

they need to be addressed much more forcefully and effectively."[401] Overall, BH providers who are working under the influence of drugs or alcohol, or who are suffering from BH challenges due to being overwhelmed or emotionally exhausted at work may be putting themselves and their patients at risk.[402,403,404] In other words, BH providers who are struggling with substance use and other BH conditions may be more likely to harm themselves and their patients.

UPHP Effectively Assists Recovering Professionals, Promoting Access to Care

Offering confidential recovery assistance through the UPHP program may help BH providers who are struggling with their own substance use or mental health concerns. UPHP offers confidential services, needs assessment, treatment access assistance, and monitoring. It provides individuals struggling with substance use a unique opportunity to retain their license while being monitored.[405] The UPHP process involves self-referral or referral from a reliable source, rigorous evaluation, treatment, and five years of monitoring.[406] The program's success is evident as 71% of physicians who receive treatment remain sober, licensed, and employed after five years.[407]

Based on Health Resources and Services Administration data, Utah currently faces a shortage of BH providers.[408] This shortage can be addressed in part by retaining and supporting more BH providers through the UPHP program. Additionally, it is more cost-effective to maintain the existing workforce rather than investing in training new professionals to replace burnt-out or licensed-revoked BH providers. Research indicates that high turnover rates within the mental health workforce result in organizational instability and financial burdens due to expenses related to employee separation and the recruitment and training of new hires.[409] Brent Kelsey, Office Director of the Office of Substance Use and Mental Health, highlighted the under-utilization of UPHP, despite its proven effectiveness for medical professionals. He noted that while there are existing recovery assistance programs for physicians, the same level of support is lacking for BH providers.[410]

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[401] See pg. 14 of Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). *Ethics of practice: The beliefs and behaviors of psychologists as therapists. American Psychologist, 42*(11), 993–1006. https://doi.org/10.1037/0003-066X.42.11.993

[402] Smith, P. L., & Moss, S. B. (2009). *Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? Clinical Psychology: Science and Practice, 16*(1), 1–15. https://doi.org/10.1111/j.1468-2850.2009.01137.x

[403] Corrigan, P.W., Holmes, E.P., Luchins, D., Buican, B., Basit, A. and Parks, J.J. (1994). *Staff burnout in a psychiatric hospital: A cross-lagged panel design*. *Journal of Organizational Behavior*, 15(1), pp.65–74. doi:https://doi.org/10.1002/job.4030150107

[404] Yang, Y., & Hayes, J. A. (2020). *Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. Psychotherapy, 57*(3), 426–436. https://doi.org/10.1037/pst0000317

[405] Utah Professional Health Program (n.d.). Available at: https://uphp.utah.gov/

[406] Utah Professional Health Program (2023). *Evaluation Toolkit*. [online] Available at: https://uphp.utah.gov/evaluation-toolkit/.

[407] See video "You are Not Alone," Utah Professional Health Program (n.d.). Available at: https://uphp.utah.gov

[408] OPLR Analysis of RxP Effects on HPSA Designations

[409] Paris, M. and Hoge, M.A. (2009). Burnout in the Mental Health Workforce: A Review. *The Journal of Behavioral Health Services & Research*, 37(4), pp.519–528. doi:https://doi.org/10.1007/s11414-009-9202-2

[410] OPLR Listening & Vetting Tour

Effective Recovery Assistance Should Address Both Substance Use & Mental Health

According to the guidelines outlined by the Federation of State Physician Health Programs (FSPHP), UPHP should provide "treatment of all health conditions including substance use disorders and other addictions, mental and behavioral disorders, and physical illness."[411] Because substance use is often linked to underlying mental health disorders, it may be more effective to expand UPHP to cover both. For instance, studies show that people with a mental health disorder often have at least one co-occurring substance use disorder, while people with substance use disorders typically have at least one co-occurring mental health disorder.[412] Of the 47 license recovery programs around the U.S., UPHP is the only program that does not provide assistance with disorders other than substance use. Among the remaining 46 programs, 21 programs provide assistance with substance use and mental and BH conditions, and 25 fully comply with the FSPHP guideline and provide assistance with substance use, BH conditions, and physical illness.

In conversation with OPLR, DOPL Director Mark Steinagel reported receiving inquiries from several legislators about UPHP addressing mental health issues, in addition to substance use-related conditions.[413] Healthcare providers[414,415] and BH providers[416,417] face work-related stressors that put them at increased risk not only for substance use disorders, but also for other mental health problems. Physicians have an increased risk of mental health concerns including substantially higher suicide rates than the general population.[418,419] A survey conducted from June to September 2020, during the height of the COVID-19 pandemic, revealed that 93% of health workers reported feeling stressed and stretched too thin, with 82% experiencing

[411] Lundberg, K. and Rhead, O. (2019). *Utah Recovery Assistance Program Evaluation Report*. [online] Department of Commerce Division of Occupational and Professional Licensing. Available at: https://le.utah.gov/interim/2019/pdf/00004759.pdf

[412] Avery, J.D., Barnhill, J.W. and American Psychiatric Publishing (2018). *Co-occurring mental illness and substance use disorders : a guide to diagnosis and treatment.* [online] Arlington, Va: American Psychiatric Association Publishing. Available at: https://www.appi.org/Co-occurring_Mental_Illness_and_Substance_Use_Disorders

[413] OPLR Listening & Vetting Tour

[414] Demerouti, E., Bakker, A.B., Nachreiner, F. and Schaufeli, W.B. (2000). *A model of burnout and life satisfaction amongst nurses. Journal of Advanced Nursing*, 32(2), pp.454–464. doi:https://doi.org/10.1046/j.1365-2648.2000.01496.x

[415] Centers for Disease Control and Prevention (2022). *Health Worker Mental Health*. [online] www.cdc.gov. Available at: https://www.cdc.gov/niosh/newsroom/feature/health-worker-mental-health.html

[416] Smith, P. L., & Moss, S. B. (2009). *Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? Clinical Psychology: Science and Practice, 16*(1), 1–15. https://doi.org/10.1111/j.1468-2850.2009.01137.x

[417] Kleespies, P., Orden, K., Bongar, B., Bridgeman, D., Bufka, L., Galper, D., Hillbrand, M. and Yufit, R. (2011). *Psychologist Suicide: Incidence, Impact, and Suggestions for Prevention, Intervention, and Postvention. Prof Psychol Res Pr,* [online] 42(3), pp.244–251. doi:https://doi.org/10.1037/a0022805

[418] Collins, M.H. and Cassill, C.K. (2021). P*sychological wellness and self-care: an ethical and professional imperative. Ethics & Behavior*, 32(7), pp.1–13. doi:https://doi.org/10.1080/10508422.2021.1971526

[419] Schernhammer, E.S. and Colditz, G.A. (2004). *Suicide Rates Among Physicians: A Quantitative and Gender Assessment (Meta-Analysis)*. *American Journal of Psychiatry*, 161(12), pp.2295–2302. doi:https://doi.org/10.1176/appi.ajp.161.12.2295

emotional and physical exhaustion.[420,421] Among nurses, 45% stated that they were not receiving enough emotional support.[422,423] Other studies reveal that 22% of healthcare workers experienced moderate depression, anxiety, and post-traumatic stress disorder.[424,425] In order to provide more comprehensive support and preventative services to both the licensees already covered under statute, as well as the BH providers to whom we recommend extending these services, we recommend that UPHP assist licensed professionals whose ability to practice may be impaired due to mental health problems.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- Which BH professionals will be included?
- What conditions will be covered?
- What resources will be needed?

UPHP, and recovery assistance programs in general, are valuable tools for maintaining the safety of practitioners and patients, and retaining critical licensed workers. That said, there are many ways to structure and implement a recovery assistance program. OPLR's recommendation is to expand recovery assistance to 1) BH workers, and 2) mental health disorders. OPLR does not have any recommendation related to how recovery assistance is administered, where UPHP is housed,[426] or how it is structured.

Which BH Professionals Will Be Included?

UPHP currently serves approximately one in every 1,000 eligible medical providers (which total nearly 90,000 providers). This proposed expansion to all BH care providers is projected to increase the pool of participants by about 17%, from the current ~90 participants, to a total of ~110 individuals.[427] Though we propose the UPHP program cover all BH providers, policymakers may wish to consider whether to expand coverage to only a subset of

[420] Mental Health America [2020]. *The mental health of healthcare workers in COVID-19*. [online] Available at: https://mhanational.org/mental-health-healthcare-workers-covid-19
[421] Centers for Disease Control and Prevention (2022). *Health Worker Mental Health*. [online] www.cdc.gov. Available at: https://www.cdc.gov/niosh/newsroom/feature/health-worker-mental-health.html
[422] Mental Health America [2020]. *The mental health of healthcare workers in COVID-19*. [online] Available at: https://mhanational.org/mental-health-healthcare-workers-covid-19
[423] Centers for Disease Control and Prevention (2022). *Health Worker Mental Health*. [online] www.cdc.gov. Available at: https://www.cdc.gov/niosh/newsroom/feature/health-worker-mental-health.html
[424] Li, Y., Scherer, N., Felix, L. and Kuper, H. (2021). Prevalence of depression, anxiety and post-traumatic stress disorder in health care workers during the COVID-19 pandemic: A systematic review and meta-analysis. *PLOS ONE*, [online] 16(3), p.e0246454. doi:https://doi.org/10.1371/journal.pone.0246454
[425] Centers for Disease Control and Prevention (2022). *Health Worker Mental Health*. [online] www.cdc.gov. Available at: https://www.cdc.gov/niosh/newsroom/feature/health-worker-mental-health.html
[426] For instance, many states house their recovery assistance programs with the state medical society, with an independent nonprofit, or an independent corporation.
[427]OPLR Analysis of DOPL Licensing Data; This figure assumes a proportional increase in program participation relative to the numbers of licensees and does not account for expanding assistance to behavioral health disorders beyond substance use.

providers—for example, BH clinicians (e.g., psychologists, LCSWs, MFTs, CMHCs), or those working in particular settings (e.g., public agencies) or professions (e.g., psychology), or at more advanced professional levels (e.g., master's-level and doctoral-level providers). Policymakers could also make this determination based on whether the BH provider holds a mandatory license or voluntary certification. The decision of which BH providers to include in the UPHP expansion may be informed by the risks associated with working in various contexts or roles, and by available program resources and bandwidth.

What Conditions Will Be Covered?

Policymakers should consider whether UPHP will provide coverage for all mental health issues, or if it will cover only serious mental illnesses, such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, and borderline personality disorder. Depending on capacity, the UPHP program could also choose to only cover mental illnesses that are co-occurring with substance use disorders, similar to Oregon's program, which monitors for additional conditions as long as the licensee is diagnosed with a substance use or mental health disorder.[428]

What Resources Will Be Needed?

Policymakers will also need to consider how to fund any UPHP expansion. UPHP costs can be thought of as two parts: the cost to administer the program (the direct cost of DOPL's UPHP staff) and the cost borne by the participant (for evaluation, testing, and treatment).

UPHP will need to hire additional administrative and clinical staff to manage the program's expansion, though this could be offset by a modest fee increase to licensees. At present, UPHP relies on only one full-time manager, one part-time medical director, two clinical coordinators, and one office specialist to run the program. The staff members already operate at maximum capacity, so additional resources will be needed. In the original UPHP bill, DOPL increased the fees for the relevant licenses by $10. A fee increase would be consistent with past approaches and could be designed to offset additional administrative program costs including staffing.

Currently, UPHP participants are responsible for the cost of an initial evaluation, subsequent re-evaluations (to address their ability to practice safely), treatment and therapy costs, and ongoing drug testing which can be as much as $4,500 in the first year. Even if the UPHP program is expanded to BH practitioners, these high costs could lead lower-income practitioners to decline participating in the program purely because they cannot pay for the evaluation and testing. By declining the UPHP program, a licensee would then move into DOPL's public probation program (and thereby have a permanent public record).

Thus, separate from the additional funding for UPHP staff, policymakers may wish to address the cost to participants of participating in UPHP, whether via state 'scholarship' funds or working

[428] Federation of State Physician Health Programs (2023). *Oregon's Health Professionals' Services Program*. [online] www.fsphp.org. Available at: https://www.fsphp.org/oregon

with the private sector to do so. Of the 29 other state programs similar to UPHP, 16 are fully funded in alternative ways—for instance, through participant fees, hospital and private donations, state medical boards, malpractice insurance companies, and charitable donations. These other sources may provide a solution to funding or subsidizing the participant cost of UPHP.

Additional Ideas

Utah policymakers may wish to consider alternative approaches instead of or in addition to expanding the UPHP program to include BH providers and to assist with mental health disorders in addition to substance use disorders.

- **Create a recovery program for BH providers, outside of UPHP.** Rather than expanding UPHP to include BH care providers, an alternative option would be to form a separate entity or committee modeled after the Utah State Bar Lawyers Helping Lawyers program to address the recovery assistance needs of BH providers.[429]
- **Increase BH professionals' awareness of UPHP**. Because UPHP has only served medical professionals up to this point, many members of the BH care workforce may be unaware of the program's existence or purpose. (A DOPL survey of all licensed professionals found that 57% of respondents had no knowledge of UPHP.)[430] To ensure that BH care professionals are aware of and can access services if needed, UPHP might conduct additional proactive outreach to BH care professionals, for example by hiring an outreach or communications professional responsible for developing marketing materials and fostering stronger relationships with professional organizations and other key stakeholders.[431] Note that any successful outreach program might trigger the need for additional UPHP staff.

[429] Utah State Bar (2022). *Lawyers Helping Lawyers*. [online] utahbar.org. Available at: https://www.utahbar.org/member-services/lawyers-helping-lawyers/.
[430] Lundberg, K. and Rhead, O. (2019). *UTAH RECOVERY ASSISTANCE PROGRAM EVALUATION REPORT*. [online] Department of Commerce Division of Occupational and Professional Licensing. Available at: https://le.utah.gov/interim/2019/pdf/00004759.pdf
[431] Ibid.

3b. Safety Checks & Disclosures

Summary of Recommendation

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.

This recommendation applies only to those licensed to practice under:

- 58-60 Mental Health Professional Practice Act
  - Licensed Clinical Social Worker
  - Certified Social Worker
  - Marriage and Family Therapist
  - Associate Marriage and Family Therapist
  - Clinical Mental Health Counselor
  - Associate Clinical Mental Health Counselor
- 58-61 Psychologist Licensing Act
  - Psychologist
  - Certified Psychology Resident

Status Quo

Currently, disciplinary oversight for the majority of licensed behavioral health (BH) professionals in Utah is primarily conducted by the Division of Professional Licensing (DOPL), which has authority to investigate consumer complaints and take disciplinary action against licensees. The Utah Department of Health and Human Services (DHHS) also regulates a portion of the BH care workforce, overseeing those certified as peer support specialists, case managers, and crisis workers via the Office of Substance Use and Mental Health (OSUMH). DHHS likewise has the authority to conduct investigations, hold disciplinary hearings, and revoke these certifications. In addition to taking actions in response to licensees' inappropriate actions, these state agencies also have authority to take proactive safety measures, including conducting safety checks and requiring the disclosure of certain information to clients.

Safety Checks. Psychologists and certified psychology residents licensed through DOPL are required to undergo fingerprinting and criminal background checks.[432] No other regulated BH professionals are currently required to undergo criminal background checks. All other DOPL BH licensees are only required to complete a declaration of any criminal or other disciplinary history

[432] Division of Professional Licensing (n.d.). *Certified Psychology Resident*. [online] Division of Professional Licensing. Available at: https://dopl.utah.gov/psychology/apply-for-a-license/certified-psychology-resident/

on their application form at initial licensure and renewal. In 2015, Utah became the first state to adopt the FBI Record of Arrest and Prosecution BACK ("Rap Back") program[433] for some licensees, including school employees,[434] real estate agents,[435] and workers in Utah's criminal justice system. The program requires one-time fingerprinting that is entered into an FBI database and maintains an individual's criminal history inside and outside of Utah.[436,437] BH practitioners are not currently required to be registered into the FBI Rapback program.

Mandatory Disclosures to Clients. DHHS-licensed health care[438] and human services[439] programs and facilities are often required to provide consumers with licensing-related information as well as information on patients' rights[440] and avenues for recourse[441] (e.g., how to file a complaint). Utah does not, however, require individual BH practitioners—including those operating small group or private practices—to disclose relevant professional licensing information (e.g., license number, supervisor name and license number) or safety-related information (e.g., when and how to file a complaint) to their clients.

Existing Approaches

Safety Checks. States have adopted a variety of safety checks, including full criminal background checks, criminal history declarations, FBI synchronous background check services, and National Practitioner Data Bank (NPDB) queries. The type of check required often varies by scope of practice, with more stringent requirements for those with more advanced scopes.

A **criminal background check** involves fingerprinting that is used to check a licensee's criminal history on a state database (managed by the Utah Bureau of Criminal Identification and Investigation) and federal database (managed by the FBI). These checks review information such as felony or misdemeanor convictions and prison records.[442]

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[433] Utah Bureau of Criminal Identification (2015). *Utah Bureau of Criminal Identification Newsletter* . [online] Available at: https://drive.google.com/file/d/1DZP14GFxRrE84OH0kEEGEL87P7gopXkh/view.

[434] *Education Background Check Amendments*. Available at: https://le.utah.gov/~2015/bills/hbillenr/HB0124.pdf.

[435] *Real Estate Amendments*. Available at: https://le.utah.gov/~2019/bills/static/SB0140.html.

[436] UCA 53-10-108

[437] *Education Background Check Amendments*. Available at: https://le.utah.gov/~2015/bills/hbillenr/HB0124.pdf.

[438] UCA 2b-2-201(13a) Health Care Facilities include: "general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, residential-assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, abortion clinics, clinics that meet the definition of hospital under Section 76-7-301 or 76-71-201, facilities owned or operated by health maintenance organizations, end stage renal disease facilities, and any other health care facility which the committee designates by rule."

[439] UCA 2b-2-201(23a): Human Service Programs include: foster homes, therapeutic schools, youth programs, outdoor youth programs, residential treatment programs, residential support programs, resource family homes, recovery residences; and facilities or programs that provide adult day care, day treatment, outpatient treatment, domestic violence treatment, child-placing services, social detoxification, and other human services.

[440] e.g., UCA 26B-2-206(3) – Health Care Facility Licensing and Inspection: "The current license shall at all times be posted in each health care facility in a place readily visible and accessible to the public."

[441] e.g., UCA 26B-2-104(1)(xiii) – Human Services Programs and Facilities, Office responsibilities: "a requirement that each human services program publicly post information that informs an individual how to submit a complaint about a human services program to the office"

[442] AccuSourceHR (n.d.). *What Shows Up In Background Check | AccuSourceHR, Inc.* [online] AccuSourceHR. Available at: https://www.accusourcehr.com/what-shows-up-in-a-background-check.

A **criminal history declaration** requires applicants to declare (at initial application and/or renewal) whether they have a history of any criminal convictions or other disciplinary action. If the individual answers "Yes," they are required to provide an explanation of the circumstances, evidence of rehabilitation, and a certified copy of court documents. Declarations are generally the most common form of background check and require less administrative burden on the part of licensee applicants and those approving licensing applications.[443] However, these declarations rely on the honesty of the applicant or licensee and are not verified through any sort of database or clearance system.

Generally, most states require clinical therapists to undergo criminal background checks, and most states require either a background check or a declaration of criminal history for associate-level licensees (see Table 3.1). Over 40% of states and territories require initial criminal background checks for clinical therapists (e.g., licensed clinical social workers, marriage and family therapists, clinical mental health counselors, master's-level addiction counselors, and psychologists).[444] Some states also require non-clinical licensees to undergo background checks as well. Most licenses that do not require a criminal history check require a declaration of criminal and disciplinary history. A few states, such as Texas, have adopted the FBI Rap Back program as a safety check for BH licensing.[445]

Table 3.1 Criminal Background Checks for Mental Health Therapists[446]

License Type	% of States with Criminal Check Requirement
Psychologists	70%
Licensed Clinical Social Worker	96%
Marriage & Family Therapist	53%
Clinical Mental Health Counselor	62%
Master Addiction Counselor	36%

The **NPDB** is a repository of reports containing information on adverse actions related to health care practitioners, providers, and suppliers. Every state is required to report serious disciplinary actions taken against individual BH practitioners to the NPDB. Entities and authorized agents may use the NPDB to lookup individuals previously or presently licensed in another state to

[443] OPLR National Review of Regulation
[444] OPLR National Review of Regulation
[445] Texas Behavioral Health Executive Council (n.d.). *Fingerprint Information* . [online] Texas Behavioral Health Executive Council. Available at: https://www.bhec.texas.gov/fingerprint-information/index.html.
[446] The calculation for each license type includes only those U.S. states/territories with an equivalent license type. E.g., The percent of states requiring a criminal background check for marriage and family therapists does not include American Samoa in the denominator because they do not currently offer a marriage and family therapist license.

check for past disciplinary actions related to their license.[447] Doing so ensures that licensees coming from other states will not pose a safety risk to consumers.

Mandatory Disclosures to Clients. In some states, all BH licensees, registrants, and certificate holders are required to disclose licensing information to patients during the initial client contact. These disclosures may include information such as the practitioner's license type and contact information for the licensing board. Disclosures must define unprofessional behaviors, outline how to file complaints, and explain confidentiality laws to clients. Practitioners must also obtain informed consent by detailing the nature, benefits, risks, and financial aspects of their treatment to their clients. These disclosures can be presented in various formats, such as intake forms requiring a client signature, an informational brochure or document, or publicly visible signage posted in a practitioner's office. In both Colorado and Vermont, BH practitioners are required to provide written disclosures to clients during the initial client contact.[448,449]

Rationale

Why Introduce Proactive Safety Measures?

- Utah may have a safety problem, and proactive safety measures can help
- Safety checks can prevent consumer harm, without reducing access to care
- Client disclosures promote consumer safety, without being overly burdensome

Utah May Have a Safety Problem, and Proactive Safety Measures Can Help

Analysis of both national- and state-level data shows that safety issues in Utah's BH care system stem from a relatively high number of repeat offenders, as well as from incidents occurring early in licensees' careers and in small, often isolated practice settings. According to data from the NPDB,[450] which tracks health care providers' malpractice payments and adverse licensing actions, Utah ranks twelfth among 51 states for the highest number of NPDB reports per BH licensee, and fourth for the highest proportion of repeat offenders.[451] At the state level, sampled DOPL data showed that between 2018 and 2022, the most common substantiated complaints occurred within the first five years of licensees' careers and in smaller practice settings (1-19 employees). Common substantiated complaints against Utah BH practitioners include boundary violations such as sexual relationships (e.g., harassment or assault), billing fraud (e.g., charging for sessions that did not occur), as well as confidentiality and other violations (e.g., failure to maintain confidentiality or inappropriate involvement in custody proceedings).[452] This unsafe care can lead to serious consequences for consumers, including

[447] National Practitioner Data Bank (n.d.). *Is My Organization an Entity or an Agent? Infographic*. [online] The National Practitioner Data Bank. Available at: https://www.npdb.hrsa.gov/hcorg/entityOrAgentGuide.jsp
[448] CRS-12-43-214
[449] VT Code of Rules 04-030-070
[450] National Practitioner Data Bank (n.d.). *The National Practitioner Database - Public Use Data File*. [online] National Practitioner Database. Available at: https://www.npdb.hrsa.gov/resources/publicData.jsp.
[451] Including the District of Columbia
[452] OPLR Analysis of DOPL Substantiated Complaint Data

exacerbation of existing symptoms;[453] additional harms to health, safety, and welfare;[454] and decreased willingness to seek care in the future.[455,456,457]

Currently, Utah's primary strategy for promoting client safety in BH is investigating complaints filed against licensees by consumers or others with knowledge of alleged unprofessional conduct. However, some incidents may go unreported because many consumers do not have the knowledge or resources to determine whether they are victims of inappropriate behavior[458] or don't know what to do when a BH provider acts inappropriately, as explained by one Utah social worker:[459]

> *"If a therapist has an inappropriate sexual relationship with a patient … the patient often does not report the behavior themselves. They tell someone else, who reports it for them because [the patient] doesn't know where to report anything and they're already facing their own challenges."*

Furthermore, existing power dynamics can deter even knowledgeable consumers from reporting incidents of misconduct. Some practitioners inappropriately take advantage of their clients' trust and vulnerabilities, and their clients may feel unable to question practitioners' authority or may avoid voicing concerns.[460] Requiring licensees to disclose relevant information regarding reporting, enforcement, and the definitions of appropriate care can promote safety by better empowering these clients to identify and report inappropriate practice.

Other gaps in current regulation also limit Utah's ability to ensure that all licensees will provide safe and quality care to the public. Currently, Utah employers can only request FBI background checks but not state background checks, thus limiting their knowledge of criminal activities that

[453] Martin, G.M. and Beaulieu, I. (2023). Sexual Misconduct: What Does a 20-Year Review of Cases in Quebec Reveal about the Characteristics of Professionals, Victims, and the Disciplinary Process? *Sexual Abuse*, 0(0), p.107906322311708. doi:https://doi.org/10.1177/10790632231170818.
[454] Reamer, F. (2003). Boundary Issues in Social Work: Managing Dual Relationships. *Social Work*, 48(1), pp.121–133. doi:https://doi.org/10.1093/sw/48.1.121.
[455] Martin, G.M. and Beaulieu, I. (2023). Sexual Misconduct: What Does a 20-Year Review of Cases in Quebec Reveal about the Characteristics of Professionals, Victims, and the Disciplinary Process? *Sexual Abuse*, 0(0), p.107906322311708. doi:https://doi.org/10.1177/10790632231170818.
[456] Feldman-Summers, S. and Gwendolyn (1984). Psychological impacts of sexual contact between therapists or other health care practitioners and their clients. *Journal of Consulting and Clinical Psychology*, 52(6), pp.1054–1061. doi:https://doi.org/10.1037//0022-006x.52.6.1054.
[457] Robins, C.S., Sauvageot, J.A., Cusack, K.J., Suffoletta-Maierle, S. and Frueh, B.C. (2005). Special Section on Seclusion and Restraint: Consumers' Perceptions of Negative Experiences and 'Sanctuary Harm' in Psychiatric Settings. *Psychiatric Services*, 56(9), pp.1134–1138. doi:https://doi.org/10.1176/appi.ps.56.9.1134.
[458] Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *Google Books*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.
[459] OPLR Listening & Vetting Tour
[460] De Varis, J. (1994). The dynamics of power in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 31(4), pp.588–593. doi:https://doi.org/10.1037/0033-3204.31.4.588.

might have occurred in the state by a licensee.[461,462,463,464] While insurance companies in Utah have the capability to access NPDB, existing state statutes do not explicitly grant DOPL or DHHS the authority to submit queries to the NPDB for BH licensees.[465,466,467] This presents a potential risk to client safety, as DOPL and DHHS are not aware of licensees coming from other states who may have had disciplinary actions taken against them.

Utah regulators and practitioners alike expressed support for more proactive safety approaches, as long as these measures do not significantly increase burdens on the state or on individual practitioners (e.g., excess time, cost, or redundant effort). It is also important that adding new safety measures does not inadvertently further restrict consumers' access to care. For instance, introducing new safety measures may require additional funds, and these costs could lead to higher licensure fees or patient charges, thus potentially reducing access.[468] Overly rigorous safety measures could demand more time and administrative work for BH practitioners, which could result in reduced availability for appointments, longer wait times, and fewer slots for new patients.[469] If the additional administrative burden becomes too overwhelming, some BH practitioners may opt to reduce their services, further limiting access to care. However, if new safety measure policies are carefully implemented, BH services will not be limited but improved.

Targeted Safety Checks Can Prevent Consumer Harm, Without Reducing Access to Care

Adopting the FBI Rap Back program limits consumer risk and avoids the significant administrative burden associated with requiring criminal background checks at every renewal. Implementing the Rap Back program would reduce the need for DOPL to perform repeated full criminal background checks and reduce the cost of performing these checks. Additionally, requiring enrollment in the Rap Back service for all master's-level BH clinicians would impose no additional burden on associates and other licensees who operate under supervision and who therefore do not pose as high a risk to consumers. Utah practitioners expressed agreement that broader requirements for background checks could be beneficial, particularly when checks are not already performed by licensees' employers.[470] While only limited research on the FBI Rap Back program is available, due to the program's recency, one study did suggest that Medicaid-

[461] Public Law 105 - 251
[462] UCA 53-10-102
[463] UCA 53-10-108
[464] Utah Department of Public Safety (n.d.). *Employment/Volunteer Background Checks*. [online] DPS – Criminal Identification (BCI). Available at: https://bci.utah.gov/obtaining-utah-criminal-history-records-of-your-employees/.
[465] United States Code Title 42 §1320a–7e
[466] UCA 26B-1-211
[467] UCA 58-1-2
[468] Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *Google Books*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.
[469] Adams, D.R. (2023). Availability and Accessibility of Mental Health Services for Youth: A Descriptive Survey of Safety-Net Health Centers During the COVID-19 Pandemic. *Community Mental Health Journal*. doi:https://doi.org/10.1007/s10597-023-01127-9.
[470] OPLR Listening & Vetting Tour

and Medicare-funded nursing homes that implemented the Rap Back program received fewer citations for deficiencies in resident health and safety.[471]

Background checks are a relatively standard practice in BH licensing that (if well-targeted) can effectively prevent consumer harm with minimal effects on consumer access. If applied too broadly or stringently, background check requirements may have the unintended effect of unnecessarily curtailing access,[472,473] so it is important to understand and mitigate these potential drawbacks. Appropriately, DOPL's current guidelines require that applicants with serious criminal convictions undergo an administrative review as part of the application process, but no past conviction automatically disqualifies an individual from obtaining a BH license.[474,475]

Further, checking whether license applicants have adverse actions or medical malpractice claims listed in the NPDB during the initial licensure and/or renewal application process could help to identify and prevent bad actors from practicing in Utah. Organizations who query the NPDB rate it as a very useful tool, with over 20% of queries providing new information, and with this new information altering institutional credentialing decisions in more than 5% of cases.[476] Utah's state licensing agencies are not currently authorized (nor are they required) to use this information as part of the professional licensure application process. As researchers note:[477]

> *"While the Data Bank provides information that may be potentially useful, regulations do not stipulate how or when the information must [or may] be used.… The absence of [these] regulations… opens up the possibility that many organizations may be complying with reporting and querying requirements without making optimal use of the data. We note that even the best system cannot improve quality and safety if it is not used."*

[471] Roberts, F., Davis, J., Meier, K.J. and Amirkhanyan, A. (2020). *Limiting Managerial Discretion in a New Public Management World: Nursing Homes and the National Background Check Program.* SSRN Electronic Journal. doi:https://doi.org/10.2139/ssrn.3604523.
[472] Dunlap, B., Basye, A. and Skillman, S. (2021). *Background Checks and the Health Workforce: Practices, Policies and Equity*. [online] UW Department of Family Medicine, pp.1–35. Available at: https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2021/11/Background-Checks-FR-2021.pdf.
[473] O'Connor, J., Dunlap, B., Gattman, N. and Skillman, S. (2020). *Washington's Behavioral Health Workforce: Barriers and Solutions Phase II Report and Recommendations*. [online] University of Washington Center for Health Workforce Studies, pp.1–53. Available at: https://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2020/11/Behavioral-Health-Workforce-Assessment-2020.pdf.
[474] Division of Occupational Licensing (n.d.). *What Crimes Affect my Path to Licensure?* [online] Utah Commerce Division of Professional Licensing. Available at: https://dopl.utah.gov/criminal-history-guidelines/what-crimes-affect-my-path-to-licensure/.
[475] Division of Occupational Licensing (n.d.). *Social Work Criminal History Guidelines*. [online] Utah Commerce Division of Occupational Licensing. Available at: https://dopl.utah.gov/social-work/criminal-history-guidelines/.
[476] Waters, T.M., Parsons, J., Warnecke, R., Almagor, O. and Budetti, P.P. (2003). How Useful is the Information Provided by the National Practitioner Data Bank? *The Joint Commission Journal on Quality and Safety*, 29(8), pp.416–424. doi:https://doi.org/10.1016/s1549-3741(03)29050-x.
[477] See pp. 2 of Waters, T. and Budetti, P. (2004). The National Practitioner Data Bank: Promoting Safety and Quality. *AMA Journal of Ethics*, 6(3). doi:https://doi.org/10.1001/virtualmentor.2004.6.3.pfor2-0403.

Authorizing Utah's state licensing agencies to query the NPDB database and to use this information in making licensure-related determinations would not impose an excessive burden, as only 19% of the Utah BH workforce reports holding a license in at least one other state.[478] Since most of Utah's BH professionals are not licensed in another state, the process of querying the NPDB to check disciplinary histories would likely not create an excessive burden on state regulators. Further, authorizing rather than requiring regulators to query the NPDB and to use this information in licensing-related decisions would enable the use of this data, without creating significant additional administrative burden.

Client Disclosures Can Promote Consumer Safety, Without Being Overly Burdensome

Client disclosures can promote consumer safety by enabling clients to make informed decisions about their care and treatment options, establishing appropriate professional boundaries between BH practitioners and their clients, and increasing the visibility of channels for reporting unprofessional or inappropriate behaviors that may arise in the course of care. Disclosures emphasize BH practitioners' commitment to adhering to legal and ethical standards, which builds confidence in the therapeutic relationship and the care provided.[479] By ensuring that clients are well-informed and empowered participants in their BH treatment, client disclosures contribute to a safer and more effective therapeutic experience, promoting better outcomes and reducing the potential for misunderstandings or harm.[480]

Effective client disclosures can be implemented without becoming overly burdensome to practitioners—both in terms of required content and in terms of communication channels. For instance, these disclosures may be required to include only the most essential information that clients need to know. State licensing agencies may even provide a template to be filled in and used by practitioners to further reduce the burden. These disclosures may be added to the existing set of forms provided to new clients (e.g., in print, via email, or through an online patient portal), or posted publicly in the practitioners' work setting, neither of which should add substantially to the administrative burden placed on providers.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- What additional safety checks will be required, when, and for which licensees?
- How will safety check policies be designed to avoid unnecessarily limiting access?
- What disclosures will be required, by whom, at what time, and in what format?

[478] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[479] Darby, W.C. and Weinstock, R. (2018). The limits of confidentiality: Informed consent and psychotherapy. *FOCUS*, [online] 16(4), pp.395–401. doi:https://doi.org/10.1176/appi.focus.20180020.
[480] Ibid.

What Additional Safety Checks Will Be Required, When, and for Which Licensees?

Type of Safety Checks. OPLR recommends that DOPL utilize the FBI Rap Back service to conduct safety checks. This strategy requires minimal administrative burden, as licensees only need to be fingerprinted once to ensure DOPL has access to up-to-date information on their criminal and disciplinary record. This would also likely entail only minimal additional costs to licensees. DOPL also could query the NPDB to cross-check individuals who were previously or currently licensed in another state. This process would help identify any past disciplinary actions associated with their license, ensuring that licensees moving from other states do not pose a risk to consumer safety. To determine the appropriate safety checks for licensees and/or applicants, additional analysis of each of these options may be needed to fully assess potential resource requirements and bottlenecks in the licensure process.

Impacted Licensees. OPLR recommends that DOPL enroll all incoming master's- and doctorate-level clinicians[481] in the FBI Rap Back service. DOPL may also want to consider requiring more comprehensive or frequent safety checks for those licensees with previous substantiated complaints within DOPL or for those with previous reports to the NPDB. Policymakers may wish to include an exemption for applicants who have already submitted a criminal background check (i.e., if they have been fingerprinted by DOPL in the past two years). Policymakers will also want to carefully consider whether to require existing clinicians to enroll in the FBI Rap Back program, for example, during the next renewal cycle.

Timing. Policymakers will need to determine whether safety checks will be required at initial licensure and at renewal periods. The frequency and type of safety checks could be established based on the license type. For instance, all BH clinicians could be required to undergo more comprehensive and frequent safety checks relative to those with extender licenses.

How Will Safety Checks be Designed to Avoid Unnecessarily Limiting Access?

Research has shown that mandating background checks may lead individuals to self-select and refrain from applying, thereby decreasing access. For example, when Delaware instituted compulsory background checks for health and human services applicants, the proportion of applicants denied due to disqualifying backgrounds decreased from 4-5% to 1% over several years.[482] This suggests that individuals with disqualifying backgrounds stopped applying for these positions. It should be clearly communicated that criminal backgrounds do not automatically disqualify individuals from licensure, to encourage well-qualified applicants with criminal backgrounds to still apply. DOPL will also need to ensure appropriate training for board members and staff reviewing licensee applicants to avoid bias toward those with criminal records. Studies have suggested any sort of criminal history may create potential stigma that

[481] Psychologist, certified psychology resident, LCSW, CSW, MFT, AMFT, CMHC, ACMHC.
[482] Dunlap, B., Basye, A. and Skillman, S. (2021). *Background Checks and the Health Workforce: Practices, Policies and Equity*. [online] UW Department of Family Medicine, pp.1–35. Available at: https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2021/11/Background-Checks-FR-2021.pdf.

might influence decisions regarding a person's eligibility for licensure.[483,484] Additionally, staff and board members reviewing licensee applicants and renewals should be informed that the Rap Back program may provide incomplete or inaccurate histories at times and applicants should be provided with opportunities to explain any issues before their licensure is impacted.[485,486]

What Disclosures Will Be Required, By Whom, At What Time, & In What Format?

Providers Required to Provide Client Disclosures. Policymakers will need to address which BH licensees will be required to provide licensing and safety-related disclosures to their clients. OPLR suggests that only clinical-level practitioners be required to provide disclosures rather than every worker in the BH system. If policymakers wish to restrict this list further, they could include an exemption for any practitioner working as an employee of a DHHS licensed facility. If policymakers wish to expand this list further, they might consider likewise requiring certain non-clinicians to provide disclosures (e.g., Social Service Workers, Advanced Substance Use Disorder Counselors, Behavior Analysts, Assistant Behavior Analysts, Master Therapeutic Recreation Specialist, Therapeutic Recreation Specialist, Vocational Rehabilitation Counselor, Music Therapists).

Information Included in Client Disclosures. Policymakers will need to specify what information BH providers will be required to include in client disclosure materials. As seen in Colorado and Vermont, OPLR recommends that required disclosures include 1) information about the BH practitioner's license (e.g., license type, license number, professional qualifications/degrees, how to verify their license status, whether they are practicing independently or under supervision, and if applicable their supervisor's name and contact information), 2) information about the clients' rights (e.g., right to receive a second opinion, right to terminate treatment, and right to confidentiality), and 3) information about when and how to file a complaint (e.g., standards for care, explanation of what is never appropriate, how to file a complaint). Lawmakers could require Utah BH providers to disclose all of this information, a portion of this information, or this information along with additional details such as documentation of continuing education hours, the nature of suggested treatments (e.g.,

[483] Alexander, D., Fields, J., Little, M., Williams, P., Bageant, R., Spencer, B., Montgomery, J., Finley, A., Burton, D., Barger, J., Erdman, R. and Svoboda, D. (1997). *Fingerprint-Based Background Checks: Implementation of the National Child Protection Act of 1993*. [online] United States General Accounting Office, pp.1–57. Available at: https://www.gao.gov/assets/ggd-97-32.pdf.
[484] Sugie, N.F., Zatz, N.D. and Augustine, D. (2019). Employer aversion to criminal records: An experimental study of mechanisms. *Criminology*, 58(1), pp.5–34. doi:https://doi.org/10.1111/1745-9125.12228
[485] National Employment Law Project. (2015). Faulty FBI Background Checks for Employment: Correcting FBI Records Is Key to Criminal Justice Reform. Retrieved from https://www.nelp.org/publication/faulty-fbi-background-checks-for-employment.
[486] Nelson, A. (2019). *Broken Records Redux: How Errors By Criminal Background Check Companies Continue to Harm Consumers Seeking Jobs and Housing*. [online] *National Consumer Law Center*, National Consumer Law Center, Inc. , pp.1–56. Available at: https://www.nclc.org/wp-content/uploads/2022/09/report-broken-records-redux.pdf.

methods, cost, duration), alternative treatment options, common safety issues,[487,488,489,490] and cultural considerations.

Timing of Client Disclosures. The timing of these mandatory disclosures to clients should aim to ensure safety without imposing undue burdens on BH providers. Disclosures could occur during the initial client contact, annually, at every visit, or at another appropriate interval.

Format of Client Disclosures. Policymakers will also need to consider what formats of client disclosure are acceptable. OPLR suggests providing substantial latitude in how this requirement may be met, to accommodate the varying circumstances of individual clinicians. For instance, this could take the form of a printed document for clients to sign. Another option would be to allow disclosures to be publicly posted online via an organization website, where clients are provided a link to the site rather than a form to sign. Disclosures could also be shared via online portals, email messages, or using secure messaging systems so that clients may refer back to them at their convenience. Further, publicly posted signage within a BH facility may be allowed to stand in place of disclosures to each individual client. Taken together, allowing a wide variety of implementation approaches should help to strike a balance between improving consumer awareness while avoiding unintended burdens on practitioners.

Additional Ideas

Utah policymakers may wish to consider alternative approaches instead of or in addition to expanding the proactive safety measures listed above.

- **Require all regulated BH care providers to immediately report changes in their criminal history/record** to their state licensing agency, not just to declare them during the initial license application or renewal process. This would mean requiring licensees to report any criminal arrest, charge, indictment, or conviction to their licensing agency (i.e., DOPL and/or DHHS) within 72 hours.
- **Authorize effective penalties against entities and/or licensees who fail to report** unprofessional conduct or egregious wrongdoing by BH licensees. By enforcing

[487] OPLR Analysis of DOPL Substantiated Complaint Data; Between 2018 and 2022, the most common categories of substantiated complaints against DOPL BH licensees were, in order of frequency, 1) ethical standards, 2) unauthorized practice, 3) other criminal conduct, 4) sexual misconduct, and 5) incompetence/negligence.
[488] Frueh, B.C., Knapp, R.G., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A., Cousins, V.C., Yim, E., Robins, C.S., Monnier, J. and Hiers, T.G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric services (Washington, D.C.)*, [online] 56(9), pp.1123–33. doi:https://doi.org/10.1176/appi.ps.56.9.1123 A variety of factors can put clients at higher risk for receiving unsafe care or becoming the victim of inappropriate or unlawful behavior. Clients with a previous history of serious mental illness or sexual trauma are at higher risk for experiencing or witnessing additional traumatic events in inpatient psychiatric settings.
[489] Martin, G.M. and Beaulieu, I. (2023). Sexual Misconduct: What Does a 20-Year Review of Cases in Quebec Reveal about the Characteristics of Professionals, Victims, and the Disciplinary Process? *Sexual Abuse*, 0(0), p.107906322311708. doi:https://doi.org/10.1177/10790632231170818. Further, clients who are females being treated by male providers, who are significantly younger than their providers, and/or who have a previous history of serious mental illness or sexual trauma are at higher risk for sexual victimization in a professional relationship with a BH provider.
[490] Reamer, F. (2003). Boundary Issues in Social Work: Managing Dual Relationships. *Social Work*, 48(1), pp.121–133. doi:https://doi.org/10.1093/sw/48.1.121

consequences for non-compliance, those with proximate knowledge and involvement in care who become aware of consumer harm would be incentivized to report these incidents. In this way, Utah may foster a stronger culture of responsibility and transparency among BH organizations and professionals, enhancing patient safety.

- **Create an education and enforcement fund for BH providers** to put funds collected through fines toward improving safety for consumers. Although it would take some time for funds to build up through administrative penalties or other means, once obtained, DOPL could use the funds for training and outreach—for example, through a dedicated suicide prevention course; meaningful continuing education classes; outreach on licensing, legislation, ethics, and enforcement; or an annual conference on these topics for licensees. Examples of some of the regulated professionals that already have these types of funds designated include nurses,[491] pharmacists,[492] and security personnel.[493]
- **Implement negative licensure for BH practitioners.** A negative licensure system would allow some BH practitioners (such as those practicing under supervision or whose scope only includes lower-risk tasks) to practice without applying for an initial license. Practitioners who engage in unprofessional or unlawful conduct would be prohibited from practicing and placed on a registry of individuals ineligible to practice. This approach could reduce barriers to entry, particularly for extenders, and increase access to care, while still retaining a mechanism for protecting consumers from negligent or bad actors.
- **Require BH practitioners to share additional information** (e.g., their professional qualifications, continuing education history) **upon request by a patient.** This right would be stated on the client disclosure. This could enable clients to make informed decisions about their BH practitioners and motivate practitioners to be vigilant in their training.

[491] UCA 58-31b-103. Nurse Practice Act, Nurse Education and Enforcement Account
[492] UCA 58-17b-505. Pharmacy Practice Act, Educational and Enforcement Fund
[493] UCA 58-63-103. Security Personnel Licensing Act, Use of Money for Education, Training, and Enforcement.

4a. Extenders

Summary of Recommendation

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.

Status Quo

Behavioral health (BH) workers who extend the reach and expertise of licensed clinicians and are often referred to as 'extenders.'[494] Extenders are most often educated at the undergraduate, associate, or certificate level, rather than at the graduate degree level (see Table 3.2). They typically provide care to patients while under the direct or general supervision of more advanced practitioners. Currently, Utah's BH workforce consists of only 27% extenders, versus 73% graduate-level practitioners (~5K extenders vs. ~13.6K graduate-level providers).[495]

Table 3.2 Current Utah 'Extender' Licenses

Training & Education	License Types	Notes
Bachelor's degree (4 year)	• Social Service Worker (SSW) • Assistant Behavior Analyst • Licensed or Certified Advanced Substance Use Disorder Counselor (A-SUDC) • Therapeutic Recreation Specialist • Music Therapist	In each case, students from any undergraduate major may earn the license, provided that they complete a certain set of required courses.
Associate's degree (2 year)	• Licensed SUDC • Certified SUDC	
Academic certificate (1 year)	*None*	Utah does not currently offer licensure or voluntary certification at the 1-year certificate level.

[494] Alternatively, these individuals may be called 'paraprofessionals' or 'sub-clinical' workers in some contexts. We prefer 'extenders' in part because—while they are not licensed clinical therapists—they are BH professionals fulfilling a variety of roles, which may include performing tasks in clinical settings.
[495] OPLR Licensing Census; This ratio includes all state licensed/certified BH workers under review in this report, but excludes unregulated and exempt segments of the workforce (e.g., psychiatric technicians, clergy).

Training certificate (0-11 months)	• Therapeutic Recreation Technician (TRT) • Certified Case Manager • Certified Peer Support Specialist • Certified Crisis Worker	TRT licensure requires 1) 90 hours of structured education under a master therapeutic recreation specialist or 2) six semester hours or nine quarter hours in recreational therapy from an accredited institution.[496,497] Case management, peer support, and crisis work certifications involve ~40 hours of training through DHHS.

Unregulated Extenders. BH facilities like residential treatment centers and other intensive inpatient settings may also hire clinical support staff (e.g., psychiatric technicians)[498] who are not required to hold a state license or to have prior formal training in BH.

Existing Approaches

Most states offer a variety of BH practitioner licenses and certifications at the certificate, associate, and undergraduate degree levels. For instance, nine states offer substance use-related certifications that require one year of experience and no degree, and 19 states provide these certifications to those with an associate degree. Additionally, about ten states have a certified criminal justice certification created for individuals with just a high school degree and supervised practice. Furthermore, several states provide an entry point for BH extenders to join the workforce after earning an associate degree. For example, in four states and one U.S. territory, individuals with an associate's degree can obtain a state social work credential, allowing them to work under supervision. Ohio, Texas, and West Virginia offer a prevention specialist certification for individuals holding an associate degree.

States also have many licenses and certifications for bachelor's-level BH professionals. Notably, 24 states have established a license or certification for advanced prevention specialists with any bachelor's degree and one or more years of supervisory experience. Wyoming also offers a "Certified Mental Health Worker" certification for individuals with a bachelor's degree in any human behavior discipline (e.g., psychology, sociology). Though they cannot diagnose or serve as primary treatment providers, this certification enables bachelor-level trained providers to apply human services or psychological theory to assess and treat psychosocial challenges. . Similarly, Oregon offers a "Registered Mental Health Associate" registration for individuals with a

[496] UCA 58-40-302.
[497] R156-40-302a.
[498] U.S. Bureau of Labor Statistics (2022). Employment of psychiatric technicians, by state, May 2022 [table]. In *Occupational Employment and Wages, May 2022 29-2053 Psychiatric Technicians*. [online] U.S. Bureau of Labor Statistics . Available at: https://www.bls.gov/oes/current/oes292053.htm#st. Approximately 1,500 psychiatric technicians are currently employed in Utah, earning a median wage of $17 per hour.

bachelor's degree related to BH. This registration allows these professionals to provide mental health assessment and treatment under the supervision of a more advanced provider.

Rationale

Why create new extender roles in licensure/certification?

- Expanding workforce entry options for extenders may improve both access and safety
- Leveraging DHHS certification programs may help to build the extender workforce
- Creating a one-year BH technician certificate may help to build the extender workforce
- Creating a generalist bachelor's-level license may help to build the extender workforce

Expanding Workforce Entry Options for Extenders May Improve Both Access and Safety

Utah lacks extenders in the BH care system. Compared to the medical field, where extenders account for approximately 2 out of every 3 licensed professionals in Utah, extenders only account for around 1 out of every 4 licensed professionals in BH.[499] To address even the lower bound of Utah's current unmet need for care (~210K individuals) would require at least an estimated 2,500 additional extenders.[500] But according to Division of Professional Licensing (DOPL) licensing data, while the graduate-level workforce has grown substantially over the past decade, the number of active extender licensees (those with training equivalent to a bachelor's degree or below) has declined by approximately 3%. The growing shortage of extenders in BH not only reduces access to services, but also harms patient safety by stretching the existing workforce thin, which may lead to provider burnout, turnover, and suboptimal client outcomes.[501]

Three likely drivers of this workforce shortage include 1) a misalignment between education, licensure, and workforce demands, 2) a lack of private insurance reimbursement for extenders in many settings, and 3) the prevailing history and legacy of intensive individual interventions (e.g., psychotherapy) by licensed clinical therapists. This recommendation is an attempt to address the first issue by better aligning licensure with education programming and workforce needs.[502] The other two factors (insurance reimbursement practices and delivery mechanisms for BH care) are critical but are beyond OPLR's mandate and the scope of this review. Building a simple, robust career ladder with educational pathways that are aligned with state licensure and certification can strengthen the BH workforce by 1) providing opportunities for individuals to enter the workforce without needing to pursue graduate-level degrees, 2) improving wages and

[499] OPLR Analysis of DOPL Licensing Data
[500] OPLR applied ideal staffing ratios from the IAPT therapy manual to fill the current ~210k gap in access. Forward projections would be higher to account for attrition and population growth.
[501] Substance Abuse and Mental Health Services Administration (2022). *Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies*. [online] Rockville, MD: National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration. Available at: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf.
[502] OPLR has been working closely with USHE/TRU on this recommendation.

advancement opportunities to attract and retain talent, and 3) supporting more efficient staffing models that make the best use of clinicians' and extenders' capabilities.

Additional opportunities for entry-level BH licensure and certification could attract more workers by enabling them to move up within the profession and earn higher wages without the need to invest in time-consuming, expensive degree programs. Wages for entry-level BH positions, such as psychiatric technicians, peer support specialists, and social service workers, are relatively low,[503] which likely contributes to the fact that the majority of the workforce (roughly 12,000 of a total of 20,000 licensees) are licensed clinical therapists, who earn starting annual salaries of ~$60,000 or more. It can be difficult for individuals to make the jump from entry-level positions to the master's-level positions that offer more sustainable earnings. For many individuals who are working full-time in low-wage, entry-level positions, earning an additional two-year master's degree (and a four-year bachelor's degree if they don't already have one) in order to move up the pay scale may feel unrealistic or unattainable; this may result in some becoming discouraged and leaving the field. The proposed entry-level certifications would serve as the basis for incremental advancement in scope and wages previously unavailable before the master's level. Utah employers have expressed that these advancement opportunities would likely improve retention, particularly in state agencies where staff turnover is often a concern.

An increased pool of extenders also allows for new staffing models that may play a key role in providing more care, more broadly across the state, at a lower cost to consumers and payers. One state administrator explained how the current licensing structures are not taking full advantage of the workforce's capabilities:[504]

> *"When talking about operating at the top of licensure, in the public system, [we are] really lacking in pathways to certification and licensure. So much of the work being done by licensed clinicians could be pushed down to other professionals."*

Intermountain Health has been piloting a digital clinical program for those with mild to moderate mental health needs. After a licensed therapist assesses and develops a treatment plan for the client, the actual intervention is primarily provided by an extender, with clear guardrails to indicate when issues should be elevated to the therapist. Such models allow therapists to oversee the treatment of many more patients, and in theory may extend access at lower cost with equivalent or improved patient outcomes. Utah employers have already identified some of the functions these extenders could take on, as described by an administrator at a large mental health provider: "I'd do something [at the associate's level]...supervised by a fully licensed SSW. They [would be] doing behavioral services, coaching, mentoring, groups."

These new models of care can also improve access by allowing clinical therapists (who are perpetually in short supply) to spend more time operating at the top of their license: diagnosing, drafting treatment plans, and providing clinical therapy. Multiple Utah BH employers commented

[503] The BLS Occupational Outlook Handbook reports a median annual salary of $36,000 for psychiatric technicians.
[504] OPLR Listening & Vetting Tour

to OPLR that they see clinical therapists hired in situations, such as in educational settings, where an extender with a bachelor's degree could more than likely effectively do the job:

> *"Could you create a 'case manager' type certification [for educators]? …You need a universal person who can* handle *the behavior problems versus the suicide risks and [self-harm]—serious [issues that require a clinician]."*

Leveraging DHHS Certification Programs May Help to Build the Extender Workforce

The Utah Department of Health and Human Services (DHHS) offers certifications for peer support specialists, family peer support specialists, certified crisis workers, and certified case managers. Each of the DHSS certifications requires 40 hours of training. As of 2021, there were ~600 peer support specialists, ~50 family peer support specialists, ~350 crisis workers, and ~1050 case managers certified in Utah—for a total of approximately ~2050 extenders in the workforce who have DHHS certifications.[505] In 2022, these figures have increased by approximately 18%, to a total of ~2400. Although these extenders provide important services to consumers,[506,507,508,509,510] access to some of the training programs is limited. DHHS personnel report that some of these programs have long waitlists, indicating that demand for slots in DHHS certification training programs is outpacing supply. Further, conversations with industry stakeholders suggest that employers are eager to hire more individuals with these certifications. Expanding the capacity of these training programs could benefit consumers by increasing the availability of training for those wishing to complete these certifications, thereby expanding the talent pool from which employers may hire, and further improving access to care. Likewise, promoting these trainings more broadly, particularly those that are already available online in self-directed study formats, may help to build system capacity through the extender workforce.

Peer Support Specialist. Peer support specialists are individuals who use their lived experience recovering from mental illness or substance use disorder to deliver services that

[505] Correspondence with DHHS personnel.
[506] Videka, Neale, Page, Buche, Beck, Wayment, & Gaiser, (2019). National analysis of peer support providers: Practice settings, requirements, roles, and reimbursement. *Behavioral Health Workforce*. https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf
[507] Pfeiffer, King, Ilgen, Ganoczy, Clive, Garlick, Abraham, Kim, Vega, Ahmedani, & Valenstein, (2019). Development and pilot study of a suicide prevention intervention delivered by peer support specialists. *Psychological services*, *16*(3), p.360. https://psycnet.apa.org/manuscript/2018-54490-001.pdf
[508] Tahan, Kurland, & Baker, (2020). Understanding the Increasing role and value of the professional case manager: A national study from the Commission for Case Manager Certification: Part 1. *Professional Case Management*, *25*(3), pp.133-165. https://nursing.ceconnection.com/ovidfiles/01269241-202005000-00004.pdf
[509] Gaiser, M.G., Buche, J.L., Wayment, C.C., Schoebel, V., Smith, J.E., Chapman, S.A. and Beck, A.J., (2021). A systematic review of the roles and contributions of peer providers in the behavioral health workforce. *American journal of preventive medicine*, *61*(4), pp.e203-e210. https://doi.org/10.1016/j.amepre.2021.03.025
[510] Gidugu, V., Rogers, E.S., Harrington, S., Maru, M., Johnson, G., Cohee, J. and Hinkel, J., (2015). Individual peer support: A qualitative study of mechanisms of its effectiveness. *Community mental health journal*, *51*, pp.445-452. https://link.springer.com/article/10.1007/s10597-014-9801-0

promote recovery and resiliency.[511] They are widely accepted as being effective in helping individuals who struggle with mental health and/or substance use disorders.[512] DHHS certified peer support specialist training is offered in in-person, hybrid and remote formats. There are currently 6 different programs that provide this training, including 1 specifically for veterans, and 2 for Spanish speakers.[513] Currently, the only fully-remote training is offered in Spanish.[514] Input from peer support specialists interviewed by OPLR reveals that there is high demand for this certification, but that long waiting lists create a barrier to adding more peer support specialists to Utah's BH extender workforce.[515] In the past two years, an average of ~235 individuals have become certified as peer support specialists in Utah. DHHS reports that the current waitlist for certified peer support training exceeds 200 individuals. In other words, if DHHS increased its training capacity, they could theoretically bring twice as many certified peer support specialists into the workforce in the next year.[516] Thus, it may be helpful to increase the frequency of these trainings or to increase the total number of available seats in each training.

Certified Crisis Worker. A certified crisis worker is an individual who typically staffs a statewide mental or local mental health crisis line, statewide warm line, mobile crisis outreach team, or receiving center under the supervision of a mental health therapist. Training to become a certified crisis worker is typically offered once a month by DHHS, as well as in semester-long courses both at the University of Utah and Weber State University. Certified crisis worker training currently requires 16 hours of live virtual training, 8 hours of job shadowing, and 16 hours of self-paced asynchronous training.[517] DHHS administrators report that interest in certified crisis worker training is increasing, as other employers and agencies (e.g., recovery centers, police departments, other health and human services facilities and programs) become aware of its benefits, with the most recent monthly training filled to capacity with 40 trainees.

Certified Case Manager. Certified case managers help individuals to access needed medical and BH care services, housing, educational, and social services. Utah offers three types of case management certifications for those wishing to specialize in serving adults, youth (ages 18-30), and people experiencing homelessness. Discussions with DHHS officials suggest that there is a serious shortage of certified case managers in Utah's social service workforce.[518] Due to this shortage, case managers handle 50 to 100 cases at one time, which is often overwhelming and leads to practitioner burnout, further decreasing the number of available certified case managers in Utah's workforce. To help address this issue, DHHS now offers a self-directed training rather than a scheduled course.

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[511] Utah Department of Health and Human Services (n.d.). *Certified Peer Support Specialist*. [online] Utah.gov. Available at: https://sumh.utah.gov/education/certification/peer-support. CPSS can also work on crisis help lines.
[512] OPLR Listening & Vetting Tour
[513] Utah Department of Health and Human Services (n.d.). *Certified Peer Support Specialist*. [online] Utah.gov. Available at: https://sumh.utah.gov/education/certification/peer-support.
[514] Ibid.
[515] OPLR Listening & Vetting Tour. Full quote: "I echo what everyone said but as a CPSS i think that there could be a pre-application process to educate peers on the different types of peer support…Also, a rigorous application process would be great. Currently, there's a huge waiting list."
[516] Correspondence with DHHS Office of Substance Use and Mental Health Personnel
[517] Correspondence with DHHS Personnel
[518] OPLR Listening & Vetting Tour

Creating a 1-Year BH Technician Certificate May Help to Build the Extender Workforce

A voluntary, entry-level state certification (as a "behavioral health technician") that corresponds to a one-year educational certificate in BH can lower barriers to employment by subdividing educational requirements for licensure into more achievable pieces (the licensing equivalent of 'micro-credentialing' in education). This new educational and licensing pathway will enable individuals to enter the BH workforce who have an interest in working in the field, but who are not currently interested in or able to pursue a full associate's or bachelor's degree.

The voluntary nature of the BH technician certification is important—by making the certification voluntary, these extenders' supervised, lower-risk scopes of practice will not be made exclusive or protected, and employers will still have flexibility to hire non-certified employees if they desire. For instance, an individual could still enter the field as a psychiatric technician with no formal training or state credential, but would have a clearer, more accessible pathway to advancement in the field, which employers have indicated would aid in hiring and retention.

The development of this one-year educational certificate program, spearheaded by Talent Ready Utah (TRU), is already underway in Utah. In July of 2023, TRU transmitted to all sixteen public institutions of higher education in the state a request for proposal (RFP) to receive ongoing funding for a one-year, stand-alone, skills-based certificate in BH.[519] This RFP was the result of TRU's extensive conversations with employers in the industry and research on similar certificate programs across the country. These efforts confirmed the need in Utah for an accessible, affordable way to bridge the gap between the one-week DHHS certifications and the bachelor's- and master's-level licenses.

Administrators from major Utah BH employers and state agencies have expressed support for the creation of a BH technician credential, and explained how it would help them to attract and retain the extender workforce by providing advancement opportunities and increased wages:[520]

> *"When an individual comes in at a lower level (like case manager, crisis worker, peer), advancement within the company seems really limited to them. If they had something to shoot for in between that gap it would be beneficial."*

[519] Utah System of Higher Education (n.d.). *Behavioral Health Workforce Initiative Grant Request for Proposals*. [online] Utah System of Higher Education. Available at: https://talentready.ushe.edu/wp-content/uploads/2023/07/Behavioral-Health-Initiative-RFP.pdf
[520] OPLR Listening & Vetting Tour

> *"I like anything that helps people move up–we can do that on the pay scale. We have a significant gap in pay between someone doing case management without an SSW, and those who have [the bachelor's-level SSW] license. It's a pretty big gap…. I think this would help us to have different levels of pay."*

By bringing professional advancement and better pay within reach for the entry-level BH workforce, Utah can retain workers who, despite their interest in the field, may end up leaving due to financial pressures, as explained by a state administrator:

> *"People have interest (but not the education) who want to work in the field; if they can get started as a CPSS (Certified Peer Support Specialist), they can go to school and get more training, that's common; but now, [they] are paid so poorly that it's not a livable wage and they go to other fields. If we can attract more to those entry-level professions, there are opportunities for them."*

Further, by creating a BH technician certification, the state may also better enable employers to bill Medicaid for services provided by these extenders. In discussions with state Medicaid administrators, OPLR found that state certification for extenders could trigger Medicaid reimbursement for several related billing codes (none of which are currently available to a psychiatric technician without a state certification). However, this possibility is not a central reason for creating new certifications—reimbursement for extenders may not be a primary concern for most employers, as many extenders are deployed in 'bundled payment' settings[521] and their individual reimbursement rates do not impact the provider's overall reimbursement for a patient's care.

Finally, the introduction of BH technicians may also result in increased safety and improved patient outcomes. Relative to a psychiatric technician with no formal training, and based on the proposed learning outcomes for the one-year academic certificate programs, OPLR expects that BH technicians would yield fewer safety issues than those trained purely on the job as psychiatric technicians.

Creating a Generalist Bachelor's-Level License May Help to Build the Extender Workforce

An efficient way to quickly grow the BH workforce is to tap into the existing talent pipeline of undergraduate students with a demonstrated interest. Each year, over 2,000 undergraduate students earn degrees in social work, psychology, sociology, and human development and

[521] HealthCare.gov. (n.d.). *Payment bundling - Glossary*. [online] Available at: https://www.healthcare.gov/glossary/payment-bundling/#:~:text=A%20payment%20structure%20in%20which. Payment bundling" is a payment structure in which a team of different healthcare providers who are treating a patient for the same or related conditions are paid an overall sum for taking care of the condition, rather than being paid for each individual treatment, test, or procedure.

family studies from public USHE institutions.[522] Of those, only the 300 Bachelor of Social Work students who graduate each year have a direct path to BH licensure based on their coursework and experience, and DOPL has issued only about 100 SSW licenses each year since 2018.[523]

While the current SSW license does allow for an alternative pathway for non-social work majors who complete three related courses and 2,000 hours of experience, this alternative pathway is not a natural fit for licensing graduates from other BH-related majors who would like to practice as generalists, because much of the education and scope of practice is framed in terms of Social Work theory. One state administrator with responsibility for BH care delivery explained how aligning licensure with more educational pathways would benefit both new graduates and the BH system:[524]

> *"Psychology and sociology are some of the most popular undergraduate degrees, but there are no viable career pathways; if we can make bachelor's-level pathways viable for people right out of college, we can retain so much more talent. Focusing on lower-level professions and making them viable career paths makes a ton of sense."*

By creating paths to licensure for those with other related bachelor's degrees, Utah can greatly expand the pool of potential entry-level licensees, which could result in a tangible increase in the number of bachelor's-level licenses issued each year.[525] Currently, Utah issues approximately ~280 bachelor's-level licenses each year. If even 10% of the ~2000 annual USHE graduates in related majors (e.g., psychology, sociology, human development) became licensed, this would represent a 71% increase in bachelor's-level licensing volume. By creating certificate paths embedded in or otherwise available for students in related undergraduate majors, Utah's public institutions of higher education may be able to provide this latent workforce a pathway to licensure and employment with no significant added burdens to students in terms of additional coursework, tuition, or time.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- Which DHHS certification programs will be expanded, how, and by how much?
- How will the new BH technician certification be structured & implemented?
- How will the new bachelor's-level generalist license be structured & implemented?

[522] Utah System of Higher Education. (2022). *Institutional Data Resources: Degrees, Awards*. [online] Available at: https://ushe.edu/institutional-data-resources-degrees-awards/.
[523] OPLR Analysis of DOPL Licensing Data
[524] OPLR Listening & Vetting Tour
[525] Utah System of Higher Education (n.d.). *Institutional Data Resources: Degrees, Awards*. [online] Utah System of Higher Education. Available at: https://ushe.edu/institutional-data-resources-degrees-awards/.

Which DHHS Certification Programs Will Be Expanded, How, and by How much?

In expanding the capacity of DHHS certification training programs, policymakers may need to consider which of these trainings to prioritize and how much additional capacity to add. OPLR recommends prioritizing peer support specialist training. The Multicultural Counseling Center in Utah is an authorized DHHS certification training provider that runs a remote live/synchronous peer support specialist training after typical working hours, for Spanish speakers. However, there is currently no fully-remote training option in English. Considering that many peer support training sessions are offered only in-person, during normal working hours, it may be difficult for some interested parties to attend. Providing a remote option that is available after working hours may help to make this training available to even more potential members of the BH care workforce. Further, offering additional training in this format may be more cost effective than adding more in-person trainings. Still, multiple efforts to increase the availability of this training may be helpful to grow the overall number of certified peer support specialists in the workforce. Likewise, in addition to expanding the capacity of existing, in-person training programs, it may also be helpful to consider how training for certified case managers, certified crisis workers, and family peer support specialists may also be provided after working hours in a variety of locations, as a self-directed study course, and even potentially through a fully-remote training option. Along similar lines, for those trainings that are already available in more flexible formats, policymakers may wish to consider investing additional resources into promotion and awareness-building, to expand their reach and availability to interested applicants.

How Will the New BH Technician Certification Be Structured and Implemented?

Typically, an occupational 'license' grants both a protected title (e.g, 'Psychologist') and an exclusive scope of practice (meaning those who perform specific functions cannot do so without a license). Certification is more often a protection of title, but without an exclusive scope of practice, meaning that others may perform the same functions without breaking state law.

OPLR's strong preference would be to create a voluntary certification ('BH Technician') as the least restrictive means of achieving the objective of attracting and retaining more BH workers. A voluntary certification would allow employers to hire non-licensed workers (like Psych Techs) as they currently do, while still providing the benefits of state recognition (e.g., Medicaid reimbursement, alignment with the emerging one-year academic pathway). A voluntary certification thus benefits employers (through reimbursement, access to well-trained candidates) without imposing restriction or burden through a license which could restrict the workforce.

TRU is already proceeding with the one-year BH Technician program, planning to stand up programs at 3-5 campuses for a January 2024 start date. Depending on the demand for the program (and its graduates), legislators may want to reassess funding levels and adjust over time.

How Will the New Bachelor's-Level BH Generalist License Be Structured and Implemented?

OPLR's recommendation is to create an accessible, generalist BH professional license that will allow those from a range of related areas of study to enter the BH workforce. This new license should 1) allow the broadest possible set of educational pathways, and 2) allow the broadest possible scope of practice short of diagnosis, treatment planning (i.e., to establish medical necessity and to trigger reimbursement for clinical-level services), and psychotherapy.

Option 1 (Recommended): Stand-Alone Generalist License. OPLR recommends that a new bachelor's-level, generalist BH license be created and piloted. This license would be created in addition to existing bachelor's-level licenses in specialized areas such as social work, behavior analysis, and recreational therapy. The pilot program approach would enable the state to evaluate employers' and students' interest in and adoption of this new credential. This new generalist license would be designed to facilitate licensure for individuals with bachelor's degrees in multiple relevant areas such as psychology, human development, human services, sociology, and other related majors. Required coursework would include skills-based training similar to that required of the BH technician, with the addition of more advanced coursework, for example in crisis intervention, suicide prevention, and substance use disorders. OPLR's early conversations with USHE indicate their intention to explore creating a skills-based 'embedded' or 'enhancing' certificate in clinical or applied BH, which would be available to a broad range of undergraduate majors. The development of the precise educational courses and arrangements are best left to USHE and those with specific clinical and academic expertise.[526] This license would authorize a scope of practice similar to the current SSW scope, but without an emphasis on social work theory and practice. Similar to other licenses, minimum educational and experiential requirements could be established in statute, with additional detail in rule for ease of change given the breadth and constant evolution of BH education and practice.

Option 2 (Alternative): Combined Generalist License. Alternatively, multiple existing bachelor's-level licenses could be subsumed into the new generalist license. In this scenario, the traditional pathways to licenses such as the SSW or A-SUDC would be established as acceptable educational pathways to the new generalist license.

Option 3 (Alternative): Expanded pathways to SSW and/or SUDC licensure. The standard educational pathways to the SSW and/or SUDC licenses could be expanded to accept bachelor's degrees from other fields related to BH, with the addition of an emphasis or embedded certificate in applied skills as discussed in Option 1.

[526] OPLR Listening & Vetting Tour

Additional Ideas

Utah policymakers may wish to consider alternative approaches instead of or in addition to the above recommendation.

- **Remove constraints on work settings for DHHS certifications.** According to current administrative rules, only those who work at a statewide mental health crisis line or local mental health crisis line under the supervision of a mental health therapist may become certified crisis workers.[527] In addition, only those currently employed or subcontracted by DHHS, a local mental health authority, a local substance authority, a DHHS-licensed homeless shelter, or a targeted homeless program contracted by the Department of Workforce Services are eligible to become certified case managers.[528] Removing regulatory limitations on workplace settings for certified crisis workers and case managers may provide additional flexibility for those wishing to obtain these certifications, and for employers wishing to hire them and to bill payers for their services.
- Another way to potentially build the BH extender workforce in Utah is to **allow lower-level credentials to stack toward higher-level licenses and certifications.** This change may make career advancement more feasible for those unable to take extended breaks from the workforce to pursue traditional degree programs as full-time students. For example, an individual who becomes a certified case manager, crisis worker, or peer support specialist may become eligible for the 1-year BH technician certification after accruing a certain amount of work experience and/or by earning multiple DHHS certifications. This same BH technician could then go on to complete additional education (e.g., an associate's degree) and to complete a sufficient number of years of supervised work experience to become eligible for the bachelor's-level BH generalist license, without completing a four-year degree.
- **Create foreign-credentialing apprenticeship pathways** to promote international portability. Foreign-trained professionals may also be integrated into the BH extender workforce with the creation of apprenticeship positions or programs. These programs may enable individuals to translate their experience into a DHHS certification, the 1-year BH technician certification, or the bachelor's-level generalist licenses described above, or even help to provide a stepping stone to higher-level licenses.

[527] R523-17-4 - Behavioral Health Crisis Response Systems Standards, Definitions.
[528] R523-7-4(6)(c) - Certified Case Manager Certification; targeted homeless programs include public or private not-for-profit organizations, faith-based organizations, state departments and agencies, units of local governments and Indian tribal governments who provide services to children, individuals, and/or families who are experiencing homelessness or at risk of experiencing homelessness.

4b. Master Addiction Counselors

Summary of Recommendation

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.[529]

Status Quo

Currently, Utah does not offer a master's-level license for addiction counselors. The only state licenses and certifications offered in addiction counseling are at the bachelor's level and below (e.g., Substance Use Disorder Counselor [SUDC], Advanced Substance Use Disorder Counselor [A-SUDC]). SUDCs and A-SUDCs are not authorized to diagnose behavioral health (BH) conditions including substance use disorders, to create treatment plans, or to engage in mental health therapy. Additionally, they must work as an employee under the general or direct supervision of a licensed mental health therapist. In other words, they are not granted independent practice authority.

Existing Approaches

Unlike Utah, 41 states provide at least one type of master's-level certification or license specific to addiction counseling.[530] Across jurisdictions, there are two dominant approaches related to the scope of practice given to Master Addiction Counselors (MACs). The first is more limited, with the ability to independently diagnose and treat only substance use disorders.[531] The second is more expansive, with the ability to diagnose and treat any BH disorder.[532]

Similar to the requirements for other clinical therapists, the vast majority of the nation's MAC licenses and certifications are granted only after applicants: 1) earn a relevant master's degree from an accredited university, 2) pass a qualifying exam, and 3) complete postgraduate supervised experience hours. Most states only require that an applicant's master's degree be in

[529] OPLR's recommendation is for a full, independent clinical mental health therapist able to diagnose and treat across SUD and also mental health disorders. This recommendation is *not* for a 'SUD-only' clinician.
[530] Across these states, 56 total graduate-level licenses or certifications are offered in addiction counseling. There are also 22 graduate level licenses in licensed professional counseling that specify addiction or substance use in their scope and/or qualifications, 20 of which exist in a state with an existing graduate level addictions counseling credential. None of these licenses require passing an addiction counseling specific exam.
[531] Most master's-level addiction counselors are allowed to independently practice substance use disorder counseling. This includes assessment, treatment planning, and counseling services (individual, group, or family) related to substance use. Diagnosis and psychotherapy privileges are generally limited to the treatment of substance use disorders, and in some states, co-occurring mental health disorders only if SUD is present. Some states' scopes of practice are vaguely defined, making it difficult to determine if their graduate-level addiction counselors have either full or limited diagnostic privileges.
[532] For example, Maryland and Colorado explicitly allow MACs full diagnosing privileges, giving them a similar clinical scope to mental health therapists in Utah (e.g., licensed clinical social workers, marriage and family therapists, and clinical mental health counselors).

a behavioral-health related field,[533] the most commonly required qualifying exams are administered by either the International Certification & Reciprocity Consortium (IC&RC), the National Certification Commission for Addiction Professionals (NCC AP), or by the National Board of Certified Counselors (NBCC), and a plurality of states require 2,000 postgraduate supervision hours.[534] While the professional titles associated with these licenses and certifications vary widely,[535] the most common designation is Master Addiction Counselor.

Rationale

Why create a new Master Addiction Counselor license?

- Utahns lack sufficient access to substance use disorder treatment services
- A MAC license may help to address the clinician shortage & associated bottlenecks
- A MAC license may help to improve access by providing a pathway for existing MACs
- A MAC license may help to improve access by enabling SUDCs' advancement
- Utah's BH system can benefit from clinicians with SUD treatment specialization

Utahns Lack Sufficient Access to Substance Use Disorder Treatment Services

Substance use disorders (SUDs) of all types, including both alcohol and drug use disorders, affect hundreds of thousands of Utahns each year—in 2021, nearly 385,000 Utahns aged 12+ suffered from a (SUD), including an estimated 302,000 adults and children who needed but did not receive treatment at a specialty facility for substance use.[536] Since 2002, drug overdose deaths have been the leading cause of injury deaths in Utah; of these deaths, the proportion attributable to methamphetamine and fentanyl overdoses have been steadily increasing for more than a decade.[537,538] Untreated SUDs place increased demand on the physical healthcare system. Between January 2018 and June 2021, Utah recorded 13,000

[533] Some states specify additional coursework and training related to substance use disorders.
[534] Required hours range from 0 to 10,000, with an average of 2,860. Most states do not specify direct client contact hour requirements and only about half specify direct supervision hour requirements. For direct clinical supervision hours, the most common requirement is 100 hours, with an average of around 80 hours required.
[535] Common nomenclature for these licenses and certifications include, but are not limited to, the following designations: addiction counselors, alcohol drug counselors, alcoholism and substance abuse counselors, and substance use disorder counselors.
[536] National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia). (2021). [online] Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt39466/2021NSDUHsaeTotals121522/2021NSDUHsaeTotals121522.pdf. Specialty facilities include: drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center.
[537] Utah Department of Health, Utah Department of Human Services Substance Abuse and Mental Health, Utah Department of Public Safety, Utah Poison Control Center and Department of Public Safety Statewide Information & Analysis Center (2021). *Utah Drug Monitoring Initiative Annual Report Analysis of the impact related to illicit drug use in Utah – 2020/2021*. [online] Available at: https://poisoncontrol.utah.edu/sites/g/files/zrelqx281/files/media/documents/2021/DMI_Annual_Report.pdf
In the same time, heroin and prescription opioid overdose deaths did decrease, and the two forces largely cancel each other out to result in little increase or decrease in deaths.
[538] It should be noted that the most recent year reported is 2020, which means that there are unreported changes regarding the most recent few years.

methamphetamine-related emergency department and hospital encounters, 34% of which involved patients experiencing drug-induced or drug-associated psychosis. The Health Resources & Service Administration anticipates that by 2030, the demand for addictions counselors will outpace the supply of these professionals, projecting a 15% increase in demand for addictions counselors and only 3% growth in the actual workforce.[539,540] This disequilibrium has affected Utah BH clinicians and clients—one clinician explained that their treatment facility is turning away ten to fifteen people seeking treatment every week due to a lack of BH clinicians proficient in SUD.[541]

A MAC License May Help To Address the Clinician Shortage & Associated Bottlenecks

One key to addressing the lack of access to SUD treatment is easing the clinician shortage. Utah's clinician workforce, which currently includes approximately 12,000 workers, would need to grow by 35% just to meet the lower bound of today's unmet need for BH care. In other words, Utah needs thousands more BH clinicians. The effects of this shortage are seen in both 1) long wait times for SUD treatment and 2) a supervision bottleneck that limits the reach of Utah's nonclinical extender workforce.[542]

According to the Office of Professional Licensure Review (OPLR's) survey data, average wait times for clinicians offering SUD treatment in Utah are around 24 days for inpatient services and about 54 days for outpatient services,[543] significantly greater than the proposed federal guideline of 10 calendar days for BH outpatient wait times. Long wait times can have particularly negative effects on individuals suffering from SUD, including reducing their likelihood of completing treatment and of being able to secure future employment, and increasing their risk of being charged with a crime both before and after treatment.[544]

This clinician shortage has also resulted in a supervision bottleneck, which itself is also likely to contribute to extended wait times. Currently, there are not enough mental health therapists to oversee the practice of bachelor's-level professionals (primarily SUDCs) who constitute a substantial portion of the SUD treatment workforce. Even though many nonclinical tasks can be delegated to SUDCs, facilities' capacity to provide a full range of clinical services, including diagnosis and psychotherapy, is ultimately limited by the number of available clinicians. The number of SUDCs that facilities hire may also be limited by the need to maintain appropriate supervisor-extender staffing ratios. In short, no matter how many SUDCs or other extenders are

[539] Bureau of Health Workforce. (n.d.). *Behavioral Health Workforce Projections* . [online] Available at: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health.
[540] OPLR Analysis of DOPL Licensing Data (2013-2023); Utah's own licensing statistics support these projections of slow growth in the field—over the past ten years, the number of SUDCs licensed in the state has remained virtually unchanged, while the number of other behavioral health licensees, such as LCSWs, MFTs, and CMHCs have as much as doubled over the same time period.
[541] OPLR Listening & Vetting Tour
[542] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[543] Ibid.
[544] Williams, J. and Bretteville-Jensen, A.L. (2022). What's Another Day? The Effects of Wait Time for Substance Abuse Treatment on Health-Care Utilization, Employment and Crime. *SSRN Electronic Journal*. doi:https://doi.org/10.2139/ssrn.4114629

available, facilities' use of them is bottlenecked by the lack of supervisors, and Utah needs more clinicians overseeing non-clinical addiction counselors.[545]

A MAC license with a full clinical scope would open up avenues for BH professionals who specialize in addiction to join the workforce at a clinical level, thereby increasing the number of clinicians available to provide both direct client services as well as oversight for extenders. A partial-scope, non-clinical MAC would fail to address the pressing clinician shortage in Utah, and could in fact worsen the supervision bottleneck issue. Therefore, it is important that Utah's new MAC license provides licensees with a clinical-level scope of practice, similar to what is granted to other mental health therapists in the state. This full scope would include the treatment or prevention of mental illnesses recognized in the DSM-V, including evaluation, diagnosis, treatment planning, and psychotherapy.[546] Similar to Clinical Mental Health Counselors (CMHCs), Licensed Clinical Social Workers (LCSWs), and Marriage and Family Therapists (MFTs), MACs would be able to diagnose and treat both SUDs and mental health disorders, as well as supervise and oversee non-clinicians. Importantly, a new MAC license would not prohibit licensed clinical mental health therapists or other currently authorized providers from practicing within their existing scopes of practice, including for example the diagnosis and treatment of SUDs. Division of Professional Licensing (DOPL) administrators and industry stakeholders have expressed support for the creation of a new MAC license with a full clinical scope of practice.[547]

A MAC License May Improve Access By Providing a Pathway for Existing MACs

With a new MAC license, the state would add another tool with which to strengthen the BH workforce and address the unmet need for SUD treatment. Creating a new MAC license will not be sufficient to close all of the state's gaps in access, but it will eliminate an unnecessary barrier that currently limits competent addiction counselors' ability to serve Utahns. To work here, addiction counselors practicing at the graduate level in other states must either voluntarily demote themselves (to A-SUDC) and work far below their competency and previous compensation, or pursue another master's degree to obtain licensure as an LCSW, MFT, or CMHC. Improving licensure portability has positive effects on the efficiency of labor markets, and so may enable out-of-state talent to practice at their highest level of competency in Utah.[548] This is relevant not only for those who choose to relocate here, but also for those who provide services through telehealth.

OPLR's research indicates an existing cohort of potential licensees (both in and out of state) based on existing educational programs in neighboring states. One industry leader stated that they personally know several dozen practitioners who would immediately apply for licensure if such a pathway were made available, and that their professional network would work to recruit clinicians from the existing graduate programs in neighboring states such as Arizona, Colorado,

[545] OPLR Listening & Vetting Tour
[546] UCA 58-60-102
[547] OPLR Listening & Vetting Tour
[548] Johnson, J.E. and Kleiner, M.M. (2020). Is Occupational Licensing a Barrier to Interstate Migration? *American Economic Journal: Economic Policy*, [online] 12(3), pp.347–373. doi:https://doi.org/10.1257/pol.20170704

Nevada, and Idaho.[549] Educational institutions such as the University of Nevada Las Vegas (UNLV), Arizona State University (ASU), University of Denver (DU), and Grand Canyon University (GCU) all offer graduate degrees in addiction counseling, with ASU and GCU providing online programs that Utahns could enroll in.[550] Utah Valley University is in the process of creating an emphasis in addiction counseling, to be offered to students of its Social Work and Marriage and Family Therapy graduate programs.[551] In summary, educational pathways already exist and some practitioners have already completed them, but without a license to recognize these credentials, those who earn them may be less likely to live and work in Utah.

A MAC License May Improve Access By Enabling SUDCs' Advancement

SUDCs are non-clinicians who form an essential part of the SUD treatment workforce, especially considering the severe unmet need for this treatment. SUDCs provide front-line care to those struggling with SUDs by conducting intake assessments, treatment planning, compliance monitoring, individual and group counseling, case management, and crisis intervention services. However, SUDCs make up only a small part of the BH workforce in Utah (only ~450 total professionals hold this designation, of a workforce of roughly 18.6K). Further, the number of SUDCs has stagnated over the past ten years, in direct contrast to other segments of the BH care workforce, which have increased significantly year after year.[552]

The lack of clear advancement pathways and opportunities for professional growth for Utah's SUDCs may discourage individuals from entering this field of practice and may even push current SUDCs out of the field, thereby contributing to overall stagnation within this subspeciality of the BH workforce. Utah SUDCs have expressed their desire to pursue ongoing education specific to addiction counseling, but there is no clinical license that currently recognizes an advanced degree in this subspecialty.[553] Once SUDCs advance to the top of their scope, they are constrained to non-clinical practice and are unable to achieve greater compensation, damaging the practicality of pursuing a long-term career in this field. One industry leader noted that experience as a SUDC often serves as a stepping stone to a different degree,[554] with current regulation potentially incentivizing some of these counselors to leave the addiction counseling subspecialty or to exit the BH field entirely. Establishing a MAC license could help counter this trend by creating a path towards clinical-level work specifically designed around the professional experience and education in addiction counseling SUDCs have and want to attain.

[549] OPLR Listening & Vetting Tour
[550] UNLV and University of Denver include emphases for addictions counseling within a clinical counseling degree, whereas GCU and ASU have specific Master's degrees for addiction counseling.
[551] Markisich, C., Nance, R. and Association of Utah Substance Abuse Professionals (2023). Application for Sunrise Review. *Association of Utah Substance Abuse Professionals.* Sunrise review application for a master's-level substance use disorder counselor license, submitted to the Utah Office of Professional Licensure Review.
[552] OPLR Analysis of DOPL Licensing Data (2013-2023)
[553] OPLR Listening & Vetting Tour
[554] Ibid.

Utah's BH System Can Benefit from Clinicians with SUD Treatment Specialization

Mental illness and SUDs often co-occur; one study estimated that 18 percent of those with a reported mental illness also struggle with a SUD while 38 percent of those struggling with a SUD also suffer from mental illness.[555] Due to the complex interactions between these two types of conditions, "current treatment guidelines recommend that people with co-occurring disorders receive treatments for both disorders."[556,557,558] To adequately treat those with co-occurring disorders requires that BH professionals be trained in this complexity, acquiring specific education and experience in the diagnosis and treatment of co-occurring SUDs and mental illnesses.[559] MACs are the only BH clinicians who specialize in SUDs and their interaction with mental illness, potentially leading to better treatment outcomes for patients. This is empirically supported by the finding that a counselor's perceived self-efficacy in treating SUD is highly correlated with their knowledge and skills specific to addiction and co-occurring disorders.[560]

Additionally, when MACs become licensed supervisors, they may increase the efficacy of SUD treatment and training due to their occupation-specific knowledge. Currently, SUDCs work under the supervision of clinicians who have advanced training and knowledge in BH, but who do not necessarily have specialized training in addiction counseling or SUDs. MAC supervisors could better help SUDCs, peer support specialists, and other extenders to develop competencies specific to SUD treatment, improving the quality of services delivered to clients.[561]

Key Considerations

Policymakers need to consider the following in creating this new license:

- How will the new MAC license be structured?
- What entry and renewal requirements will be established?
- What pathways to licensure will be offered?

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[555] Han, B., Compton, W.M., Blanco, C. and Colpe, L.J. (2017). Prevalence, Treatment, And Unmet Treatment Needs Of US Adults With Mental Health And Substance Use Disorders. *Health Affairs*, 36(10), pp.1739–1747. doi:https://doi.org/10.1377/hlthaff.2017.0584.

[556] See pg. 1739 Ibid.

[557] Pettinati, H.M., O'Brien, C.P. and Dundon, W.D. (2013). Current Status of Co-Occurring Mood and Substance Use Disorders: A New Therapeutic Target. *American Journal of Psychiatry*, 170(1), pp.23–30. doi:https://doi.org/10.1176/appi.ajp.2012.12010112.

[558] Pettinati, H.M., Oslin, D.W., Kampman, K.M., Dundon, W.D., Xie, H., Gallis, T.L., Dackis, C.A. and O'Brien, C.P. (2010). A Double-Blind, Placebo-Controlled Trial Combining Sertraline and Naltrexone for Treating Co-Occurring Depression and Alcohol Dependence. *American Journal of Psychiatry*, 167(6), pp.668–675. doi:https://doi.org/10.1176/appi.ajp.2009.08060852.

[559] Substance Abuse and Mental Health Services Administration (2021b). *The Substance Use Disorder Counseling Competency Framework: An Overview*. [online] Available at: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep20-02-01-017.pdf

[560] Murdock, T., Wendler, A. and Nilsson, J. (2005). Addiction Counseling Self-Efficacy Scale (ACSES): development and initial validation. *Journal of Substance Abuse Treatment*, 29(1), pp.55–64. doi:https://doi.org/10.1016/j.jsat.2005.03.005

[561] Hutchings, J., Cooper, L. and O'Donoghue, K. (2016). Cross-disciplinary supervision amongst social workers in Aotearoa New Zealand. *Aotearoa New Zealand Social Work*, 26(4), p.53. doi:https://doi.org/10.11157/anzswj-vol26iss4id26.

In order to support standardization across the BH occupations regulated in Chapter 58-60, we recommend that to the extent possible, the statutory and administrative rule provisions for the MAC license should mirror the structure and content of the existing statutes and rules for social work, marriage and family therapy, and clinical mental health. For instance, requirements such as those for supervised experience, alternate pathways, and license renewal should be consistent with those of other licensed clinicians. Additionally, all general provisions set forth in the Mental Health Professional Practice Act would apply to the proposed new license, such as those detailing board functions, exemptions, disciplinary proceedings, unprofessional and unlawful conduct, immunity from liability, evidentiary privilege, confidentiality exemptions, and externship licenses. MAC licensing provisions that require special consideration or customization are discussed below.

How Will the New MAC License be Structured?

Scope of Practice. The crux of OPLR's recommendation for a new MAC license lies in ensuring that this license's scope of practice includes the practice of mental health therapy, as defined in Utah's Mental Health Professional Practice Act (Chapter 58-60). These licensees' level and scope of practice should be comparable with those of other clinical therapists (e.g., LCSWs, MFTs, and CMHCs), including diagnosis, treatment planning, and psychotherapy.

License Levels. In accordance with the goal of standardizing across Utah code 58-60, policymakers should create both a fully independent MAC, and an associate MAC license to allow addiction counselors seeking their postgraduate supervision hours to practice at the clinical level under supervision. This would be functionally similar to the current Certified Social Worker (CSW), Associate Marriage and Family Therapist (AMFT), and Certified Mental Health Counselor(CMHC) licenses.

What Entry and Renewal Requirements Will Be Established?

Clinical Exam. To obtain licensure as a MAC, counselors would be required to pass a clinical exam under the traditional pathway. States with full clinical scope for MACs currently accept a passing score on either the NAADAC[562] MAC exam or the IC & RC AADC exam,[563] along with a passing grade on a state jurisprudence exam.[564,565] The MAC and AADC exams test candidates' knowledge in the following areas: treatment admission (including screening, intake, and orientation); clinical assessment; treatment planning; counseling services (including individual, family and group counseling, education, and crisis intervention); documentation; case

[562] The exam is administered by the National Certification Commission for Addiction Professionals (NCCAP).
[563] The Association for Addiction Professionals (n.d.). *Master Addiction Counselor*. [online] www.naadac.org. Available at: https://www.naadac.org/mac. This MAC certification requires a master's degree in behavioral health, current credential as an addiction or professional counselor, 3 years or 6,000 hours of supervised experience as an addiction counselor, 500 contact hours of education and training in addiction counseling, and a passing score on one of three advanced addiction counseling exams.
[564] Other exams, like the eMAC exam through the National Board of Certified Counselors (NBCC), may also be considered.
[565] Utah has no precedent for requiring a jurisprudence exam for master's-level clinical behavioral health licenses, and the addiction counseling licensure process should parallel existing master's-level licensing processes.

management; discharge and continued care; legal, ethics and professional development; and physiology and psychopharmacology.[566,567]

DOPL, with input from the board, should determine which exam(s) will be accepted only after carefully considering the available exams to ensure that they adequately assess MAC candidates on the content knowledge and skills necessary to competently diagnose both substance use disorders and other mental health disorders. Similar to the requirements for LCSWs, MFTs, and CMHCs, the exam should serve as a reasonable measure of clinical competency. OPLR also recommends that if the state creates a supervision-based alternative pathway for master's-level clinical therapists in place of traditional exam requirements, candidates for MAC licensure should also be allowed to utilize this alternate pathway.[568]

Education. To promote consistency between the master's-level clinicians regulated in 58-60, OPLR recommends that the education, curriculum, and practicum requirements for master addiction counselors be substantially similar to those for LCSWs, MFTs, and CMHCs. These requirements should ensure that licensees have received training in clinical skills, such as diagnosis and treatment of both mental health and SUDs, that is equivalent to that of Utah's other master's-level clinical therapists.

Master's degrees in addiction counseling are not yet as common or accessible as traditional degrees in social work, mental health counseling, or marriage and family therapy, which necessitates broadening the range of accepted educational pathways. As such, multiple degree pathways should be accepted, including master's degrees in addiction counseling; master's degrees in behavioral health science or clinical counseling (e.g. MSW, MFT MS, CMHC) that includes an emphasis in addiction counseling; or master's degrees in behavioral health science or clinical counseling with a specified number of addiction treatment courses. DOPL, with board advice, should recognize graduate degrees from accredited colleges and universities as long as these programs adequately meet curricula and practicum requirements. This may involve requiring the educational institution to be accredited by an organization such as NAACAP or the Council on Accreditation of Counseling and Related Educational Programs (CACREP).

Similar to the discipline-specific educational requirements for other clinical licenses, applicants should also be required to complete coursework specific to substance use treatment knowledge and competencies. The content and hour requirements for this coursework may be articulated in rule.[569]

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[566] Tests.com. (n.d.). *Addiction Counselor Licensing Guide*. [online] Available at: https://www.tests.com/Addiction-Counselor-Exam-Preparation

[567] International Certification and Reciprocity Consortium (2017). *Candidate Guide for the IC&RC Advanced Alcohol and Drug Counselor Examination*. [online] *International Certification and Reciprocity Consortium*, International Certification and Reciprocity Consortium, pp.1–38. Available at: https://internationalcredentialing.org/resources/Candidate%20Guides/AADC_Candidate_Guide.pdf.

[568] Please see the Exam Alternate Paths recommendation summary for additional discussion of this proposal.

[569] See R156-60b-302a(2), for an example of curricula specifications for Utah MFTs.

What Pathways to Licensure Will Be Offered?

Licensure by endorsement. Individuals seeking MAC licensure by endorsement may not be able to immediately obtain a clinical-level license in Utah if their home states only authorize limited diagnostic scope or do not meet Utah's educational, experiential, and exam requirements. In these cases, applicants should be required to cover the incremental education or experiential requirements they lack, which may include additional coursework on the DSM-V and diagnosing mental health disorders, as well as additional hours of supervised clinical practice. The pathway to licensure for these individuals may mimic the associate level MAC but require fewer supervision hours.

National certification pathway. OPLR does not recommend requiring national certification for licensure,[570] but a national certification (such as that offered by NAADAC)[571] may also be accepted as part of an alternate pathway to achieving licensure, expediting counselors' paths to independent clinical practice.[572,573] The national certification alone may not be sufficient to meet the proposed standard, due to our recommendation that the license operates with full clinical scope. Thus, some nationally certified applicants may be required to complete additional coursework (e.g., related to the DSM-V and diagnosis of mental health disorders), as well as additional hours of supervised clinical practice.

Additional Ideas

Utah policymakers may want to explore alternative approaches instead of creating a master's level license in addiction counseling with full clinical scope as outlined above.

- Instead of a new license, **create an emphasis within the existing CMHC license**. This approach may limit the legislative and administrative burden of a new license to the state, while still recognizing the education, experience, and examination requirements unique to addiction counselors as a pathway within the CMHC license. As a licensed CMHC, MACs would have all corresponding privileges and scope, which may help to address the worker shortages described above, but they would not be granted a protected title specific to their addiction specialty. Given the pressing need for more BH practitioners, OPLR's view is that a separate license may attract more clinicians in the

[570] The three national certifying bodies for alcohol counselors consist of the following: The National Association of Alcohol and Drug Abuse Counselors (NAADAC), the National Board of Certified Counselors (NBCC), and the International Certification and Reciprocity Consortium (IC&RC).
[571] The Association for Addiction Professionals (n.d.). *Master's Addiction Counselor*. [online] www.naadac.org. Available at: https://www.naadac.org/mac. This MAC certification requires a master's degree in behavioral health, current credential as an addiction or professional counselor, 3 years or 6,000 hours of supervised experience as an addiction counselor, 500 contact hours of education and training in addiction counseling, and a passing score on one of three advanced addiction counseling exams.
[572] For instance, provided that this national certification is combined with either an existing clinical-level license (e.g., LCSW, MFT, CMHC), or with other requisite clinical-level training.
[573] UCA 58-61-705 This is similar to what is currently available for behavior analysts. Behavior analysts can either seek licensure through education, experience, and examination, or through recognition of their national certification through the Behavior Analyst Certification Board (BACB).

long run and incentivize specialization in SUD treatment at relatively low administrative cost to the state.

- **Create a MAC license with a limited scope of practice.** Many other states, like Nevada and Kansas, limit the scope of MACs to include the diagnosis and treatment of SUDs and mental illnesses only when they are co-occurring. In these states, MACs are still granted the right to independently practice without clinical supervision, but their ability to diagnose and to provide psychotherapy for non-substance use related disorders is comparatively limited. If Utah adopted a similar limited clinical license, it would allow MACs to independently practice but they could not be categorized as clinical mental health therapists. A limited license would likely increase portability for practitioners, thereby achieving the same goals of increasing access to SUD treatment. It would also likely capture many of the similar benefits of SUD specialization in supervision and treatment. However, it may place a ceiling on professional growth and earning potential, while also failing to address the BH clinician and supervisor shortages in Utah. Thus, while a MAC with a limited scope of practice would still represent an improvement over the current situation, it would ultimately fall short in addressing existing access issues.

4c. Prescribing Psychologists

Summary of Recommendation

Increase access to advanced, specialized BH care services by granting limited prescriptive authority for psychotropic medications to psychologists who complete additional training and supervision in psychopharmacology.

Status Quo

Prescriptive authority is not currently available to psychologists in Utah. Under current law, psychotropic medications may be prescribed by physicians (including psychiatrists), physician assistants, and advanced practice registered nurses.

Existing Approaches

RxP Jurisdictions

- U.S. Department of Defense (1994)
- Guam (1999)
- New Mexico (2002)
- Louisiana (2004)
- Illinois (2014)
- Iowa (2016)
- Idaho (2017)
- Colorado (2023)

Beginning in the mid 1990s, several U.S. jurisdictions and federal agencies began granting prescriptive authority to psychologists (RxP) who had completed additional training in psychopharmacology. Today, three branches of the U.S. military (including the Air Force, Army, and Navy), along with the Public Health Service and the Indian Health Service, license and employ prescribing psychologists; New Mexico, Louisiana, Illinois, Iowa, Idaho, Colorado, and Guam have also passed RxP legislation.[574] Across the United States, over 200 prescribing psychologists are actively licensed,[575] and interest in passing RxP legislation has grown in other U.S. states and internationally.[576]

In all jurisdictions with RxP, psychologists are required to undergo extensive additional training, evaluation, and supervised clinical experience.[577,578] The most common educational requirement

[574] Curtis, S.E., Hoffmann, S. and O'Leary Sloan, M. (2022). Prescriptive authority for psychologists: The next step. *Psychological Services*, [online] 20(2). doi:https://doi.org/10.1037/ser0000667
[575] Ibid.
[576] Hughes, P., Phillips, D.C. and E. Blake Fagan (2023). Prescribing psychologists: Forgotten providers in the battle against opioid use disorder. *Addiction*, 118(7), pp.1398–1399. doi:https://doi.org/10.1111/add.16204.
[577] OPLR National Review of Regulation
[578] Singer, J. (2022). *Expand Access to Mental Health Care: Remove Barriers to Psychologists Prescribing Medications*. [online] Cato Institute. Available at: https://www.cato.org/briefing-paper/expand-access-mental-health-care-remove-barriers-psychologists-prescribing

is a postdoctoral degree in psychopharmacology, although some jurisdictions allow coursework to be completed prior to or concurrently with a doctoral degree in psychology.

Idaho requires that training be substantially equivalent to the training for advanced psychiatric nurse practitioners, and Illinois requires practicum experience to be equivalent to the training standards for either physician assistant education, advanced practice nurse education, or medical education. The required supervised clinical experience generally consists of 2 to 3 years of practice, and some jurisdictions set minimum treatment quotas (e.g., the total number of patients treated or the percentage of patients treated with certain drug classes). All jurisdictions require a national certification exam, generally the Psychopharmacology Examination for Psychologists (PEP). New Mexico also requires candidates to undergo an additional peer review process by the medical and psychology boards, and Louisiana requires that the candidate be recommended by two collaborating physicians.

After receiving full licensure as a prescribing psychologist, providers are generally required to abide by practice standards that include requirements for malpractice insurance, continuing education specific to psychopharmacology, and either collaborative relationships or formal collaborative practice agreements (CPAs) with their patients' primary care providers (PCP). Collaborative relationships usually consist of requirements to regularly report to and/or consult with the patient's PCP throughout the course of the treatment regimen. CPAs are written contracts that allow the collaborating physician to place specific limits on a prescribing psychologist's scope of practice or that may require the psychologist to obtain consent from the physician before writing a prescription.

All RxP jurisdictions use a licensure model in which a prescribing psychologist's title and scope of practice are protected. The typical scope of practice includes prescriptive authority for only psychotropic medications, and two jurisdictions allow a collaborating physician to limit prescriptive authority further to a pre-specified subset of psychotropic medications. Several states also require prescribing psychologists to hold state and federal controlled substance permits and to register with the Drug Enforcement Administration. Three states give primary oversight responsibilities for prescribing psychologists to the state psychology board or allied health board (Idaho, New Mexico, Iowa, and Guam), but in each case, the psychology board works in collaboration with the medical board, pharmacy board, and/or a specialized advisory board to set entry and practice standards and to conduct disciplinary proceedings. Other oversight models include primary oversight by the medical board in collaboration with a medical psychology advisory committee (Louisiana) and primary oversight by the Secretary of Financial and Professional Regulation, in collaboration with an advisory board (Illinois).

For additional details regarding the regulation of prescribing psychologists in other U.S. states and territories, please see the Appendix.

Rationale

Why extend prescriptive privileges to psychologists?

- Prescribing psychologists provide safe and competent care
- Primary care providers do not provide optimal behavioral health care services
- Utah needs more access to advanced BH prescribers, particularly in rural areas
- RxP legislation may improve access to care, especially in rural areas
- Concerns with RxP legislation may be mitigated with thoughtful, holistic policymaking

The rationale for this recommendation rests primarily on safety. From the perspective of the state, occupational regulation exists to protect the public by requiring a minimum level of training and competency for entry into occupations that may pose "a present, recognizable, and significant harm to the health, safety, or financial welfare of the public" (Utah Code 13-1b).[579] All other considerations mentioned below are thus helpful—but secondary—pillars of the argument to extend limited prescribing privileges to psychologists.

It is not the regulator's role to prefer one occupation, discipline, training path, or profession over another where safety is demonstrably equivalent. By allowing any and all practitioners to practice—so long as they do so safely—regulators empower higher education, industry groups, payors, employers, and others the flexibility to innovate in ways that ultimately benefit consumers in terms of access, cost, and efficacy.

Prescribing Psychologists Provide Safe & Competent Care

When combined with doctoral-level clinical psychology training, prescribing psychologists' additional training in psychopharmacology, pathophysiology, mental health diagnosis, and other key areas makes them well-prepared to treat patients with complex mental and BH disorders.[580,581] This dual specialty in BH and psychopharmacology is important for ensuring quality care.

[579] Nunn, R. and Scheffler, G. (2019). Occupational Licensing and The Limits of Public Choice Theory. *Administrative Law Review Accord, University of Pennsylvania Institute for Law & Economic Research Paper No. 19-18.* Available at: https://scholarship.law.upenn.edu/faculty_scholarship/2072/

[580] Muse, M. and McGrath, R.E. (2009). Training comparison among three professions prescribing psychoactive medications: psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. *Journal of Clinical Psychology*, 66(1), p.n/a-n/a. doi:https://doi.org/10.1002/jclp.20623.

[581] Singer, J. (2022). *Expand Access to Mental Health Care: Remove Barriers to Psychologists Prescribing Medications*. [online] Cato Institute . Available at: https://www.cato.org/briefing-paper/expand-access-mental-health-care-remove-barriers-psychologists-prescribing?ref=moodfuel-news

A growing body of evidence suggests that prescribing psychologists are safe and effective prescribers, in addition to being safe providers of BH care more generally.[582,583,584,585] First, malpractice claim and liability insurance data suggest that prescribing psychologists practice safely within their expanded scope. The primary liability insurer for prescribing psychologists reported that between 2005 and 2021, malpractice claim rates against prescribing psychologists averaged approximately 2.1%, virtually the same as the rate of claims against psychiatrists indicating that prescribing psychologists do not present a heightened risk to patients.[586,587] As Fox and colleagues comment, "In the states where prescriptive authority for psychologists has been authorized, as well as in those federal systems where psychologists are authorized to prescribe, there is every indication that the notion is fulfilling the original intent of expanding access to quality mental health care and no evidence that patient safety has been compromised."[588]

One innovative thesis from 2020 even directly tested the comparative content knowledge of various psychopharmacological prescribers and BH professionals (including psychiatrists, general physicians, psychiatric nurse practitioners, general nurse practitioners, prescribing psychologists, and general psychologists) and found that prescribing psychologists performed comparably to psychiatrists, psychiatric nurse practitioners, and general physicians, while outperforming general nurse practitioners and non-prescribing psychologists.[589] Because each licensed BH profession completes a different educational degree program, and takes a different licensing exam, a side-by-side comparison of this kind is helpful for evaluating the specialized BH knowledge and prescribing competency resulting from the training that the various disciplines provide.

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[582] Choudhury, A. and Plemmons, A. (2023). Effects of giving psychologists prescriptive authority: Evidence from a natural experiment in the United States. *Health Policy*, [online] 134, p.104846. doi:https://doi.org/10.1016/j.healthpol.2023.104846.

[583] Hughes, P. M., McGrath, R. E., & Thomas, K. C. (2023). Evaluating the impact of prescriptive authority for psychologists on the rate of deaths attributed to mental illness. *Research in Social & Administrative Pharmacy*, 19(4), 667–672. https://doi.org/10.1016/j.sapharm.2022.12.006.

[584] Shoulders, A. and Plemmons, A. (2023). Quality and Access to Mental Health Services after Prescriptive Authority Expansion for Psychologists. *Forthcoming in Contemporary Economic Policy.* doi:https://doi.org/10.2139/ssrn.4112652.

[585] Hughes, P., Phillips, D.C., McGrath, R.E. and Thomas, K.C. (2023). Examining psychologist prescriptive authority as a cost-effective strategy for reducing suicide rates. *Professional Psychology: Research and Practice*, 54(4). doi:https://doi.org/10.1037/pro0000519.

[586] Curtis, S.E., Hoffmann, S. and O'Leary Sloan, M. (2022). Prescriptive authority for psychologists: The next step. *Psychological Services*. [online] doi:https://doi.org/10.1037/ser0000667.

[587] The liability insurer received reports of 10 board complaints and 5 lawsuits against prescribing psychologists for prescription errors, for 15 total claims. After extrapolating growth rates from available data on licensed prescribing psychologists between 2005 and 2021 and applying the same rate of malpractice claims faced by psychiatrists as reported by the insurance carrier (2.6%), the insurer should have received 19 claims against prescribing psychologists, four more than were actually reported during this time period. In other words, the actual volume of complaints was 21% lower than would be expected. This suggests a rate of claims closer to 2.1% for prescribing psychologists.

[588] See pp. 11. Fox, R.E., DeLeon, P.H., Newman, R., Sammons, M.T., Dunivin, D.L. and Baker, D.C. (2009). Prescriptive Authority and Psychology: A Status Report. *American Psychologist*, 64(4), pp.257–268. doi:https://doi.org/10.1037/a0015938.

[589] Cooper, R. (2020). *Comparing Psychopharmacological Prescriber Training Models via Examination of Content-Based Knowledge*. [Thesis] Available at: https://dash.harvard.edu/bitstream/handle/1/37365636/COOPER-DOCUMENT-2020.pdf?sequence=1http://

Further, the "two studies to date that [demonstrate] a reduction in deaths related to mental health would strongly suggest that qualified psychologists can successfully prescribe."[590] Controlling for other relevant factors, after New Mexico granted RxP, they saw a reduction in the rate of deaths attributable to mental illness.[591] Similarly, while controlling for other factors and by narrowing in on policy impacts, RxP has been show to have a beneficial impact on suicide rates among male, white, and middle-aged (35-55) sub-populations.[592] While other factors, such as increased rates of suicide reporting or population growth, may ostensibly inflate the number or rate of these mental-health related deaths in jurisdictions where RxP has been implemented, multiple robust analyses now demonstrate that RxP legislation may help to stem the tide of these deaths. In this way, granting RxP has the potential to contribute significantly to one of Utah's most pressing public health issues—suicide. Suicide is the leading cause of death in Utah for youth and young adults aged 15-24, and the second and third leading cause of death for adults aged 25-34 and 35-44, respectively, placing Utah 9th in the nation for highest rate of suicide per capita.[593] Implementing prescriptive authority for psychologists has the potential to reduce suicide rates and to improve BH outcomes for Utah consumers.[594]

Finally, prescribing psychologists may bring a unique, holistic approach to mental health treatment due to their psychotherapeutic and psychopharmaceutical training. The vast majority of prescribing psychologists rate combination treatment (therapy and medication) as the most effective, with a majority of their patients engaged in both modalities.[595] Respondents reported that they treated only around 16% of their patients with medication alone.[596] Given that primary care physicians are less likely to provide or recommend psychotherapy services for patients,[597,598] while prescribing psychologists clearly prioritize therapy, RxP legislation may help expand the use of complementary, non-pharmaceutical mental health treatments.

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[590] See pp. 292 of Hughes, P., Phillips, D.C., McGrath, R.E. and Thomas, K.C. (2023). Examining psychologist prescriptive authority as a cost-effective strategy for reducing suicide rates. *Professional Psychology: Research and Practice*, 54(4). doi:https://doi.org/10.1037/pro0000519.

[591] Ibid; Hughes, P. M., McGrath, R. E., & Thomas, K. C. (2023). Evaluating the impact of prescriptive authority for psychologists on the rate of deaths attributed to mental illness. *Research in Social & Administrative Pharmacy*, 19(4), 667–672. https://doi.org/10.1016/j.sapharm.2022.12.006

[592] Choudhury, A. and Plemmons, A. (2023). Effects of giving psychologists prescriptive authority: Evidence from a natural experiment in the United States. *Health Policy*, [online] 134, p.104846. doi:https://doi.org/10.1016/j.healthpol.2023.104846

[593] American Foundation for Suicide Prevention (2022). Utah State Facts. [online] Available at: https://afsp.org/facts/utah

[594] Choudhury, A. and Plemmons, A. (2023). Effects of giving psychologists prescriptive authority: Evidence from a natural experiment in the United States. *Health Policy*, [online] 134, p.104846. doi:https://doi.org/10.1016/j.healthpol.2023.104846.

[595] Peck, K.R., McGrath, R.E. and Holbrook, B.B. (2020). Practices of prescribing psychologists: Replication and extension. Professional Psychology: Research and Practice, 52(3). doi:https://doi.org/10.1037/pro0000338.

[596] Ibid.

[597] Olfson, M. (2016). The Rise of Primary Care Physicians in the Provision of US Mental Health Care. Journal of Health Politics, Policy and Law, [online] 41(4), pp.559–583. doi:https://doi.org/10.1215/03616878-3620821.

[598] Beck, A., Page, C., Buche, J., Schoebel, V. and Wayment, C. (2019). *Behavioral Health Service Provision by Primary Care Physicians*. [online] Anne Arbor, Michigan: School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf

In summary, through the lens of malpractice claim rates, content-knowledge comparisons, mental-health-related death rates, and a dearth of evidence suggesting detrimental outcomes as a result of RxP legislation, prescribing psychologists have consistently shown themselves to be safe and effective prescribers. Given the growing number of prescribing psychologists in other states, the benefits that RxP legislation may provide, and the lack of evidence suggesting any negative impacts to consumer safety due to such legislation, Utah policymakers should provide a way for psychologists to gain prescriptive authority in Utah.

Primary Care Providers Do Not Provide Optimal Behavioral Health Care Services

While primary care is often the "first point of contact for patients with mental health and substance use disorder needs,"[599] it is not the optimal setting for the treatment of serious BH disorders. Integrated care, which involves medical and BH providers working together, and advanced specialists, who themselves have substantial training in BH diagnosis and treatment, more consistently provide effective treatment in BH than PCPs.[600] Although primary care can provide front-line BH care services in circumstances or locations where patients do not have access to specialist care (such as when patients lack insurance coverage or reside in rural areas), sole reliance on PCPs to treat BH care is not ideal, particularly for individuals with serious or complex conditions. Research demonstrates that patients treated by non-specialist providers are less likely to receive minimally adequate treatment, including appropriate prescription medication and follow-up visits.[601,602] Primary care patients tend to receive suboptimal care for BH conditions in terms of 1) assessment and diagnosis, 2) prescription practices, and 3) the use of non-pharmacological interventions.

Recent research from the Behavioral Health Workforce Research Center found that 42% of surveyed primary care physicians do not consistently[603] use validated mental health screening tools, and that over half do not consistently use validated addiction screening tools (57%), consult with psychiatrists (71%), or consult with other BH providers (59%).[604] Patients screened for depression by primary care physicians are also less consistently diagnosed ("nearly one-half of primary care patients who screen positive are not diagnosed by their physicians").[605]

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[599] See pg. 9 of Utah Behavioral Health Assessment & Master Plan. (2023). [online] Salt Lake City, Utah: Ken C. Gardner Policy The University of Utah. Available at: https://gardner.utah.edu/wp-content/uploads/DRAFT_BehaviorHealthPlan-Jul2023_for-review.pdf?x71849

[600] Goodrich, D.E., Kilbourne, A.M., Nord, K.M. and Bauer, M.S. (2013). Mental health collaborative care and its role in primary care settings. *Current Psychiatry Reports*, 15(8). doi:https://doi.org/10.1007/s11920-013-0383-2.

[601] Wang, P.S., Demler, O. and Kessler, R.C. (2002). Adequacy of Treatment for Serious Mental Illness in the United States. *American Journal of Public Health*, 92(1), pp.92–98. doi:https://doi.org/10.2105/ajph.92.1.92.

[602] Ibid.

[603] Includes responses of "half of the time" and "never/seldom," as compared to "usually/always."

[604] Beck, A., Page, C., Buche, J., Schoebel, V. and Wayment, C. (2019). *Behavioral Health Service Provision by Primary Care Physicians*. [online] Anne Arbor, Michigan: School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf

[605] Olfson, M. (2016). The Rise of Primary Care Physicians in the Provision of US Mental Health Care. *Journal of Health Politics, Policy and Law*, [online] 41(4), pp.559–583. doi:https://doi.org/10.1215/03616878-3620821.

While between 50-80% of all prescriptions for psychotropic medications are written by primary care physicians and other non-psychiatrists,[606,607,608,609] primary care physicians are "less likely than psychiatrists to follow best practice guidelines"[610,611] when prescribing psychotropic drugs. Research has also shown an increase in the proportion of primary care visits in which patients were prescribed antidepressants but not given a psychiatric diagnosis, which may be cause for concern if these medications are "being prescribed for uses not supported by clinical evidence" or are unnecessarily contributing to higher healthcare costs.[612]

Further, primary care physicians are less likely to provide or recommend psychotherapy services for patients with BH disorders,[613,614] and large proportions of surveyed physicians reported that they had little or no confidence in their abilities to treat patients with SMI (61%), bipolar disorder (41%), or substance use disorders (39%).[615] This is a particular issue for patients in rural areas without an adequate supply of specialist providers, like psychiatrists, who are prepared to treat and prescribe for these complex conditions.

Finally, the amount of BH-specific training received by primary care physicians is often limited; for example, while common mental illnesses are covered by accredited curricula for family medicine physicians (those who provide primary care for both children and adults), the educational requirements for internists (physicians who exclusively treat adults) do not mention BH training.[616] Only 24% of surveyed medical school programs "had more than 12 hours of training in addiction medicine" as of 2013.[617]

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[606] Jetty, A., Petterson, S., Westfall, J.M. and Jabbarpour, Y. (2021). Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey. *Journal of Primary Care & Community Health*, 12, p.215013272110238. doi:https://doi.org/10.1177/21501327211023871.
[607] Mark, T.L., Levit, K.R. and Buck, J.A. (2009). Datapoints: Psychotropic Drug Prescriptions by Medical Specialty. *Psychiatric Services*, 60(9), pp.1167–1167. doi:https://doi.org/10.1176/ps.2009.60.9.1167.
[608] DeLeon, P.H. and Wiggins, J.G. (1996). Prescription privileges for psychologists. *American Psychologist*, 51(3), pp.225–229. doi:https://doi.org/10.1037/0003-066x.51.3.225.
[609] Beardsley, R.S. (1988). Prescribing of Psychotropic Medication by Primary Care Physicians and Psychiatrists. *Archives of General Psychiatry*, 45(12), p.1117. doi:https://doi.org/10.1001/archpsyc.1988.01800360065009.
[610] See pg. 4 of Beck, A., Page, C., Buche, J., Schoebel, V. and Wayment, C. (2019). *Behavioral Health Service Provision by Primary Care Physicians*. [online] Anne Arbor, Michigan: School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf
[611] Rettew, D.C., Greenblatt, J., Kamon, J., Neal, D., Harder, V., Wasserman, R., Berry, P., MacLean, C.D., Hogue, N. and McMains, W. (2015). Antipsychotic Medication Prescribing in Children Enrolled in Medicaid. *Pediatrics*, 135(4), pp.658–665. doi:https://doi.org/10.1542/peds.2014-2260.
[612] See pp. 1 of Mojtabai, R. and Olfson, M. (2011). Proportion Of Antidepressants Prescribed Without A Psychiatric Diagnosis Is Growing. *Health Affairs*, [online] 30(8), pp.1434–1442. doi:https://doi.org/10.1377/hlthaff.2010.1024.
[613] Olfson, M. (2016). The Rise of Primary Care Physicians in the Provision of US Mental Health Care. *Journal of Health Politics, Policy and Law*, [online] 41(4), pp.559–583. doi:https://doi.org/10.1215/03616878-3620821.
[614] Beck, A., Page, C., Buche, J., Schoebel, V. and Wayment, C. (2019). *Behavioral Health Service Provision by Primary Care Physicians*. [online] Anne Arbor, Michigan: School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf
[615] Ibid.
[616] See pp. 4 of Beck, A., Page, C., Buche, J., Schoebel, V. and Wayment, C. (2019). *Behavioral Health Service Provision by Primary Care Physicians*. [online] Anne Arbor, Michigan: School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf
[617] Ibid.

Utah Needs More Access to Advanced BH Prescribers, Particularly in Rural Areas

Utah is currently facing a shortfall of prescribing professionals who specialize in treating complex behavioral and psychiatric conditions. Utah ranks 46th worst in terms of the ratio of psychiatrists per population at only 7.4 per 100,000, versus a national average of 12.9.[618] As of 2023, 27 counties, including Salt Lake County and Utah County, lack a sufficient psychiatry workforce, for a statewide shortfall of approximately 60 to 80 practitioners.[619]

In addition to the current shortfall, the American Medical Association has raised concerns about the aging psychiatrist workforce and additional impending shortages of well-trained psychiatrists who can meet the growing demand for mental health services.[620] Demand for psychiatry is projected to exceed supply in the years ahead, with some estimates putting the national workforce shortage as high as 25%.[621,622] The nation-wide shortage of advanced specialists in the field of mental health is well-documented.[623,624,625] Combined with Utah's high prevalence of serious mental illness (the state ranked 3rd in the nation for serious mental illness among adults in 2021)[626,627] and reported unmet need for care (one quarter of those with severe mental illness

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[618] Beck, A., Page, C., Buche, J., Rittman, D. and Gaiser, M. (2018). *Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce*. [online] University of Michigan School of Public Health Behavioral HEALTH Workforce Research Center , pp.1–16. Available at: https://behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf

[619] Health Resources and Services Administration (2023). *HPSA Find*. [online] data.HRSA.gov. Available at: https://data.hrsa.gov/tools/shortage-area/hpsa-find. Davis and Weber counties are not currently designated as Mental Health Geographic HPSAs or Population HPSAs.

[620] Wautier, G. and Tolman, A. (2007). Psychology and psychopharmacology: Natural partners in holistic healthcare. *Papeles del Psicólogo*, [online] 28(2), pp.2–12. Available at: https://www.researchgate.net/publication/237777181_Psychology_and_psychopharmacology_Natural_partners_in_holistic_healthcare

[621] Beck, A., Page, C., Buche, J., Rittman, D. and Gaiser, M. (2018). *Mapping Supply of the U.S. Psychiatric Workforce Project Team*. [online] University of Michigan School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/01/Y3-FA1-P2-Psych-Mapping-Full-Report-with-Appendix.pdf

[622] Medical Director Institute (2018). *The Psychiatric Shortage: Causes and Solutions*. [online] The National Council for Mental Wellbeing, pp.1–60. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Revised-Final-Access-Paper.pdf

[623] National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025. (2016). [online] United States Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis, pp.1–35. Available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

[624] Wilson, W., Bangs, A. and Hatting, T. (2015). *The Future of Rural Behavioral Health* . [online] National Rural Health Association, pp.1–12. Available at: https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/The-Future-of-Rural-Behavioral-Health_Feb-2015.pdf

[625] Medical Director Institute (2018). *The Psychiatric Shortage: Causes and Solutions*. [online] The National Council for Mental Wellbeing, pp.1–60. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Revised-Final-Access-Paper.pdf

[626] *2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)*. [online] Substance Abuse and Mental Health Services Adminsitration Center for Behavioral Health Statistics and Quality, pp.1–71. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf.

[627] Substance Abuse and Mental Health Services Administration (2021). *2021 NSDUH Detailed Tables | CBHSQ Data*. [online] www.samhsa.gov. Available at: https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables.

reported unmet need in 2019),[628] addressing the state's behavioral health (BH) care needs should include a focus on increasing access to advanced BH care providers with both prescriptive authority and specialized training in BH.

The need for specialized prescribers is particularly acute in Utah's rural regions. The difference in access to psychiatric care between urban and rural counties is a persistent issue across the country, and Utah is no exception.[629] Nationwide, rural counties have substantially fewer psychiatrists per population than urban counties[630] and as of 2018, 51.5% of U.S. counties had no psychiatrists at all.[631] Utah's numbers are even more stark, with 69% of counties listing no active psychiatrists (see Figure 3.2).[632, 633] Based on Utah's population and prevalence of mental illness, this translates to roughly 22,000 adults in Utah who both have a serious mental illness, and who do not have access to a psychiatrist within their own county.

Utah's shortage of BH providers in rural areas extends beyond psychiatrists as well. Other advanced BH providers (e.g., psychiatric nurse practitioners, psychiatric physician assistants, and psychiatric pharmacists) are likewise in short supply, with Utah ranking 18th lowest in the nation for total psychiatric workers per 100,000 residents—at 25% less than the national median (16.8 versus 22.61, respectively).[634] Further, the ratio of all BH providers to the population is substantially lower in rural versus urban counties.[635] In fact, every county in Utah with a BH provider ratio worse than 1:600 (i.e., where there is only one BH provider for every 600+ members of the population) is a rural county. Due in part to these well-documented workforce shortages, individuals in rural areas are more likely to receive BH care from their PCP.[636,637] Yet

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[628] Kaiser Family Foundation (2021). *Adults with Mental Illness in Past Year Who Did Not Receive Treatment*. [online] Available at: https://www.kff.org/other/state-indicator/adults-with-mental-illness-in-past-year-who-did-not-receive-treatment/

[629] Wilson, W., Bangs, A. and Hatting, T. (2015). *The Future of Rural Behavioral Health* . [online] National Rural Health Association, pp.1–12. Available at: https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/The-Future-of-Rural-Behavioral-Health_Feb-2015.pdf

[630] Beck, A., Page, C., Buche, J., Rittman, D. and Gaiser, M. (2018). Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. [online] University of Michigan School of Public Health Behavioral HEALTH Workforce Research Center , pp.1–16. Available at: https://behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf; Rural counties had 3 times fewer psychiatrists (10.6 vs. 3.2), 4 times fewer child and adolescent psychiatrists, (12.06 vs. 3.50), and 5 times fewer geriatric psychiatrists per 100,000 population

[631] Ibid.

[632] OPLR Analysis of Psychiatrist & Psychologist Licensees Geographic Distribution

[633] OPLR Analysis of Psychiatry Board Certification Listings
American Board of Psychiatry and Neurology, Inc. (n.d.). *verifyCERT® Certification and Status Verification*. [online] verifyCERT. Available at: https://apps.abpn.org/verifycert/?stateId=44&certificationId=19.

[634] OPLR analysis of Psychiatric Workforce Distribution

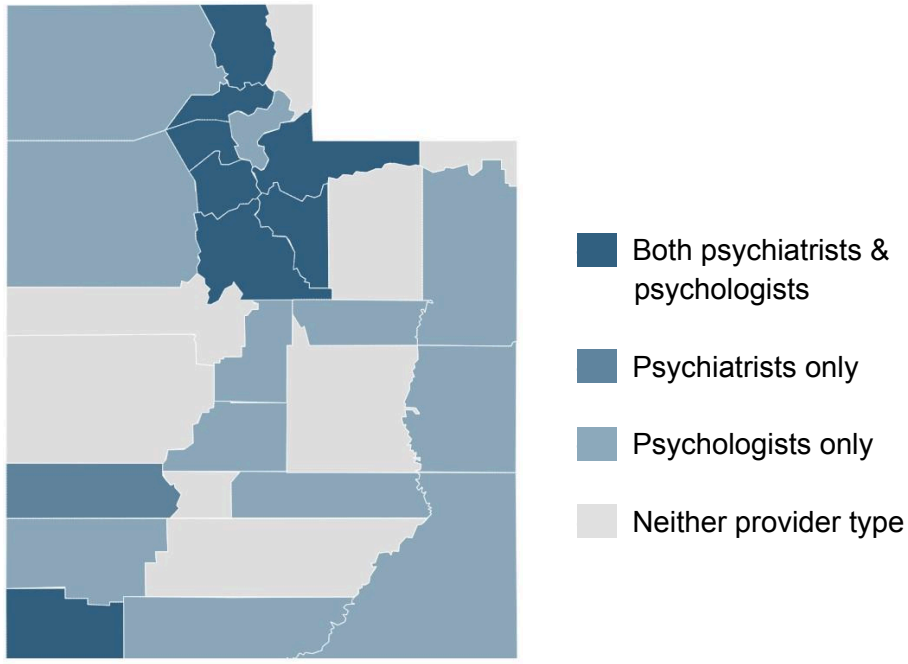
[635] University of Wisconsin Population Health Institute (2023). *2023 County Health Rankings National Findings Report Cultivating Civic Infrastructure and Participation for Healthier Communities*. [online] *www.countyhealthrankings.org*, University of Wisconsin Population Health Institute, pp.1–20. Available at: https://www.countyhealthrankings.org/reports/2023-county-health-rankings-national-findings-report.

[636] Beck, A., Page, C., Buche, J., Schoebel, V. and Wayment, C. (2019). *Behavioral Health Service Provision by Primary Care Physicians*. [online] Anne Arbor, Michigan: School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf

[637] Cherry, D., Albert, M. and McCaig, L. (2018). *Mental Health-related Physician Office Visits by Adults Aged 18 and Over: United States, 2012–2014*. [online] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for

PCPs in rural areas are less likely to be colocated with a BH provider, meaning they are providing BH care without the consultative expertise that a colocated BH professional may help to provide.[638,639]

Figure 3.2: Location of Psychiatrists & Psychologists in Utah, by County[640,641]



RxP Legislation May Improve Access to Care, Especially in Rural Areas

Granting RxP in Utah could help address this shortfall of prescribers with a BH expertise, and could be especially impactful in reaching those who need this care in Utah's rural counties. Evidence suggests that states that grant RxP see an uptick in psychologist practices in the years following this change, representing an overall capacity increase of 60 or more patients per month, per county—"often in counties that may not have had options for mental and behavioral

Disease Control and Prevention National Center for Health Statistics, pp.1–8. Available at: https://www.cdc.gov/nchs/data/databriefs/db311.pdf

[638] Richman, E., Lombardi, B., de Saxe Zerden, L. and Randolph, R. (2018). *Where is Behavioral Health Integration Occurring? Mapping National Co-Location Trends Using National Provider Identifier Data*. [online] University of Michigan School of Public Health Behavioral Health Workforce Research Center, pp.1–3. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2018/12/NPI-Brief-Report_Final.pdf

[639] Goodrich, D.E., Kilbourne, A.M., Nord, K.M. and Bauer, M.S. (2013). Mental health collaborative care and its role in primary care settings. *Current Psychiatry Reports*, 15(8). doi:https://doi.org/10.1007/s11920-013-0383-2.

[640] Geographic data for psychologists was obtained from a DOPL report of actively licensed psychologists and associated contact addresses, accessed on August 8, 2023. Geographic data for psychiatrists was obtained from the addresses of board-certified psychiatrists listed on the American Board of Psychiatry and Neurology (ABPN) public registry lookup tool, accessed on August 8, 2023 and available at https://apps.abpn.org/verifycert/?stateId=44&certificationId=19. Please note, for both psychologists and psychiatrists, listed addresses may reflect the practitioners' residence or mailing address, rather than their practice location(s).

[641] OPLR Analysis of Psychiatrist & Psychologist Licensees Geographic Distribution

healthcare prior to the policy change."[642] Recent studies of states with prescriptive authority found that psychologists were able to reach many patients from rural communities, lower socioeconomic statuses, and minority backgrounds.[643,644,645] In one survey of New Mexico prescribing psychologists, providers estimated that over 60% of their patients were living in rural areas, and over 90% self-reported that they accept Medicaid.[646] As one psychologist commented:[647]

> *"There are significant structural, professional, financial, and psychological disincentives for psychiatrists to work with the elderly, children, and SDMI [severe and disabling mental illness] populations, particularly those that reside in rural areas. The needs of these groups for diagnosis, medication, and medication monitoring are underserved. Psychologists are more available and accessible to monitor and treat these groups."*

Critically, prescribing psychologists act as a complement to the existing advanced BH prescriber workforce rather than as a replacement. States authorizing RxP see an increase in the number of psychologists and counseling practices, without a reduction in the number of psychiatrists.[648] Utah's prescribing psychiatric workforce, which includes psychiatric nurse practitioners, physician assistants, and pharmacists, in addition to psychiatrists, is estimated at roughly ~500 workers total—with around 300 psychiatrists, almost 200 psychiatric nurse practitioners, and fewer than 10 each of psychiatric physician assistants and psychiatric pharmacists.[649] Utah has over four times as many psychologists as psychiatrists (~1250 and 300, respectively), and more than twice as many psychologists as all other psychiatric workers (~1250 and 500, respectively).

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[642] See pg. 7 of Shoulders, A. and Plemmons, A. (2023). Quality and Access to Mental Health Services after Prescriptive Authority Expansion for Psychologists. Forthcoming in *Contemporary Economic Policy*. doi:https://doi.org/10.2139/ssrn.4112652.

[643] Peck, K.R., McGrath, R.E. and Holbrook, B.B. (2020). Practices of prescribing psychologists: Replication and extension. *Professional Psychology: Research and Practice*, 52(3). doi:https://doi.org/10.1037/pro0000338.

[644] Shoulders, A. and Plemmons, A. (2023). Quality and Access to Mental Health Services after Prescriptive Authority Expansion for Psychologists. Forthcoming in *Contemporary Economic Policy*. doi:https://doi.org/10.2139/ssrn.4112652.

[645] Linda, W.P. and McGrath, R.E. (2017). The current status of prescribing psychologists: Practice patterns and medical professional evaluations. *Professional Psychology: Research and Practice*, 48(1), pp.38–45. doi:https://doi.org/10.1037/pro0000118.

[646] Vento, C. (2014). Report from the trenches: Survey of New Mexico prescribing psychologists' outpatient practice characteristics and impact on mental health care disparities in calendar 2013. Archives of Medical Psychology, 5, 30 –34.

[647] See pg. 88. Lynn, M. (2007). *Prescriptive Authority For Psychologists: Issues and Considerations*. [online] Honolulu, Hawaii : Legislative Reference Bureau. Available at: https://lrb.hawaii.gov/wp-content/uploads/2007_PrescriptiveAuthorityForPsychologists.pdf.

[648] Shoulders, A. and Plemmons, A. (2023). Quality and Access to Mental Health Services after Prescriptive Authority Expansion for Psychologists. Forthcoming in *Contemporary Economic Policy*. doi:https://doi.org/10.2139/ssrn.4112652.

[649] Beck, A., Page, C., Buche, J., Rittman, D. and Gaiser, M. (2018). *Mapping Supply of the U.S. Psychiatric Workforce Project Team*. [online] University of Michigan School of Public Health Behavioral Health Workforce Research Center. Available at: https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/01/Y3-FA1-P2-Psych-Mapping-Full-Report-with-Appendix.pdf

Further, Utah psychologists list addresses in twice as many counties as Utah psychiatrists (19 and 9, respectively).[650]

Growth in the number of licensed prescribing psychologists in other jurisdictions suggests that if RxP legislation is passed in Utah, and depending on how this regulation is implemented, the state could have up to 200 active prescribing psychologists within the next 20 years.[651] This would represent a 40% increase in the state's advanced, specialized BH workforce, relative to today's approximately 500 prescribing psychiatric workers. Further, if current growth trends in the number of prescribing psychologists in other states continue to hold, there could be over 2,000 prescribing psychologists around the country by 2033.[652] With the advent of modern communication and travel technologies, that national workforce may be able to provide services to Utah residents, even if they reside elsewhere, if Utah provides a pathway to licensure (e.g., by endorsement) for prescribing psychologists from other states.

Concerns With RxP Legislation May Be Mitigated With Thoughtful, Holistic Policymaking

Proposals to grant prescriptive authority to upskilled psychologists are generally met with two core counterarguments—that doing so will 1) compromise patient safety due to inadequate training, and 2) not substantially improve access to care. The foregoing section provides substantial evidence regarding the safety and competency of prescribing psychologists, in spite of cross-occupational differences in training. Furthermore, policies that improve access to care—including those that provide only modest gains—are worth considering, given the significant impacts of unmet need,[653] particularly when such policies have been shown to be cost-effective in achieving state-level population health goals.[654] In short, objections regarding training and access are overstated and can be addressed with straightforward policy decisions.

Training Equivalence. A common argument against extending RxP with additional training in psychopharmacology centers on the adequacy of their training. Opponents highlight substantial differences in prerequisite scientific training for those entering the healthcare field versus for those entering BH—as well as in the instruction that prescribing psychologists receive in scientific foundations and pathophysiology during didactic training relative to other

[650] OPLR Analysis of Psychiatrist & Psychologist Licensees Geographic Distribution; Geographic data for psychologists was obtained from a DOPL report of actively licensed psychologists and associated contact addresses, accessed on August 8, 2023. Geographic data for psychiatrists was obtained from the addresses of board-certified psychiatrists listed on the American Board of Psychiatry and Neurology (ABPN) public registry lookup tool, accessed on August 8, 2023 and available at https://apps.abpn.org/verifycert/?stateId=44&certificationId=19. Please note, for both psychologists and psychiatrists, listed addresses may reflect the practitioners' residence or mailing address, rather than their practice location(s).
[651] OPLR Analysis of RxP Effects on HPSA Designations
[652] Ibid.
[653] See "Utah Needs More Access to Advanced BH Specialists, Particularly in Rural Areas" and "RxP Legislation May Improve Access to Care, Especially in Rural Areas"
[654] Hughes, P., Phillips, D.C., McGrath, R.E. and Thomas, K.C. (2023). Examining psychologist prescriptive authority as a cost-effective strategy for reducing suicide rates. *Professional Psychology: Research and Practice*, 54(4). doi:https://doi.org/10.1037/pro0000519.

prescribers.[655,656] The comparative impact of various professions' training requirements—including the subject areas covered during didactic instruction and the practical experience gained during supervised experience—may be difficult to directly link to client outcomes, given the lack of cross-occupational research in this space. For example, "because each licensed professional takes their own unique board exam (nurses, physicians, prescribing psychologists)... there has been no way to compare more direct psychiatric prescriptive knowledge of each provider, side-by-side"[657] nor to compare the impact of such knowledge on the quality and safety of care that clients ultimately receive. Insofar as this review has been able to ascertain, there is not yet a substantial body of evidence comparing the impact of various BH professions' training practices on actual client outcomes.

Policymakers with an interest in understanding training guidelines for prescribing psychologists may refer to the American Psychological Association's model program guide[658] and designation criteria[659] for additional information. Further, it is worth mentioning that in contrast to other prescribers, prescribing psychologists are also required to undergo rigorous evaluation specific to psychopharmacology and prescribing for mental health disorders: in all U.S. jurisdictions that currently allow prescriptive authority for psychologists, candidates must pass the PEP exam.

The evidence presented above—including malpractice claim rates that are comparable to psychiatrists,[660] content knowledge that is comparable to psychiatrists, psychiatric nurse practitioners, and general physicians,[661] and potentially reduced rates of mental health-related deaths after RxP legislation is passed[662]—strongly suggests that although there may indeed be important differences in training between various professional fields, prescribing psychologists are able to provide care that is as safe as or even safer than the care provided by existing prescribers. In other words, prescribing psychologists' track record of safe practice in other jurisdictions provides compelling evidence that while prescribing psychologists' training may not be identical to that of other medical professionals, it is sufficient to ensure their ability to safely and competently practice and prescribe.

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[655] Heiby, E.M. (2009). Concerns about substandard training for prescription privileges for psychologists. *Journal of Clinical Psychology*, 66(1). doi:https://doi.org/10.1002/jclp.20650.
[656] Robiner, W.N., Tompkins, T.L. and Hathaway, K.M. (2019). Prescriptive authority: Psychologists' abridged training relative to other professions' training. *Clinical Psychology: Science and Practice*, 27(1). doi:https://doi.org/10.1111/cpsp.12309.
[657] See pp. 32 of Cooper, R. (2020). *Comparing Psychopharmacological Prescriber Training Models via Examination of Content-Based Knowledge*. [Thesis] Available at: https://dash.harvard.edu/bitstream/handle/1/37365636/COOPER-DOCUMENT-2020.pdf?sequence=1http://
[658] American Psychological Association (2019). *Model Education and Training Program in Psychopharmacology for Prescriptive Authority.* [online] Available at: https://www.apa.org/about/policy/rxp-model-curriculum.pdf.
[659] American Psychological Association (2019). *Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority.* [online] Available at: https://www.apa.org/education-career/grad/rxp-designation-criteria.pdf.
[660] Curtis, S.E., Hoffmann, S. and O'Leary Sloan, M. (2022). Prescriptive authority for psychologists: The next step. *Psychological Services*. [online] doi:https://doi.org/10.1037/ser0000667.
[661] Cooper, R. (2020). *Comparing Psychopharmacological Prescriber Training Models via Examination of Content-Based Knowledge*. [Thesis] Available at: https://dash.harvard.edu/bitstream/handle/1/37365636/COOPER-DOCUMENT-2020.pdf?sequence=1http://
[662] Hughes, P., Phillips, D.C., McGrath, R.E. and Thomas, K.C. (2023). Examining psychologist prescriptive authority as a cost-effective strategy for reducing suicide rates. *Professional Psychology: Research and Practice*, 54(4). doi:https://doi.org/10.1037/pro0000519.

Further, other jurisdictions who have granted RxP have enacted safeguards to ensure the comparability of prescribing psychologists' training to that of other prescribers. For instance, Idaho requires prescribing psychologists' training to be substantially equivalent to that of an advanced practice psychiatric nurse practitioner.[663] Other states require collaboration between prescribing psychologists and their patients' PCPs or a collaborating physician, to ensure that the medico-scientific approach to knowledge and training is retained in the provision of BH care that includes medication-based treatment.[664] Measures like these may be effectively implemented to address concerns regarding training adequacy.

Impact on Access to Care. Opponents of RxP legislation also argue that granting prescriptive privileges to psychologists may not meaningfully improve consumers' access to care, given that there are relatively few prescribing psychologists overall nationwide. While it is true that the number of prescribing psychologists in the state may be small, particularly in the first few years after RxP legislation is passed, the presence of even a few more specialized BH prescribers can still result in tangible effects on consumer access by increasing the number of providers who can deliver comprehensive mental health care and to whom generalist primary care providers can refer their patients.[665,666] Utah is experiencing a significant shortage of psychiatrists, requiring between 60-80 additional psychiatrists to reach recommended provider-population ratios,[667] so the addition of even a handful of new specialized prescribers could serve as a step toward closing the state's gaps in access to care.

The recommendation to grant RxP to psychologists who receive additional training and supervised experience in psychopharmacology is only one of a wide range of solutions that may be used to further address Utah's access problem. RxP is a licensing-related regulatory change that falls within the purview of the Office of Professional Licensure Review (OPLR), and is meant to serve as a complement to the entire array of licensing-related recommendations set forth by OPLR—which itself must be considered alongside other efforts in the state to improve access to care for Utah consumers. Policymakers interested in further improving access to care, and especially Utahns' access to specialized BH care by capable prescribers, may consult Additional Ideas below.

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[663] IDCA-54-2317

[664] Illinois, Iowa, and Guam all require written collaborative practice agreements (CPA) with a primary care physician. In other states where written CPAs are not required, conditions for collaborative relationships are still specified. For example, in Colorado, prescribing psychologists must receive written permission from the patient's primary physician before prescribing medication; in Louisiana, prescribing psychologists are not allowed to treat patients who do not have an established primary physician, must consult with the physician before beginning or changing a prescription protocol, and must provide regular reports of patient consultations, treatment, and condition; and in New Mexico, prescribing psychologists must provide written notice of prescriptions to patients' health care providers within 24 hours of issuance.

[665] Curtis, S.E., Hoffmann, S. and O'Leary Sloan, M. (2022). Prescriptive authority for psychologists: The next step. *Psychological Services*. [online] doi:https://doi.org/10.1037/ser0000667.

[666] Choudhury, A. and Plemmons, A. (2023). Effects of giving psychologists prescriptive authority: Evidence from a natural experiment in the United States. *Health Policy*, [online] 134, p.104846. doi:https://doi.org/10.1016/j.healthpol.2023.104846.

[667] Health Resources and Services Administration (2023). HPSA Find. [online] data.HRSA.gov. Available at: https://data.hrsa.gov/tools/shortage-area/hpsa-find.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- What will be required to become licensed as a prescribing psychologist?
- What will be included in prescribing psychologists' scope of practice?
- How will prescribing psychologists be required to collaborate with medical providers?
- What regulatory bodies will provide oversight for prescribing psychologists?

Legislation that grants RxP should carefully address several key areas: 1) entry requirements to become a prescribing psychologist 2) scope of practice for prescribing psychologists, including what medications they may prescribe, and 3) practice requirements, including what will be required in terms of collaboration with medical colleagues.

What Will Be Required to Become Licensed as a Prescribing Psychologist?

We recommend that Utah model its entry requirements after those of other RxP jurisdictions:

- Education: Graduate degree in psychopharmacology, including a clinical practicum
- Exam: Passing score on the PEP
- Experience: 2 years of experience prescribing under the supervision of a prescriber (e.g., physician)

We recommend that Utah allow applicants to complete their graduate psychopharmacological education before, during, or after their doctorate, rather than specifying the order of training. Additional requirements that may supplement the core education, exam, and experience requirements listed above include: treating a minimum number of patients during clinical practicum and/or supervision (e.g., no fewer than 100), completing a peer review process by a panel of prescribers, or receiving written recommendations from collaborating physicians.

Additionally, if any classes of controlled substances are included in prescribing psychologists' scope of practice, they will also need to hold both a state Controlled Substances License, as well as register with the Drug Enforcement Administration's Diversion Control Division. Policymakers may further require that prescribing psychologists maintain malpractice insurance.

What Will Be Included in Prescribing Psychologists' Scope of Practice?

We recommend that prescribing psychologists be authorized to prescribe and administer only those medications customarily used in the treatment and management of BH disorders. Policymakers may wish to specify which controlled substances prescribing psychologists are authorized to prescribe or to clarify any exclusions. Prescribing psychologists should also be authorized to order and review relevant laboratory tests and imaging/studies (e.g., MRI, EKG,

sleep study, etc.), and to authorize hospitalization related to their prescribing, similar to what would be available to other prescribers in primary care or psychiatry.[668]

How Will Prescribing Psychologists Be Required to Collaborate with Medical Providers?

We recommend that prescribing psychologists be allowed to practice independently within their scope while maintaining a collaborative relationship with their patients' PCP. This relationship could include requirements that the prescribing psychologist provide their patient's PCP with written notice of the issuance of new prescriptions, consult with the PCP on changes in medication regimens, and/or provide periodic updates on the patient's treatment. Collaborative relationship guidelines are preferable to requirements for a CPA with a physician or other prescriber, as these arrangements have been found to "tether" practitioners to primary practice locations in more populated areas and thereby to continue to limit access to services in rural areas.[669]

What Regulatory Bodies Will Provide Oversight for Prescribing Psychologists?

Policymakers must also determine which regulatory bodies will be involved in rule-writing, administrative licensing functions, and disciplinary procedures for prescribing psychologists. This could include Division of Professional Licensing (DOPL) medical and/or pharmacy boards taking a co-regulatory or advisory role to the proposed multi-profession BH board or the relevant subcommittee, as is common in other jurisdictions that have passed RxP legislation. Of states that have authorized RxP, some give primary oversight responsibilities for prescribing psychologists to the state psychology board or an allied health board, in collaboration with medical or pharmacy boards. Other states give primary oversight responsibilities to medical or special advisory boards. Utah's approach should align with the recommendation to create a multi-profession advisory board, with subcommittees responsible for day-to-day licensing tasks.

Additional Ideas

To address the shortfall of prescribers with specialized training in treating BH conditions, Utah policymakers may also want to consider the following alternative approaches instead of or in addition to granting RxP.

- **Grant limited prescriptive authority to pharmacists** who have completed additional training in psychopharmacology. A growing body of research suggests that prescribing

[668] Colorado, Iowa, and New Mexico RxP scopes include similar language (e.g., Colorado: "ordering and reviewing laboratory tests in conjunction with a prescription for the treatment of a mental health disorder").
[669] Plemmons, A., Shakya, S., Cato, K., Sadarangani, T., Poghosyan, L. and Timmons, E. (2022). Exploring the relationship between nurse practitioner full practice authority, nurse practitioner workforce diversity, and disparate primary care access. *Policy, Politics, & Nursing Practice*, 24(1), p.152715442211380. doi:https://doi.org/10.1177/15271544221138047.

pharmacists can deliver care with similar outcomes to traditional prescribers[670] and may even make fewer prescribing errors in some settings than doctors.[671]

- **Expand the pool of medical providers specializing in BH** by allocating increased resources to and expanding capacity in training programs for psychiatrists, psychiatric physician assistants, and psychiatric nurse practitioners. For instance, further increase the number of psychiatric residency positions available in the state (beyond the earlier expansion in 2019 via HB174).
- **Invest in integrated care strategies for PCPs** to provide additional support to PCPs, thereby increasing the quality and safety of the BH care that they provide. As outlined in the Gardner Institute Utah Behavioral Health Assessment & Master Plan,[672] additional strategies to enable collaborative BH care may include: 1) "Creating regionally based referral networks to support primary care providers with clear pathways to specialty BH providers for patients who need higher-level care" 2) "Continu[ing] to support statewide consultation support to primary care providers (e.g., Psychiatric Consultation Program, or CALL-UP)" and 3) "Provid[ing] state-supported education, training, and technical assistance to primary care providers across the state to invest in the Collaborative Care Model."

[670] Weeks, G., George, J., Maclure, K. and Stewart, D. (2016). Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care. *The Cochrane database of systematic reviews*, [online] 11(11), p.CD011227. doi:https://doi.org/10.1002/14651858.CD011227.pub2.

[671] Poh, E.W., McArthur, A., Stephenson, M. and Roughead, E.E. (2018). Effects of pharmacist prescribing on patient outcomes in the hospital setting. *JBI Database of Systematic Reviews and Implementation Reports*, [online] 16(9), pp.1823–1873. doi:https://doi.org/10.11124/jbisrir-2017-003697.

[672] Utah Behavioral Health Assessment & Master Plan. (2023). [online] Salt Lake City, Utah: Ken C. Gardner Policy The University of Utah, p.9. Available at: https://gardner.utah.edu/wp-content/uploads/DRAFT_BehaviorHealthPlan-Jul2023_for-review.pdf?x71849

5a. Multi-Profession Board

Summary of Recommendation

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.

This recommendation applies to all of those licensed or certified to practice under:

- 58-60 Mental Health Professional Practice Act
- 58-61 Psychologist Licensing Act

Status Quo

The majority of Utah's behavioral health (BH) care workforce is currently regulated by the Division of Professional Licensure (DOPL), supported by recommendations from advisory boards for the following seven BH professions: Social Work, Marriage and Family Therapy, Clinical Mental Health Counseling, Substance Use Disorder Counseling, Psychology (including Behavior Analysis), Recreational Therapy, and Vocational Rehabilitation Counseling. The Utah Department of Health and Human Services (DHHS) also regulates a portion of the BH care workforce, overseeing peer support specialists, case managers, and crisis workers via the Office of Substance Use and Mental Health (OSUMH).

Board Duties & Responsibilities. DOPL's advisory boards make recommendations regarding state licensure for their respective professions. As laid out in statute, the specific responsibilities of each board include both policy and licensing functions.

- Policy functions include:
  - Recommending changes to rules and statutes.
  - Recommending policy and budgeting changes.
  - Recommending whether the board supports a change to a licensing act.[673]

- Licensing functions include:
  - Approving and establishing passing scores for examinations.
  - Screening applicants and recommending licensing, renewal, reinstatement, and re-licensure actions.
  - Assisting in reviewing complaints and advising regarding investigations.[674]
  - Conducting hearings associated with disciplinary action (when designated).

Board Appointment Process. Board members are recommended by the DOPL director, based on input from members of the respective professions and industry associations. Board members

[673] UCA 58-1-202(1)
[674] This is completed by a designated member of the board who is assigned on a rotating basis.

are then appointed by the executive director of the Department of Commerce and confirmed by the governor to serve for 4 years, with a maximum 2-consecutive terms.[675]

Board Composition. Most of DOPL's BH boards include four to six licensed professionals, out of a total of five to seven members. Most of these board members represent the highest levels of licensure for each occupation (e.g. Licensed Clinical Social Workers [LCSWs] on the Social Work Board, Psychologists on the Psychology board), but many also include at least one member at a lower level of licensure (e.g. certified social workers, behavior analysts, etc.). Each board includes 1 member of the public, for a total of 7 members of the public on DOPL's BH boards, or 18% of total board membership. These boards are not currently required to include other stakeholders from the BH system, such as employers, payers, or other public administrators with responsibility for BH care.

Existing Approaches

Across the U.S., BH licensees are typically overseen by independent regulatory boards that directly conduct licensing-related administrative and disciplinary tasks (e.g., issuing and renewing licenses, investigating complaints against licensees, and writing related rules). In some states, such as Utah, licensing boards are advisory in nature, providing recommendations and input to the regulatory body but without direct authority to make rules or take disciplinary action. This advisory board structure is relatively less common, but is believed to reduce anticompetitive industry capture of regulatory bodies and is becoming more widely adopted since the North Carolina Dental Board vs Federal Trade Commission (FTC) Supreme Court case.[676] The structure and composition of these boards vary by jurisdiction. An increasing number of states are beginning to adopt multi-profession and public-oriented boards to improve their responsiveness to consumers' BH needs.

Single-Profession and Multi-Profession Board Structures

In the U.S, 32% of states, including Utah, have a predominantly single-profession board structure that oversees and advises on BH occupational oversight. 68% percent of states (34 total) have a board that merges oversight for multiple core BH professions (see Table 3.3).[677]

[675] UCA 58-1-201(1-2)
[676] *North Carolina Board of Dental Examiners v. Federal Trade Commission* [2015] Available at: https://www.oyez.org/cases/2014/13-534.
[677] OPLR Analysis of BH Board Composition; OPLR National Review of Regulation
These boards often function autonomously, rather than in an advisory capacity.

Table 3.3 Jurisdictions with a Multi-Profession BH Board[678]	
• Arizona • Arkansas • California • Delaware • Florida • Georgia • Idaho • Indiana • Iowa • Kansas • Maine • Maryland • Massachusetts • Minnesota • Mississippi • Montana • Nebraska	• Michigan • Nevada • New Hampshire • New Mexico • New York • Ohio • Oklahoma • Oregon • Pennsylvania • Rhode Island • South Carolina • Tennessee • Texas • Vermont • Virginia • Wisconsin • Wyoming

Board Composition

States with multi-profession boards range from having as few as 5 members to as many as 16, with an average of 10 members.[679] Utah has 40 total board members divided among 7 occupation-specific boards. The amount of public representation on advisory boards differs depending on jurisdiction. Some states have increasingly prioritized public representation, and states with multi-profession advisory BH boards currently include public membership of 23% on average.[680] Some states also include department-level leadership or other government staff with the requisite policy experience on their healthcare-related licensing boards.[681]

Each state with a BH multi-profession board has varying representation of different occupations and different levels within BH related occupations (see Table 3.4). These multi-profession boards generally oversee some or all of the social work, professional counseling, and marriage & family therapy licensees, and several states have multi-profession BH boards that also include school social workers, school psychologists, and peer support specialists. In Utah, these latter three professions are regulated by other state agencies and are not involved with DOPL's advisory boards.[682]

[678] OPLR Analysis of Recovery Assistance Programs
[679] OPLR Analysis of BH Board Composition
[680] Ibid.
[681] KY Rev. Stat. 311.530(2). The Kentucky State Board of Medical Licensure includes the commissioner of public health.
[682] OPLR Analysis of BH Board Composition

Table 3.4 Average Public Representation on Multi-Profession BH Boards	
Highest (California)	54%
National Mode	33%
Utah	**18%**[683]
Lowest (Mississippi)	0%

Rationale

Why create a multi-profession advisory board?

- Single-profession boards may inhibit collaboration & consistency in BH regulation
- Multi-profession board structures support system-level thinking
- Increased public & expert representation encourages consumer-focused policy

Single-Profession Boards May Inhibit Collaboration & Consistency in BH Regulation

Despite being regulated separately, many of Utah's BH professions share overlapping scopes, responsibilities, and professional values—and indeed, at many times fill the same roles in the BH workforce and perform the same core functions in their work. For instance, psychologists, LCSWs, Clinical Mental Health Therapists (CMHCs), and Marriage and Family Therapists (MFTs) are all authorized to practice "mental health therapy,"[684] and these professions' respective practice acts all contain similar standards of professional conduct.

However, because the regulation of each BH profession is strongly influenced by their separate, single-profession boards, their current and evolving entry requirements, practice standards, and disciplinary processes may be difficult to keep consistent. This may be problematic for a variety of reasons. For example, the requirements to achieve licensure for similar scopes of practice may be inconsistent—meaning that someone trained in one field may be expected to complete substantially more training than someone trained in another, in order to ultimately be allowed to perform many of the same functions in the workforce. Similarly, multiple individuals who engaged in the same form of unprofessional conduct may end up with different disciplinary actions—not because of substantive differences in the nature of their violations, but because of which licensing board is responsible for the outcomes of their case. This also may apply to how discipline is carried out, with boards implementing often inconsistent approaches to assessing fines for non-compliance and to authorizing early reinstatement for probationers.

[683] This reflects the 7 of 40 board positions that are filled by members of the public in Utah's current single-profession board structure. Given that public members may concurrently serve on more than one of DOPL's advisory boards, the percentage of public representatives may be even lower in practice.
[684] UCA 58-61-102 [Psychologist]; UCA 58-60-202 [LCSW]; UCA 58-60-302 [MFT]; UCA 58-60-402 [CMHC]

During OPLR's review, professionals and employers alike expressed concerns with the regulatory status quo, and with the inconsistencies that it precipitates.[685] For instance, some stakeholders shared their desire for more parity and patient focus in the occupational regulation of BH providers. Others expressed how the reality of working in collaborative, interdisciplinary teams was at odds with the current board oversight structure, especially given that "collaborative work is one of the profession's core principles." As one practitioner from a local mental health authority shared, "We'd hear in an annual report about the other professions, but never had a clear understanding of the broader system." This concern is also reflected in the Gardner Institute's recent Utah Behavioral Health Assessment & Master Plan, which points to different siloed state agencies as part of the reason for the lack of system-level coordination. This report highlights how "workforce shortages are being aggravated by a lack of system-level coordination, disrupting care, and limiting access" and that,[686]

> *"the lack of system-level coordination… stems from an increasing number of state agencies [and other system stakeholders] addressing behavioral health issues in positive ways with initiatives that are needed, well-intentioned, and often well-designed—but often doing so in an uncoordinated way."*

As an administrator at a major BH agency expressed, "There seems to be a disconnect as we go through these [licensing] processes, so bringing the boards into one board seems like a great idea."[687] One survey respondent even suggested that "...a board could be created of multidisciplinary professions related to health and mental health that bridges professions in their values and goals."[688] Representatives from consumer advocacy organizations were especially supportive of the idea of "adding more voices" to boards, to better represent the needs of BH consumers.[689]

The responsibilities of DOPL's advisory boards include duties related to administering day-to-day issues for individual licensees, as well as guiding regulation and advising on policy. While the administration of licensing functions (e.g., reviewing complaints against licensees, recommending whether a license should be granted, reinstated, or revoked) may be accomplished well by those who understand individual licensees' circumstances best (e.g., others who work in similar settings/roles, or from within the same profession), policy functions may be better accomplished using a board structure and composition that puts the BH system—and particularly the BH consumer—at the fore, rather than the specific work role,

[685] OPLR Listening & Vetting Tour
[686] Pg. 6, Utah Behavioral Health Assessment & Master Plan. (2023). [online] Salt Lake City, Utah: Ken C. Gardner Policy The University of Utah, Available at: https://gardner.utah.edu/wp-content/uploads/DRAFT_BehaviorHealthPlan-Jul2023_for-review.pdf?x71849.
[687] OPLR Listening & Vetting Tour
[688] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[689] OPLR Listening & Vetting Tour

setting, or occupation of any given member or group within the BH workforce. As an in-depth review of mental health occupational regulation outlines,[690]

> *"A compelling case can be made for a buffer or advisory body between individual professional associations… and the elected government of the day. Such a body, comprised broadly of representatives of the various mental health care provider groups and demand-side or patient/client groups, would review proposed regulations originating with individual accredited professional bodies pertaining to entry standards, post-entry codes of conduct, and disciplinary procedures. It would then advise governments on whether to accept or reject the proposed requirements in the form of official government regulations."*

Creating a multi-profession board would promote interprofessional collaboration and help to facilitate increased standardization of BH regulation across the different professions. This in turn would provide greater consistency in regulation not only for licensed professionals themselves, but also for the organizations that employ them, and for the consumers who access their services.[691]

Multi-Profession Board Structures Support System-Level Thinking

Some of the existing regulatory inefficiencies and lack of systems-level thinking may stem from Utah's current single-profession board structures, which research suggests can create regulatory 'siloes,' limit collaboration across occupations, and drive fragmented licensure policies, ultimately hampering the state's ability to address systemic issues.[692,693] Although the purpose of a regulatory board (from the state's perspective) is to prevent consumer harm, academic and policy researchers have found that single-profession board systems can in fact promote professional self-interest over the needs of consumers, thereby decreasing the public's trust in the BH system.[694] Single-profession regulatory boards tend to emphasize the regulation

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[690] See pp. 67 of Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *JSTOR*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.
[691] Lloyd, I., Dunn, J. and Wardle, J., (2021). Regulation of the Naturopathic Workforce. *Naturopathy: Practice, Effectiveness, Economics, Safety. In: Lloyd I, Steel A, Wardle J, eds. Toronto, Canada: World Naturopathic Federation*, pp.28-5. Available at: https://www.omnes.fr/assets/Uploads/Health-Technology-Assessment-HTA-eBook-WNF.pdf#page=60
[692] Leslie, K., Bourgeault, I.L., Carlton, A.L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., Cometto, G. and Lin, V., (2022). Design, operation and strengthening of health practitioner regulation systems: A rapid integrative review. https://doi.org/10.21203/rs.3.rs-2370701/v1
[693] Finnochio, L., Blower, C., Blick, N. and Gragnola, C. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation Taskforce on Health Care Workforce Regulation*. [online] San Francisco, CA: Pew Health Professions Commission. Available at: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf.
[694] Derbyshire, R.C. (1983). How effective is medical self-regulation? *Law and Human Behavior*, 7(2-3), p.10. doi:https://doi.org/10.1007/BF01044523

of exclusive scopes of practice, which can lead to scope disputes between related professions, leaving many professionals underutilized and thereby limiting access to care for patients.[695,696]

The creation of a multi-profession board will promote a systems-level approach to BH licensure. Multiple studies and reviews suggest that increased efficiency and collaboration are two factors driving the increase in multi-profession boards and regulation across the country.[697] Key stakeholders from across the BH care system, including both regulators and practitioners, agree that a multi-profession board would not only streamline the regulatory processes of these related professions, but also facilitate greater inter-professional communication to improve workforce leaders' understanding of the system and its needs as a whole.[698]

Formal inter-professional coordination between DOPL's BH boards is currently limited. One DOPL administrator attends the various board meetings and conveys relevant information between boards; combining the boards could expedite communication among the various BH occupations and provide broader perspectives regarding disciplinary measures. Research suggests that unified boards do in fact promote consistency within disciplinary actions among the different BH professions.[699] This is further backed by research indicating that strengthening regulation systems provides significant benefits to the health and safety of consumers, including improving the competence of the health workforce, increasing the safety of provided services, and fostering flexibility and innovation within the BH workforce to meet population needs.[700]

Some experts frame a multi-professional approach to regulation as a necessity for the well-being of health care systems. One researcher stated that "given the lack of information on patient safety in mental health, the experiences, research, and practices of other health care settings can provide an invaluable source of information [for BH workers]."[701] A multi-profession board would also parallel the interdisciplinary, team-based approaches now common within the BH care sector. Many Utah practitioners explained to OPLR that they already deliver BH

[695] Leslie, K., Bourgeault, I.L., Carlton, A.L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., Cometto, G. and Lin, V., (2022). Design, operation and strengthening of health practitioner regulation systems: A rapid integrative review. https://doi.org/10.21203/rs.3.rs-2370701/v1.

[696] Finnochio, L., Blower, C., Blick, N. and Gragnola, C. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation Taskforce on Health Care Workforce Regulation*. [online] San Francisco, CA: Pew Health Professions Commission. Available at: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf.

[697] Leslie, K., Bourgeault, I.L., Carlton, A.-L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., Cometto, G. and Lin, V. (2022). Design, operation and strengthening of health practitioner regulation systems: A rapid integrative review. doi:https://doi.org/10.21203/rs.3.rs-2370701/v1.

[698] OPLR Listening & Vetting Tour

[699] Lloyd, I., Dunn, J. and Wardle, J., (2021). Regulation of the Naturopathic Workforce. *Naturopathy: Practice, Effectiveness, Economics, Safety. In: Lloyd I, Steel A, Wardle J, eds. Toronto, Canada: World Naturopathic Federation*, pp.28-5. Available at: https://www.omnes.fr/assets/Uploads/Health-Technology-Assessment-HTA-eBook-WNF.pdf#page=60

[700] Leslie, K., Bourgeault, I.L., Carlton, A.-L., Balasubramanian, M., Mirshahi, R., Short, S., Carè, J., Cometto, G. and Lin, V. (2022). Design, operation and strengthening of health practitioner regulation systems: A rapid integrative review. doi:https://doi.org/10.21203/rs.3.rs-2370701/v1.

[701] See pg. 2 of Brickell, T.A. and McLean, C. (2011). Emerging Issues and Challenges for Improving Patient Safety in Mental Health. *Journal of Patient Safety*, 7(1), pp.39–44. doi:https://doi.org/10.1097/pts.0b013e31820cd78e.

services in multi-profession teams. For example, one practitioner shared, “we work multi-disciplinary at the [Utah State] Hospital…[and there is] lots of value [in that approach].”[702]

Some BH professionals have already begun to independently respond to the need for greater interprofessional collaboration by creating an industry working group that coordinates across occupations to discuss legislative and professional concerns.[703] Creating a formal, multi-profession advisory board will formalize these efforts to foster communication and collaboration among different BH related professions. After learning of the proposal for a multi-profession board, one DOPL board member commented, “I assumed [some kind of combined board or collaboration] was happening at some level anyways. But there hasn’t been.”[704] As one practitioner put it, a multi-profession board could “bridge professions in their values and goals,”[705] encouraging BH professionals to take a broader view of community- and system-wide challenges when developing and implementing policy.

Increased Public & Expert Representation Encourages Consumer-Focused Policy

Historically, licensing boards have been composed primarily of members who are themselves licensed practitioners of the regulated occupation (“active market participants”). However, in recent years, particularly since the North Carolina Dental Board v. FTC case,[706] states have become increasingly aware of profession-dominated boards’ potential for engaging in anti-competitive or antitrust behavior. Even before this case, Utah’s DOPL boards were already advisory in nature and included at least one public member on each board, measures that may help to counteract anti-competitive pressures.

In addition to increasing system-level awareness via the creation of a multi-profession board, Utah can further strengthen its focus on protecting consumer safety and welfare by increasing the new BH board’s proportional representation of public members and other experts. As recommended by the Pew Health Professions Commission, public representation should comprise at least one-third of board membership, an increase from the current statutory requirement that DOPL’s five-member boards include one public member.[707,708] In fact, public representation on DOPL’s BH boards currently may be even lower than usual, as there is a vacancy on one board, and a single individual sits as the public member on two other

[702] OPLR Listening & Vetting Tour
[703] Ibid.
[704] OPLR Listening & Vetting Tour
[705] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[706] *North Carolina Board of Dental Examiners v. Federal Trade Commission* [2015] Available at: https://www.oyez.org/cases/2014/13-534.
[707] UCA 58-1-1(b)
[708] Finnochio, L., Blower, C., Blick, N. and Gragnola, C. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation Taskforce on Health Care Workforce Regulation*. [online] San Francisco, CA: Pew Health Professions Commission. Available at: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf.

boards.[709,710] According to state administrators, this may be due in part to difficulties in finding public members who are interested in and willing to invest time in serving as board members.

Public representation from those with expertise in patient safety, health policy, and economics is crucial if regulation is to "objectively serve consumer protection and broader health policy goals."[711] Even when practitioners from multiple professions are represented on a licensing board, if those professions have overlapping scopes, they may still be incentivized to support policies that protect industry interests over those of the consumer.[712] Greater public representation on health profession boards has been shown to promote a consumer focus in terms of both access (e.g., by reducing the number of "nonsense requirements" that limit entry into BH occupations and increase costs)[713,714,715] as well as safety (as indicated by higher rates of serious disciplinary actions against licensees).[716] Consumer advocates, including those with expertise in substance use disorders and suicide prevention, have also voiced their desire for increased public representation and consumer focus on DOPL's BH boards.[717] As early as 2004, in a report specific to health care regulation,[718] the FTC recommended that states "broaden the membership of state licensure boards," explaining that

> *"...state licensure boards with broader membership, including representatives of the general public, and individuals with expertise in health administration, economics, consumer affairs, education, and health services research, could be less likely to limit competition by allied health professions and new business*

[709] Utah Department of Commerce Division of Professional Licensing . (n.d.). *Social Work Board Members*. [online] Available at: https://www.dopl.utah.gov/social-work/board-members/
[710] Utah Department of Commerce Division of Professional Licensing . (n.d.). *Psychology Board Members*. [online] Available at: https://www.dopl.utah.gov/psychology/board-members/
[711] See pg. 16. of Finnochio, L., Blower, C., Blick, N. and Gragnola, C. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation Taskforce on Health Care Workforce Regulation*. [online] San Francisco, CA: Pew Health Professions Commission. Available at: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf
[712] Allensworth, R.H. (2017). Foxes at the Henhouse: Occupational Licensing Boards up Close. *California Law Review*, [online] 105, p.1567. Available at: https://heinonline.org/HOL/LandingPage?handle=hein.journals/calr105&div=50&id=&page=
[713] Pg. 614, Graddy, E. and Nichol, M.B. (1989). Public Members on Occupational Licensing Boards: Effects on Legislative Regulatory Reforms. *Southern Economic Journal*, 55(3), p.376-400. doi:https://doi.org/10.2307/1059577.
[714] Finnochio, L., Blower, C., Blick, N. and Gragnola, C. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation Taskforce on Health Care Workforce Regulation*. [online] San Francisco, CA: Pew Health Professions Commission. Available at: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf
[715] See pg. 17 of Leslie, K., Demers, C., Steinecke, R. and Bourgeault, I.L., 2022. Pan-Canadian Registration and Licensure of Health Professionals: A Path Forward Emerging from a Best Brains Exchange Policy Dialogue. *Healthcare Policy*, *18*(1). https://www.scienceopen.com/document_file/91883439-1d39-4790-b08e-14bc95033b87/PubMedCentral/91883439-1d39-4790-b08e-14bc95033b87.pdf
[716] Graddy, E. and Nichol, M.B. (1989). Public Members on Occupational Licensing Boards: Effects on Legislative Regulatory Reforms. *Southern Economic Journal*, 55(3), p.610. doi:https://doi.org/10.2307/1059577.
[717] OPLR Listening & Vetting Tour
[718] See pg. 22 of Hyman, David, ed. *Improving Healthcare: A Dose of Competition A Report By The Federal Trade Commission and Department of Justice (July, 2004), with various Supplementary Materials*. Boston, MA: Springer US, 2005. https://link.springer.com/book/10.1007/b135898

forms for the delivery of healthcare, and are less likely to engage in conduct that unreasonably increases prices or lowers access to health care."

While general public membership is important and has been associated with the creation of policies more favorable to consumers, expert membership is also crucial. Individuals with specific expertise in economics and/or consumer advocacy are better prepared than general public members or even practitioners themselves to understand "the costs—in terms of price and availability—that may be associated with a restriction aimed at improving quality."[719,720,721]

Expert members with experience in policy and governmental operations are also well-positioned to provide insight on how to design effective, easily implemented policies and facilitate coordination between government agencies. For instance, in Utah, BH care facility licensing and Medicaid are regulated by DHHS, a separate agency that has minimal systematic communication or coordination with DOPL, which licenses individual practitioners. Including a DHHS representative on the multi-profession board would help bridge this gap and foster both system-level and consumer-focused thinking by improving the two agencies' coordination regarding individual- and facility-level licensure requirements, investigations and consumer safety, and Medicaid reimbursement (which is closely tied to individual practitioners' licenses). Additionally, incorporating the perspectives of employers, payers, and researchers would also provide valuable insights into challenges within the current BH system.

Key Considerations

What key decisions will policymakers need to make to implement this change?

- How will the multi-profession board be structured? (entities & responsibilities)
- Who will be appointed to the multi-profession board? (size & composition)

How Will the Multi-Profession Board Be Structured? (Entities & Responsibilities)

The existing DOPL boards are responsible for two sets of functions: policy functions (e.g., advising on licensing law and policy), and licensure functions (e.g., advising on the issuance of licenses and disciplinary actions against licensees). Under OPLR's recommendation, the

[719] See pg. 1605 of Allensworth, R.H. (2017). Foxes at the Henhouse: Occupational Licensing Boards up Close. California Law Review, [online] 105, p.1567. Available at: https://heinonline.org/HOL/LandingPage?handle=hein.journals/calr105&div=50&id=&page=.

[720] The Connecticut Board of Examiners for Nursing currently includes the director of a patient safety organization. Connecticut State Department of Public Health (n.d.). *Board of Examiners for Nursing*. [online] Connecticut State Department of Public Health . Available at: https://portal.ct.gov/DPH/Public-Health-Hearing-Office/Board-of-Examiners-for-Nursing/Board-of-Examiners-for-Nursing.

[721] Patient Centered Outcomes Research Institute (2015). *Lisa Freeman*. [online] Patient Centered Outcomes Research Institute. Available at: https://www.pcori.org/people/lisa-freeman

multi-profession BH board would be responsible for the policy functions, and subcommittees would carry out licensure functions. Both levels (the main board, and the subcommittees) would maintain their advisory relationship to DOPL. In the case of the main board, this would involve advising on policy, while in the case of the subcommittees this would involve advising on individual-level licensing-related matters.

In order to effectively manage this change, policymakers should carefully consider how to structure both the main multi-profession BH board, as well as the subcommittees, and how to effectively divide labor between them. Some key points to consider might include:

- How to divide responsibilities between the main board and the subcommittees
- How to organize the subcommittees, and what responsibilities will be delegated to each

Subcommittees could be divided by licensing and administrative functions.[722] By functions, this might involve establishing one committee on educational and entry functions (e.g., to verify licensees' qualifications), one committee to handle criminal history and investigations (e.g., to evaluate whether an applicant's criminal history would disqualify them from licensure), and one committee to monitor probationers or others who have had disciplinary action taken against their licenses. Each of these subcommittees would include members with relevant experience, such as educators and criminal justice experts, alongside BH professionals. Board subcommittees could also be organized to reflect the work roles, settings, scopes of practice, or professions of licensed practitioners, or the consumers served by BH licensees. For instance, a subcommittee could be organized for clinical-level providers who are authorized to assess, diagnose, and treat BH disorders, while a separate extenders' subcommittee could be organized for non-clinician providers who provide psychosocial support services. Regardless of the organizing principle, it will be important that the subcommittees be staffed by those with relevant expertise and experience to advise DOPL on day-to-day licensing and disciplinary functions for licensees.

Policymakers will need to take into consideration the specific responsibilities of the main multi-profession board and how they will differ from the various subcommittees. We recommend that the overarching multi-profession behavioral health board keep the same duties and responsibilities established under statute 58-1-202 of Utah code, while designating specific direct licensure responsibilities requiring specialized training and experience to the various subcommittees.

Who Will Be Appointed To The Multi-Profession Board? (Board Size & Composition)

Board Size. Policymakers will also need to determine an appropriate size for the multi-profession board. The seats on DOPL's seven BH boards currently total 40 board positions, but maintaining this number of members would likely be impractical—industry experts expressed concern that it would be difficult for an overly large board to efficiently reach

[722] For example, California's Board of Behavioral Sciences initially adopted this approach with an education committee, licensing committee, examination committee, and consumer services committee. https://www.bbs.ca.gov/pdf/publications/sunset_2004.pdf.

consensus.[723] We recommend that the multi-profession board be composed of 10-15 total members. This board size is consistent with that of multi-profession boards in other jurisdictions and will be both 1) large enough to allow for sufficient professional, public, and expert representation and 2) small enough to facilitate productive discussion and collaboration.

The subcommittees may be composed both of members of the main board, in addition to other advisory members who serve only on the subcommittee. Each subcommittee should include as many members as needed to manage the workload of licensing-related matters over which they have responsibility. If, for example, subcommittees are organized according to similar scopes, with a clinicians' subcommittee and an extenders' subcommittee, the scale of each of these workforces (i.e., the clinician workforce, and the extender workforce) would need to be taken into account in determining an appropriate number of subcommittee members.

Board Composition. Policymakers will also need to carefully address board composition, especially for the main multi-profession BH board in its policy advising duties. Considering that academic research suggests at least one third of board members should represent the public, OPLR recommends that Utah adopt this ratio of public representation in the multi-profession BH board.[724] This will help the board to maintain a more consumer-focused approach and remain accountable to prioritizing public interests over professional interests. In particular, OPLR proposes that the 'public members' represent specific expertise important to the BH system: consumer advocates, employers, insurers/payers, researchers, medical professionals (with a psych specialty), and DHHS. DHHS is particularly critical given its many ties to and oversight of the BH system through Medicaid, facility-level licensing, its oversight of Local Mental Health Authorities (LMHAs), and as a major employer through the Utah Division of Child and Family Services, Corrections, and other divisions.

Discussions of board composition should also consider how the board membership will represent the needs of demographic groups that statistically have less access to BH care in Utah. A recent report from the Kem C. Gardner Institute at the University of Utah points to rural communities, culturally and linguistically diverse communities, and individuals with complex behavioral needs as experiencing a particular lack of access to BH care.[725] One potential approach would be to select board members who are a part of these groups to ensure the board takes into consideration particular challenges or obstacles that are contributing to the current lack of access. This approach has been adopted by several states, including Maryland,[726] North

[723] OPLR Listening & Vetting Tour
[724] Finnochio, L., Blower, C., Blick, N. and Gragnola, C. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation Taskforce on Health Care Workforce Regulation*. [online] San Francisco, CA: Pew Health Professions Commission. Available at: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf.
[725] Utah Behavioral Health Assessment & Master Plan. (2023). [online] Salt Lake City, Utah: Ken C. Gardner Policy The University of Utah, p.9. Available at: https://gardner.utah.edu/wp-content/uploads/DRAFT_BehaviorHealthPlan-Jul2023_for-review.pdf?x7184.
[726] MDCA-17-202(3)

Dakota,[727] Iowa,[728] Oregon,[729] and Louisiana,[730,731] which require that board appointments demonstrate various combinations of geographic, ethnic, gender, and racial diversity. Alternatively, board members would not need to belong to an underserved group, but could be designated to elevate and represent the needs of particular subpopulations that have relatively limited access to BH care. If DOPL chooses to adopt this adjustment, they would need to consider how these groups would be represented and how board nominations would be solicited going forward. Two examples are provided in Table 3.5 below.

Table 3.5 Examples of Multi-Profession Board Composition

	Example 1: Scope Focus	Example 2: Education Focus
Regulated Professionals	• 4 BH Clinicians (e.g., LCSW, MFT, CMHC, Psychologist) • 3 BH Non-Clinicians (e.g., SUDC, Rec Therapist, Voc Rehab)	• 1 doctoral-level clinicians • 4 master's-level clinicians • 2 non-clinical master's-level practitioners • 1 bachelor's-level practitioner • 1 associate/certificate level practitioner
Public Members/ Subject Matter Experts	• 1 Consumer Advocate • 1 Employer • 1 DHHS Official • 1 Medical professional	• 1 Consumer Advocate • 1 Employer • 1 Academic/Researcher • 1 Payer/Insurer • 1 DHHS Official • 1 Medical professional
Total	11	15

Additional Ideas

Utah policymakers may wish to consider alternative approaches instead of or in addition to creating a multi-profession BH board.

- **Require a higher proportion of public members on single-profession boards.** Rather than creating a multi-profession board, policymakers might also consider

[727] NDCA 54-06-19
[728] IA-69-16A
[729] ORS-675-100(2)(b) Oregon requires the governor to strive to represent the state's geographic areas and ethnic groups in appointing psychology board members.
[730] LARS-37-3703 Louisiana's boards that oversee behavioral health also require the governor to "…ensure that his appointments demonstrate race, gender, ethnic, and geographical diversity."
[731] LARS-37-1104

mandating that a higher proportion of the existing boards be members of the public. This might include employees involved in the behavioral system from within other agencies (DHHS, Utah State Board of Education), public health experts, employers/providers, payers, & consumer advocates. Academic research suggests that at least 33% of board composition should include members of the public.[732] This adjustment would maintain current board structures, but increase public representation, and thus help the boards to prioritize the needs of consumers.

- **Mandate additional data collection,** including data related to access to care and patient safety and health outcomes. Improved data collection could help provide further insights into potential gaps in BH occupational oversight.[733,734]

[732] Finnochio, L., Blower, C., Blick, N. and Gragnola, C. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation Taskforce on Health Care Workforce Regulation*. [online] San Francisco, CA: Pew Health Professions Commission. Available at: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf.
[733] Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st Century. National Academies Press (US). http://www.ncbi.nlm.nih.gov/books/NBK222274/
[734] Niles, L., & Olin, S. (2021). *Behavioral health quality framework: A roadmap for using measurement to promote joint accountability and whole-person care* (pp. 1–38). The National Committee for Quality Assurance. https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf

Key Takeaways

The combined set of recommendations outlined above can provide meaningful improvements to both access and safety for Utah consumers. Licensure reform lays a foundation for these improvements, but it is only one piece of the puzzle. The actions of regulatory agencies (Division of Professional Licensing [DOPL], Department of Health and Human Services [DHHS]), individual practitioners, supervisors, employers, and payers will be critical to realizing improvements for consumers. To that end, this section lays out risks and opportunities to bear in mind as these recommendations are considered and implemented, and as policymakers work toward comprehensive, system-wide solutions to improve both access to behavioral health (BH) care and the safety of BH care for Utahns.

Key Considerations for Implementation

First, the impact of these recommendations will hinge, to a great extent, on how they are implemented. The following considerations are critical to keep in mind during this process.

- **The Office of Professional Licensure (OPLR's) recommendations are interconnected.** For instance, creating a supervision-based alternative pathway to licensure for clinical therapists in lieu of clinical exam is a low-risk policy for consumers' safety, as long as the quality of clinical supervision is strengthened in the ways recommended above. Adopting the recommendations piecemeal may result in unintended consequences.
- **DOPL and DHHS have limited resources** to implement changes. As mentioned above, DOPL tends to have lower fees and fewer full time employees (FTEs), but faster licensing application processing times compared to other states' licensing bodies. Further, although DHHS administers training and occupational regulation for the three certifications in this review, this is neither their sole nor primary responsibility. Thus the changes recommended above will require a heavy lift from both agencies in a context of already constrained resources.
- **Interagency coordination is a key piece** of the puzzle on safety. Because licensing is divided between DHHS (for facilities) and DOPL (for individual practitioners), and safety problems may come first to law enforcement, there is a potential for issues to be lost between the artificial divisions inherent in any large organization. Facilities with safety problems may stem from a small number of practitioners. Conversely, poor facility-level policies and culture can produce a cohort of ill-prepared practitioners. The issues are intertwined and require joint efforts to untangle and regulate effectively.

Apart from these specific issues, the most basic risk around licensure reform is that workforce improvements alone may not fully address the need for improved access and safety in BH care. OPLR's statutory mandate is to review occupational regulation. Licensure reforms have the potential to increase the number of licensed practitioners, and to a lesser extent, labor force participation, and workforce distribution (geographic) and composition. However, there are other factors that influence access beyond workforce availability—like insurance coverage, transportation, facilities' locations and hours of operation, societal and cultural attitudes and stigmas around seeking BH services. Throughout the review process, stakeholders consistently raised important issues beyond licensure that will be essential to improving access to care, and to maintaining or improving safety. For example, industry leaders from the Utah Association of Counties' Behavioral Healthcare Committee (UBHC) shared:

> *"The biggest issue facing access for Utah residents is cost of treatment… For example, at the beginning of the Affordable Care Act, only 3% of Utah residents had high deductible health plans. In 2021, that number reached an incredible 68% of working Utahns. That places Utah in the top 10 in the country… many people seek out treatment only to leave after the first or second visit due to not being able to pay for treatment out of pocket… many more don't even seek out treatment because they know they can't afford it… In behavioral health, you are most likely to see a therapist 7-12 times before treatment is completed. That's a lot to pay out of pocket. This is the biggest barrier to treatment in Utah."*

Further analysis of how Utah is performing on the various dimensions of the 6 A's of access to care is critical to ensuring that Utah's unmet need for care is addressed. That is, analyzing more fully the extent to which BH care is available, affordable, accessible, acceptable, and adequate in the eyes of Utah consumers, and to what extent they are aware of BH care offerings, will be important moving forward. OPLR's recommended licensing policy reforms may help to increase the size of the available workforce, but they alone will not fully address the access issue. Likewise, building a better understanding of the relationship between various regulatory levers and safety outcomes for consumers is critical. Safety must be maintained or improved—not degraded—as changes are made to improve access, and occupational regulation must work in concert with other system-level changes to address safety concerns.

System-Wide Considerations

Risks

Although the licensing policy reforms outlined above may help to improve access and safety, making these changes without additional coordinated, system-wide efforts will miss the mark. Policymakers should work to improve other aspects of the system—particularly post-secondary education and insurance—in conjunction with implementing OPLR's recommended licensure policy changes.

- **Higher education capacity is a significant constraint**—likely more important than licensure burdens. Conversations with Utah System of Higher Education (USHE) and specific institutions indicate that graduate level programs are turning away qualified applicants due to lack of capacity (faculty, space. Simultaneously, OPLR estimates a need for ~8,000 additional practitioners just to meet Utah's current unmet need for care (not accounting for workforce attrition, population growth, or increases in BH disorder prevalence following the COVID-19 pandemic). To the degree that higher education capacity is a bottleneck leading to unmet need in BH, this should be a top priority for lawmakers.
- **Insurance plans and funders play a large role** in the BH care of Utahns. Insurance policies, in many ways, drive the market. This is true around paneling, credentialing, and contracting with practitioners, and also in terms of which services are reimbursed and at what levels. Licensure and higher education changes may help to open up significant new workforce capacity—but payers will play a major role in retaining (or losing) that workforce. Access issues may also be exacerbated or alleviated through the efforts of insurance companies and public payers to provide adequate networks and coverage to consumers.

Opportunities

Further, additional opportunities for improvement and advancement of the BH field are critical for both policymakers and industry participants to keep in mind as the State pursues comprehensive reforms to improve both access and safety for Utah consumers.

- **Client feedback, patient outcomes, and evidence-based practices** are beyond the scope of licensure (and thus this review) but hold a great deal of potential for addressing the mental health crisis in Utah. BH is more difficult to measure than physical health in many instances—there is no blood pressure cuff to detect depression as yet. However, there are ways to incorporate more data-driven and outcomes-focused efforts into BH interventions. Simple client feedback is a first step; implementing evidence-based treatments with more fidelity is another. Measurement-based care, which involves using systematic and routine assessment of the patient's perspective on their progress, has consistently been associated with improved patient outcomes, and is itself a core element of evidence-based practice.[735] There are likely gains in terms of cost savings, improved safety, and improved outcomes from simple changes in practice on this front.
- **Extenders in the BH workforce could spur innovation** in norms and modes of care that lower cost and/or improve outcomes. As we discovered in our review, there is a growing interest among some industry insiders to explore new models and interventions beyond 1:1 clinical therapy and medication. Extenders provide an opportunity to innovate with new ways of addressing BH issues through education, prevention, early

[735] American Psychological Association (2022). *Measurement-based Care*. [online] Apaservices.org. Available at: https://www.apaservices.org/practice/measurement-based-care#:~:text=Measurement%2Dbased%20care%20(MBC),inform%20treatment%20decisions%20and%20engage

detection, and therapeutic interventions that broaden the reach of advanced practitioners by complementing their expertise with extenders.

A Unified Path Forward

The adoption and implementation of OPLR's recommended policy reforms will require ongoing monitoring and course correction. Some of these changes will require revisiting statutes, rules and policies over time. Consequently, the various regulatory bodies and industry groups dedicated to thinking about BH and the healthcare workforce should continue to work together to implement these recommendations in a coordinated, unified manner.

- The Utah Substance Use Advisory and Mental Health Advisory Council (**USAAV+**)[736] was created by the 1990 Utah Legislature for the purpose of coordinating the state's efforts related to substance use and now coordinates efforts across the state to eliminate substance use and mental health disorders throughout Utah. USAAV+ may play multiple roles related to these recommendations, but may be particularly helpful in educating and disseminating information about any changes to licensure, and also gathering broad input for rulemaking or other decisions.
- The newly formed Health Workforce Advisory Council (**HWAC**)[737] is charged with providing information and recommendations to help expand and strengthen Utah's health workforce. The HWAC, and related functions like the Health Workforce Information Center (HWIC) will be crucial in monitoring changes in the BH workforce over time related to these recommendations, and suggesting additional changes to statute and rule as needed.
- Compared to this review, the **Behavioral Health Master Plan** effort, led by the Utah Hospital Association, the Kem C. Gardner Institute and others, has taken a much broader view toward improving the BH care system as a whole. Many of the findings and recommendations in the Master Plan document are related to and supportive of OPLR's recommendations. Those involved in implementing the recommendations of the Master Plan would also be well positioned to help maintain the focus on licensure and the policy recommendations outlined in this report.
- **Multiple executive branch agencies** (beyond DOPL within Commerce, and DHHS) will be invaluable in implementing these recommendations. USHE and its embedded workforce development policy group, Talent Ready Utah (TRU), will be critical for monitoring the throughput of higher education programs. The Utah Insurance Department (UID) will be important for convening major insurance plans, educating and supporting them in making effective use of the changes. Similarly, the Department of Workforce Services (DWS) can play an important role in marketing and promoting opportunities for entry-level roles within the BH workforce and supporting needed policy changes.

[736] Utah Department of Health and Human Services Primary Care and Rural Health. (n.d.). *About Health Workforce Advisory Council | PCRH*. [online] Available at: https://ruralhealth.utah.gov/about-hwac/.
[737] Utah Department of Health and Human Services Primary Care and Rural Health. (n.d.). *About Health Workforce Advisory Council | PCRH*. [online] Available at: https://ruralhealth.utah.gov/about-hwac/.

- Lastly, there are many individuals and groups within the **Utah Legislature** that have been instrumental in this report, have interest in mental health and substance use issues, and would be well positioned to continue their oversight of this issue. Beyond the obvious interim committees (Business and Labor, Health and Human Services), there are multiple additional councils and working groups that can play this role.

Although licensure policy is only one part of the answer to the challenges facing Utah's BH workforce and consumers, OPLR believes that if implemented, the recommendations contained in this report are likely to have a positive and long-lasting impact on Utahns' well-being through improved access to safe BH services.

Appendix

Appendix I. Data & Methods

Contents

Behavioral Health Care Workforce Survey (CPMDS)

The Behavioral Health Care Workforce Survey (CPMDS) was distributed via Qualtrics to all active DOPL licensees in the reviewed BH professions (16,235 unique individuals) on Feb 27, 2023. The survey instrument, available on request, used core questions from the Cross Profession Minimum Data Set (CPMDS), with some minor adjustments and additions to facilitate analysis. The CPMDS was developed by Dr. Hanna Maxey of the Indiana University School of Medicine, and Director of the Bowen Center for Health Workforce Research and Policy, in collaboration with several national health professions' regulatory associations (e.g., the Association of Social Work Boards [ASWB] and the Association of State and Provincial Psychology Boards [ASPPB]). The instrument is now in various stages of vetting with several other states. OPLR received 4,039 responses, including over 1,000 open-ended responses, for a response rate of 24.8% and a completion rate of 91%. Table 5.1 details the number of survey responses submitted by licensees from each BH occupation.

Table 5.1 Survey Respondents by Occupation

Occupation	# of Respondents[738]	# of Active Licensees[739]	% Responding
Social Work	2,001	9,835	20%
Marriage and Family Therapy	395	1,539	26%
Clinical Mental Health Counseling	779	2,895	27%
Substance Use Disorder Counseling	463	463	23%
Psychology	326	1,251	26%
Behavior Analysis	133	752	18%
Music Therapy	20	75	27%
Recreational Therapy	160	547	29%
Vocational Rehabilitation	59	165	36%

The survey was fairly representative across occupations, with most professions represented within about 1% point except for social workers, who were underrepresented by 5.87%, and clinical mental health counselors (CMHCs), who were overrepresented by about 3.1%.

[738] The sum of DOPL respondents by occupation may not equal the total number of survey respondents due to incomplete responses or some DOPL licensees who also hold DHHS certifications selecting those occupations (e.g., crisis worker or case manager) as their primary occupation type.
[739] OPLR Analysis of DOPL Licensing Data

2,953 out of 4,039 respondents had a primary practice location in Utah and provided the zipcode of their primary practice, which OPLR used to find the number of respondents from each county in Utah (see Table 5.2). All counties except for Piute County were represented. Although relatively few responses were received from rural counties, these counties have very few estimated providers, so the rural population of providers was adequately represented here.

Table 5.2 Survey Respondents by County

County	# of Respondents	Estimated # of Providers[740]	% Responding
Beaver	3	5	60%
Box Elder	27	275	10%
Cache	104	275	38%
Carbon	25	43	58%
Daggett	1	1	100%
Davis	242	882	27%
Duchesne	13	37	35%
Emery	3	11	27%
Garfield	6	6	100%
Grand	9	26	35%
Iron	67	185	36%
Juab	2	63	3%
Kane	6	18	33%
Millard	4	23	17%
Morgan	2	3	67%
Piute	0	8	0%
Rich	2	2	100%
Salt Lake	1294	6460	20%
San Juan	9	26	35%
Sanpete	15	281	5%
Sevier	20	54	37%
Summit	33	95	35%

[740] County Health Rankings & Roadmaps (2010). Explore Health Rankings | Rankings Data & Documentation. [online] County Health Rankings & Roadmaps. Available at: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation. In instances where the county mental health rankings data estimated a total number of mental health providers fewer than the number who responded to the survey, this estimate was increased to the number of survey responses received by OPLR.

Tooele	31	78	40%
Uintah	30	55	55%
Utah	610	2094	29%
Wasatch	25	38	66%
Washington	178	582	31%
Wayne	5	18	28%
Weber	187	705	27%

Descriptive Analyses

The survey response data was downloaded from Qualtrics, cleaned, and coded as numerical and categorical variables to make it suitable for quantitative analysis. This data was used to conduct various analyses examining workforce characteristics such as demographics, employment characteristics, wait times, geographic location, services provided, populations served, and payment types accepted. Much of this analysis was used to identify differences between professions (e.g., which professions reported the highest wait times, or which professions had the highest proportion of licensees working full-time or in direct client care).

Open-Ended Response Analysis

The open-ended responses were exported to a spreadsheet and manually coded to indicate whether content referred to any of the following topics: oversight, model of regulation, parameters of regulation, pathways & portability, preparation & entry requirements, application logistics, compliance & enforcement, professional development & renewal requirements, renewal logistics, or other topics. Of the responses that contained sufficient content to be categorized, 31% mentioned preparation & entry requirements, 15% mentioned pathways & portability, and 11% mentioned professional development and renewal requirements. These responses were used both to identify potential policy changes and recommendations, as well as to evaluate licensees' sentiments toward potential policy changes.

Limitations

- Nonresponse bias, which is difficult to measure, is one potential limitation of the survey results. Although the response rate was very high, at about 25%, there may be something systematically different about those who chose to answer the survey versus those who did not. Those characteristics may be related to other measures OPLR analyzed. For example, those with strong opinions about continuing education (CE) may have been more likely to respond due to the opportunity a survey provides to express those opinions; thus, the survey results would overestimate the degree to which CE hours are an issue.

- Another possible limitation is measurement error, which occurs when questions do not accurately measure the variable interest due to errors in question design. For example, social desirability bias, when respondents give inaccurate responses to be more socially acceptable, occurs less often in an anonymous online survey, but it is still possible (e.g., if licensees wished to downplay their wait times). Recall bias, when respondents forget the answer to a question and give an inaccurate response, is far more likely in this survey, especially in asking about patient wait times, as many providers likely do not know or can not accurately respond, providing a guess instead.
- Finally, the survey also may also lead to potentially inaccurate responses insofar as BH licensees in the state of Utah have a limited or inaccurate understanding of patient wait times. Administrators and receptionists may have more readily available, accurate recall on patient wait-times, and patients themselves may be more able to provide accurate information regarding the waits they experience in seeking BH care in Utah. Additionally, there was no way to limit responses to one licensee per primary practice location. Therefore, data may be skewed if multiple licensees from one practice location, with survey answers deviating from the median, responded to the survey.

All of these potential errors may cause some variability or systematic bias, which means that the survey data should primarily be used to outline patterns and general trends rather than to provide exact estimates around narrow subgroups of practitioners. The survey helpfully captures data from around the state, including the experiences and perspectives of practitioners working in a wide variety of roles and settings, across many license types and occupations.

Stakeholder Listening & Vetting Tour

Listening Tour Data Collection & Analysis

Initial Exploratory Discussions. Before beginning the review process, OPLR engaged in extensive stakeholder outreach to explore licensing issues in behavioral health. OPLR met with officials from Utah's executive branch and from the Utah State Legislature, along with industry representatives, consumer advocacy groups, and academic experts. These initial exploratory discussions helped to illustrate the urgency of addressing workforce shortages and issues surrounding access to care and safety in this space.

Industry Association Focus Groups. OPLR also held focus groups with each licensed BH occupation under review. Members of each focus group were invited to participate by their respective industry associations or certifying bodies. Guided by a semi-structured protocol, the focus groups provided practitioners with an opportunity to comment on how occupational regulation might be altered to improve access to safe and competent care for Utahns. Focus groups were conducted via video conference, to facilitate the participation of licensees from around the state, and then recorded and transcribed to facilitate analysis. A total of 12 focus groups were held, with an average of ~7 attendees, for a total of 86 participants. The focus

groups lasted ~90 minutes on average, totalling over 1,000 minutes of recorded material overall, and over 300 pages of single-spaced transcribed text.

Board Chair Interviews. OPLR used a semi-structured interview protocol to interview DOPL board chairs and relevant leaders from DHHS (e.g., those administering Peer Support Specialist training and certification within DHHS). All ten interviews were conducted via video conference and recorded and transcribed. The interviews lasted an average of 57 minutes and created a cumulative 570 recorded minutes, and 241 single-spaced transcribed pages of text.

Qualitative Data Analysis. Following the initial exploratory discussions, focus groups, and board chair interviews, OPLR reviewed all transcripts to identify discrete ideas for change. Among these ideas, OPLR identified suggestions relevant to both occupational regulation, as well as to other elements of the BH care system (e.g., higher education, insurance/payers). OPLR coded and categorized these ideas for change according to:

1) the outcome(s) they hoped to address (i.e., access, safety, both, other)
2) the means by which they would implement change (e.g., statute/rule, practice)
3) the professions that would be impacted (e.g., one occupation, multiple occupations)

This effort resulted in a list of approximately 200 distinct ideas for how to change occupational regulation to improve access to safe BH care for Utah consumers, along with many suggested changes for other aspects of the BH system. As OPLR worked to iteratively refine and hone this list, a set of themes began to emerge, resulting in a consolidated set of ~70 ideas that involved changes to policy (not just practice), with the potential to impact Utahns by impacting consumer access and/or safety, and by impacting more than one occupational group. At this stage, OPLR began working to explore these ideas more fully to better understand the suggested change and the research base for making it a recommendation. This evidence vetting process helped to further hone and synthesize the list, and to organize it according to regulatory lever.

Vetting Tour Data Collection & Analysis

OPLR workshopped its provisional recommendations extensively, thus attempting to include the voices and perspectives of a variety of stakeholders not only in the idea-generation phase of the listening tour, but also in moving from the long list of ideas coming out of that phase toward a clear, achievable set of evidence-based recommendations. Building on the consolidated list of ideas developed through the listening tour data collection and analysis, OPLR next began a series of vetting conversations with individual stakeholders and stakeholder groups. This included over 50 total meetings, with over 250 participants in attendance.[741] These discussions were held in person, over the phone, and remotely via video conferencing software; in both one-to-one meetings with industry experts and leaders, and in large and small group settings. Throughout this process, team members took extensive notes both during and following meetings, working to create detailed notes and to reflect on and synthesize feedback across multiple discussion sessions. The team approached the vetting tour as a creative workshopping

[741] This sums each individual in attendance at each vetting discussion, and so may double count individuals who attended more than one. In other words, this figure reflects total attendance numbers, not total unique participants.

process—working off of rough initial concepts to develop more fully formed and refined recommendations. Following vetting conversations, those in attendance would brief the other OPLR team members on what they had learned—how external partners and stakeholders had reacted, and what new insights and ideas they had raised. Through this process, OPLR continued to consolidate and refine its list of provisional recommendations accordingly.

Summary

All told, OPLR held dozens of meetings, and consulted with hundreds of individuals during the listening and vetting tour (see Table 5.3). Importantly, OPLR worked with many interested stakeholders from a variety of organizations—including the legislative and executive branches of government, consumer groups, advocacy groups, and industry associations.

Table 5.3 Stakeholder Engagement	
Utah State Legislature	
Legislative Leadership	**Sen. Stuart Adams,** President **Sen. Evan Vickers,** Majority Leader **Sen. Ann Millner,** Majority Whip **Sen. Kirk Cullimore,** Majority Assistant Whip **Sen. Todd Weiler,** Senate Parliamentarian **Sen. Luz Escamilla,** Minority Leader **Rep. Brad Wilson,** Speaker **Rep. Mike Schultz,** Majority Leader **Rep. Jefferson Moss,** Majority Whip **Rep. Karianne Lisonbee,** Majority Assistant Whip **Rep. Sandra Hollins,** Minority Assistant Whip
Utah House of Representatives	**Rep. Cory Maloy** **Rep. Candice Pierucci** **Rep. Dunnigan** **Rep. Ken Ivory** **Rep. Steve Eliason** **Rep. Stephanie Gricius**
Business and Labor Interim Committee	**Sen. Curtis Bramble**, Chair **Rep. Cory Maloy**, Co-Chair
Health and Human Services Interim Committee	**Sen. Mike Kennedy**, Chair **Rep. Ken Ivory**, Co-Chair
Legislative Staff	**Brian Bean**, Senior Policy Advisor **Abby Osborne,** Chief of Staff, Utah House of Representatives **Mark Thomas,** Chief of Staff, Utah Senate
Other Government Stakeholders *(e.g., agencies, councils, boards, committees)*	
Office of the Governor	**Governor Spencer J. Cox**

Governor's Office of Economic Opportunity (GOEO)	**Natalie El-Deiry**, Director of Immigration and New American Integration **Dane Ishihara**, Director, Office of Regulatory Relief
Department of Commerce	**Margaret Busse,** Executive Director **Jacob Hart,** Deputy Director **Carolyn Dennis,** Assistant Deputy Director **Mark Steinagel,** Director, Division of Professional and Licensing **Deborah Blackburn**, Assistant Division Director, Division of Professional Licensing **Jana Johansen,** Bureau Manager, Division of Professional Licensing **Benjamin Baker,** Investigator, Division of Professional Licensing
Division of Professional Licensing (DOPL) Advisory Board Chairs	**Marette Monson**, Social Work **Kevin Barlow**, Marriage & Family Therapy **Katherine Brown**, Clinical Mental Health Counseling **Bradley Hieb**, Substance Use Disorder Counseling **Jamie Brass**, Psychology **Gwendolyn Adams**, Recreational Therapy **Christine Anderson**, Vocational Rehabilitation
Department of Health and Human Services (DHHS)	**Tracy Gruber**, Executive Director **Nate Checketts**, Deputy Director **David Litvack**, Deputy Director **Dr. Michelle Hofmann**, Executive Medical Director **Rebecca Brown**, Assistant Deputy Director **Brent Kelsey**, Office Director, Office of Substance Use and Mental Health **Dallas Earnshaw**, Director, Utah State Hospital **David Wilde**, Health Program Manager, Integrated Healthcare Division **Simon Bolivar**, Director, Office of Licensing **Ashley Moretz**, Director, Utah Office of Primary Care and Rural Health **Kendyl Brockman**, Analyst, Utah Office of Primary Care and Rural Health **Joanna Sutherland**, Program Manager, Crisis Services **Eric Tedahara**, Assistant Director, Office of Substance Use and Mental Health **Shanel Long**, Administrator, Office of Substance Use and Mental Health (SAME Peer support interview) **Pete Caldwell**, Administrator, Case Management **Nichole Cuhna**, Program Administrator, Office of Substance Use and Mental Health
Utah Substance Use Advisory and Mental Health Advisory Council (USAAV+)	**Elizabeth Klc**, Council Director **Santiago Cortez**, Workforce Subcommittee Chair **Patrick Fleming**, Chair

One Utah Health Collaborative	**Jaime Wissler,** Executive Director **John Poelman**, Director of Innovation **Kelsey Witt**, Director of Communications **Elise Saarela**, Program Manager **Richard Saunders**, Board Member
Behavioral Health Crisis Response Commission	**Ross VanVranken,** Chair **Doug Thomas**, Vice Chair
Health Workforce Information Center (HWIC)	**Sydney Groesbeck**, Lead & Informaticist **Matt Cotrell**, Research Analyst
Utah Insurance Department (UID)	**Jon Pike**, Commissioner **Tanji Northrup**, Deputy Commissioner **Shelley Wiseman**, Director
Department of Workforce Services	**Casey Cameron,** Executive Director **Greg Paras,** Deputy Director **Chris Williams,** Workforce Research and Analysis **Aaron Thompson,** Rehabilitation Services Director, Utah State Office of Rehabilitation (USOR)
Department of Corrections	**Rebecca Brown,** Deputy Executive Director
Mental Health Crisis Intervention Council (CIT)	**Darin Adams,** Chair **Scott Stephenson,** Director
Consumer & Advocacy Groups *(e.g., advocacy groups, special interest groups)*	
Utah Association of Counties / Utah Behavioral Healthcare Committee	**Brandy Grace**, CEO **Katherine Rhodes**, Behavioral Health Director **Steve Hunter**, Director of Government Affairs
National Alliance on Mental Illness (NAMI), Utah Chapter	**Rob Wesemann**, Executive Director
American Foundation for Suicide Prevention (AFSP), Utah Chapter	**Taryn Hiatt**, Utah and Nevada Area Director **Mary Lou Arveseth**, Founding Board Member
Utah Support Advocates for Recovery Awareness (USARA)	**Evan Done**, Associate Director **Mary Jo McMillen**, Executive Director
American Association of Retired Persons (AARP), Utah Chapter	**Alan Ormsby**, CEO
Voices for Utah Children	**Maurice Hickey,** Executive Director **Anna Thomas**, senior policy analyst
Better Business Bureau	**Jane Rupp,** CEO
EDCUtah	**Ze Min Xiao,** Director of Center for Economic Opportunity and

	Belonging
International Rescue Committee Utah	**Annie Healion,** State Advocacy Officer
Libertas Institute	**Connor Boyack,** Executive Director
Americans for Prosperity	**Kevin Greene,** Policy Director **Heather Andrews**, Western Regional State Director
R Street	**Shoshanna Weismann,** Director, Digital Media, Communications
Utah Foundation	**Shawn Teigen**, President
Industry Stakeholders *(e.g., employers, professional associations)*	
National Association of Social Workers (NASW), Utah Chapter	**Katie Mansell**, Executive Director **Annika Hunt**, President
Utah Social Work Association (SWA)	**Andrew Layne**, President **Jennifer Cornett**, Treasurer **Mark Dale**, Board Member **Emmie Gardner**, Board Member
Utah Mental Health Counselors Association (UMHCA)	**Anna Lieber**, President **Dr. Gray Otis**, Presidential Advisor
Utah Association of Marriage and Family Therapists (UAMFT)	**Whitney Sanchez**, Executive Director **Roberto De Giorgio**, Legislative Chair
Association of Utah Substance Abuse Professionals (AUSAP)	**Corey Markisich**, President **Richard Nance**, Past President
Utah Psychological Association	**Tom Mullin,** President **Kirt Cundick,** Past President **Nanci Klein,** Director of Professional Affairs
Utah Association for Behavior Analysis (UtABA)	**Christine Manning,** Past President **Shawnee Collins,** Public Policy Chair
Utah State Office of Rehabilitation (USOR)	**Aaron Thompson,** Rehabilitation Services Director
Utah Recreational Therapy Association (URTA)	**Ashley Bowen,** Legislative Chair **Michele Beal,** Executive Director
Utah Peer Network	**Brayden Robinson,** Program Manager

Utah Hospital Association	**Greg Bell,** President and CEO, Utah Hospital Association **Jordan Sorenson**, Project Manager, Utah Hospital Association
Intermountain Healthcare	**Tammer Atallah**, Executive Clinical Director **Heather Brace**, Chief People Officer **Mason Turner**, Psychiatric M.D. **Janelle Robinson**, Healthcare Administrator, BH Service Line Director **Doug Thomas**, Community Health Director **Angela Chavez**, Student Programs Director
Huntsman Mental Health	**Ross Van Vranken**, Executive Director **David Eldredge**, Senior Director of Clinical Operations
Valley Behavioral Health	**Jared Sanford,** President and CEO **Steve Havertz,** VP of Adult Services **Julie Winn,** VP of Children, Family, and IDD Services
First Step House	**Shawn McMillen**, Executive Director
Odyssey House	**Adam Cohen**, CEO
Volunteers of America	**Kathy Bray,** President and CEO **Audrey Rice,** COO
Affiliated Industry Stakeholders *(e.g., insurance, medicine)*	
Utah Medical Association	**Michelle McOmber,** CEO **Mark R Greenwood**, President **Sarah Woolsey**, Board Member
Utah Health Insurance Association	**Mike Sonntag,** Executive Director **Stephen Foxley,** President **Ryan Smart,** President Elect **Eliana White,** Member **Amanda Massey,** Member **Michelle White,** Member **Mykel Severson,** Member **Jack Kim,** Member **Machi Johnson,** Member **Riccardo Palagi,** Member
HMA Leavitt	**Rebecca Nielsen,** Managing Director **Jen Coladominico**, Senior Director
Subject-Matter Experts *(e.g., academics, analysts)*	
Behavioral health workforce & policy researchers	**Laura Summers**, M.P.P., Senior Analyst, Kem C Gardner Policy Institute, University of Utah **Dr. Cole Hooley**, Assistant Professor, Brigham Young University **Dr. Hannah Maxey,** Bowen Center for Health Workforce Research and Policy at the Indiana University School of

	Medicine **Courtney Medlock**, Bowen Center for Health Workforce Research and Policy at the Indiana University School of Medicine **Dr. Shelby Hockenberry**, National Governors Association **Dr. Teresa Scheid,** Professor, University of North Carolina Charlotte
Occupational regulation researchers	**Dr. Ryan Nunn,** Assistant Vice President, Community Development and Engagement, Federal Reserve Bank of Minneapolis **Dr. Morris Kleiner,** Professor, University of Minnesota **Dr. Nicholas A. Carollo,** Economist, Division of Research and Statistics, Federal Reserve Board of Governors **Dr. Sara Markowitz,** Professor, Emory University **Dr. Edward Timmons,** Director, Knee Center for the Study of Occupational Regulation at West Virginia University **Dr. Alicia Plemmons,** Assistant Professor, Knee Center for the Study of Occupational Regulation at West Virginia University **Dr. Ivy Bourgeault,** Professor, University of Ottawa **Dr. Griffin Edwards,** Associate Professor, University of Alabama at Birmingham
Behavioral health educators	*University of Utah* **Dr. Philip J. Osteen,** Dean, College of Social Work **Dr. Michelle Camacho,** Dean, Psychology **Dr. Emily Bleyl,** Professor, Social Work **Dr. Aaron Fischer,** Associate Professor, Educational Psychology **Dr. Benjamin Chan,** Director, Rural & Underserved Utah Training Experience *Utah State University* **Dr. Jess Lucero,** Department Head, Social Work *Utah Valley University* **Dr. Kristin Lambert,** Director, Master of Social Work Program *Weber State University* **Dr. Brent Horn,** Associate Dean, College of Social and Behavioral Sciences, Weber State University **Dr. Mark Bigler,** Social Work Department Chair **Dr. Corina Segovia-Tadehara,** Associate Professor and Interim Chair, Master of Social Work Program *Southern Utah University* **Shawn Christiansen,** Professor, College of Education and Human Development *Brigham Young University* **Dr. Gordon Limb,** Director, School of Social Work, Brigham Young University

Supplemental Primary Data Collected By Stakeholder Groups

During the course of the listening and vetting tour, additional primary data was collected and shared with OPLR by several industry partners.

- The Utah Mental Health Counselors Association (UMHCA) conducted a member survey in December of 2022, with a total of 177 respondents, and shared their findings with OPLR. The survey covered issues including workforce shortages, training and supervision, and public safety. The survey also helped to identify ideas for how to regulate BH care more effectively. UMHCA also conducted a focus group and interview, and shared themes with OPLR related to clinical supervision, the licensure process, and improving public protection.
- The Utah chapter of the National Association of Social Workers (NASW) issued a call to social workers to watch OPLR's August 9th Business & Labor Interim Committee presentation on the recommendations and to share feedback and comments. They specifically asked for social workers' overall impression of the recommendations, and to identify which recommendations would have a positive or negative impact on their work. NASW-Utah shared the row-level data that they collected with OPLR, including a total of 117 responses, and OPLR cleaned and analyzed the data as part of the vetting process to identify patterns of support and opposition to its provisional recommendations.

Limitations

Although OPLR dedicated considerable effort to engaging a wide range of stakeholders throughout the review, the results of its data collection and analysis efforts were limited by time and resources and thus likely omitted some stakeholders with divergent perspectives. By design, data collected through the listening and vetting tour highlights patterns and perspectives among those deemed by OPLR to be the most central to this review process—Utah consumers, the BH professionals who provide the majority of BH care services to Utah consumers and whose working lives will be impacted most directly by recommended policy changes, and the policymakers and agencies who will need to be involved in implementing these changes. Thus, the listening and vetting tour cannot and should not be understood to be fully representative of the views of all Utahns, of all BH professionals, of all BH regulators, or of any other person, group, or population.

For example, despite a strong desire to engage consumers and consumer advocates, it was difficult to identify and engage with consumers and consumer groups. In contrast, industry groups had more ready-made avenues for engagement, and were eager to engage, yielding much more input from the industry perspective than the consumer perspective overall.

Table 5.4 Industry Versus Consumer Stakeholder Engagement	
Industry Group	# of Meetings[742]
National Association of Social Workers-Utah; Utah Social Worker Association	10
Utah Mental Health Counselor Association	7
Utah Association of Marriage and Family Therapists	9
Utah Psychological Association; Utah Association for Behavior Analysis	10
Utah Recreational Therapy Association	6
Association of Utah Substance Abuse Providers	9
Utah Medical Association	10
Consumer Group	# of Meetings
National Alliance on Mental Illness (NAMI), Utah Chapter	7
American Foundation for Suicide Prevention (AFSP), Utah Chapter	2
Utah Support Advocates for Recovery Awareness (USARA)	7
American Association of Retired Persons (AARP), Utah Chapter	2
Voices for Utah Children	3
Better Business Bureau	1

[742] Includes any meetings, in-person or virtual, 1:1 or in a group, where representatives were invited to engage with OPLR directly, or through another group (such as the USAAV+ group hosting OPLR). Does not include email and phone communications.

Access to Care Analyses

Met vs. Unmet Need for Care

All data were drawn from the 1) 2020-2021 National Survey of Children's Health (NSCH), which is led by the Child and Adolescent Health Measurement Initiative, and supported by the Health Resources and Service Administration (HRSA) and 2) 2018-2019 National Survey on Drug Use and Health (NSDUH), which is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency which leads public health efforts to advance behavioral health.

To estimate the number of Utahns currently receiving care OPLR summed NSCH and NSDUH estimates of children receiving mental health treatment, children receiving substance use disorder treatment at a specialty facility, adults receiving mental health treatment, and adults receiving substance use disorder treatment at a specialty facility.

To calculate Utahns with a clinical unmet need for care, OPLR summed the NSCH estimates for children and adults with a clinical unmet need for mental health treatment and the NSDUH estimates for children and adults with a SUD not receiving treatment at a specialty facility, and to calculate Utahns with a perceived unmet need for care, OPLR substituted clinical unmet need measures for perceived unmet need measures.

There are significant limitations with using this data to answer the question of whether and to what extent Utahns have sufficient access to BH care. First and foremost, met and unmet need are an imperfect proxy for demand for and access to BH care services. Some individuals may have a clinical unmet need for care, but not be interested in pursuing BH care. Others may even perceive an unmet need for care, but not be seeking or even willing to receive treatment, meaning the actual demand for services may be lower than it appears to be based on these figures. Further, an unmet need for care does not necessarily mean a lack of access. An individual may opt out of receiving care, even if services are readily available to them.

Further, because the available data is from 2020-2021 for children and from 2018-2019 for adults, because Utah has experienced substantial population growth during this period, and because the COVID-19 pandemic has increased the prevalence of behavioral health disorders, the figures presented likely represent an underestimate of the number of individuals who might benefit from access to behavioral health care services in the state of Utah. The original figures also do not attempt to control for the double counting of individuals with both substance use disorder and mental health treatment needs, and so may be an overestimate of the total number of individuals needing care. The purpose of these estimates is to provide rough approximations, rather than exact calculations, of the magnitude of met vs. unmet need for BH care in Utah.

Table 5.5 Measures of Met vs. Unmet Need				
Category of Need	Group	Dimension	Source	Measure(s)/Calculation
Met Need	Adults	Mental Health	NSDUH	*Received mental health services in the past year*
Met Need	Children	Mental Health	NSCH	*Received treatment or counseling from a mental health professional during the past 12 months*
Met Need	Adults	Substance Use	NSDUH	*Substance use disorder in the past year (18+)* ***LESS*** *Needing but not receiving treatment at a specialty facility for substance use in the past year (18+)*
Met Need	Children	Substance Use	NSDUH	*Substance use disorder in the past year (12-17 estimate)* ***LESS*** *Needing but not receiving treatment at a specialty facility for substance use in the past year (12-17)*
Clinical Unmet Need	Adults	Mental Health	NSDUH	*Adults with AMI who did not receive treatment*[743]
Clinical Unmet Need	Children	Mental Health	NSCH	*Percent of children with a mental/behavioral condition who receive treatment or counseling*
Clinical Unmet Need	Adults	Substance Use	NSDUH	*Needing but not receiving treatment at a specialty facility for substance use in the past year (18+)*
Clinical Unmet Need	Children	Substance Use	NSDUH	*Needing but not receiving treatment at a specialty facility for substance use in the past year (12-17)*
Perceived Unmet Need	Adults	Mental Health	NSDUH	*Adults with AMI reporting an unmet need for treatment*[744]
Perceived Unmet Need	Children	Mental Health	NSCH	*Received treatment or counseling from a mental health professional during the past 12 months*
Perceived Unmet Need	Adults	Substance Use	NSDUH	*Substance use disorder in the past year (18+)* ***LESS*** *Needing but not receiving treatment at a specialty facility for substance use in the past year (18+)* ***MULTIPLIED BY*** *4.3%*[745]
Perceived Unmet Need	Children	Substance Use	NSDUH	*Substance use disorder in the past year (12-17)* ***LESS*** *Needing but not receiving treatment at a specialty facility for substance use in the past year (12-17)* ***MULTIPLIED BY*** *4.3%*[746]

[743] Accessed via Mental Health America, Reinert, M., Nguyen, T. and Fritze, D. (2022). *The State of Mental Health in America 2022*. [online] mhanational.org. Available at: https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf
[744] Ibid.
[745] "Among people aged 12 or older in 2019 who were classified as having an SUD and did not receive substance use treatment at a specialty facility, only 4.3 percent perceived that they needed treatment"; Substance Abuse and Mental Health Services Administration (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55)*. [online] Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm.
[746] Ibid.

Weighted Wait-Time Analysis

The data for the wait-time analysis came from the OPLR Behavioral Workforce Survey (CPMDS), which asked a few core questions necessary to determine the average wait-times for each license and profession. The questions upon which OPLR based this analysis are as follows:

1) What is the name of your license?
2) What is the average wait time for a first appointment for new patients at your primary practice location?
3) What is your employment status?
4) In what state is your primary practice location?

First, respondents were filtered. Only those who answered all these questions, indicated that their employment status was "actively working in a position that requires this license/certification," who were currently still accepting clients,[747] and who had a primary practice location in Utah were included in the analysis. This left 2,739 of the 4,039 total respondents, around 68% of the sample. Then, a weighted index was constructed in order to perform quantitative analysis on the wait times, due to the response options for Question 2. Respondents indicated their average wait time through pre-bucketed ranges, and these ranges had to be converted into a single value in order to perform any calculations. The index is detailed in Table 5.4 below.

Table 5.6 Wait Time Index

Response options for Q2	No wait	Less than 1 month	Between 1-3 months	Between 3-6 months	Between 6-12 months	Over 12 months
Converted time, in months	0	0.5	2	4.5	9	13

OPLR converted the CPMDS responses according to this index to calculate a weighted average for the entire BH field, as well as by profession. The weight in this case was the proportion of each license type who answered each response option in Q2. This means that if 25% of respondents answered "Between 1-3 months", then the converted time, 2 months, would be weighted by 0.25. The weighted average was found for the field in aggregate and then done individually by BH profession.

Due to the construction of the survey response options for Q2 and necessity of an index, this analysis does not provide a precise estimate of wait times for professional services as the wait time was assumed based on a large range. Additionally, the question asked respondents to

[747] Question 2 included the response option "Not currently taking clients", and this was filtered out.

recall from memory the wait time for their services, and estimates based on memory often include a degree of human error. Representativeness is also an issue, as multiple respondents from the same primary practice location may skew the results, if the wait time at that location deviates substantially from the median. Similar to many of the other analyses in this report, aggregates and broad comparisons may be more useful than individual estimates themselves.

Safety of Care Analyses

NPDB Analysis

All data were drawn from 1) the National Practitioner Data Bank (NPDB) Public Use Data File (PUF), which reliably extends from 2000-2023, and 2) the County Health Rankings number of Mental Health Providers, which reliably extends from 2015-2022.

The NPDB PUF contains selected variables from medical malpractice payment and adverse licensure, clinical privileges, professional society membership, and Drug Enforcement Administration (DEA) reports (adverse actions) received by the NPDB concerning physicians, dentists, and other licensed health care practitioners. It also includes reports of Medicare and Medicaid exclusion actions taken by the Department of HHS Office of Inspector General. For OPLR's analysis, the data was filtered by license type to examine behavioral health related licenses specifically. This included practitioners who were classified as the following: Clinical Social Worker, Psychologist, Mental Health Counselor, Professional Counselor, Addictions Counselor, Marriage and Family Therapist, Professional Counselors of Family/Marriage and Alcohol. The NPDB data dictionary[748] provided the information necessary to properly code and label data by variables of interest, e.g. license type and license state.

The County Health Rankings[749] number of Mental Health Providers (MHPs) is an estimate based on the National Provider Identifier (NPI) data file. MHPs include the following practitioners: Psychiatrists, Psychologists, Licensed Clinical Social Workers, Counselors, Marriage and Family Therapists, Mental Health Providers that treat alcohol and other drug abuse, and Advanced Practice Nurses specializing in mental health.

State estimates were aggregated by the license state NPDB variable, and missing license state data was imputed, where possible, with work state. In only 1% of reports did the license state differ from work state, implying interchangeability between the two. To calculate the number of

[748] National Practitioner Data Bank (2023). Public Use Data File. [online] www.npdb.hrsa.gov. Available at: https://www.npdb.hrsa.gov/resources/publicData.jsp

[749] County Health Rankings & Roadmaps (2023). *Mental Health Providers*. [online] County Health Rankings & Roadmaps. Available at: https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/clinical-care/access-to-care/mental-health-providers?year=2023

MHPs across the 7-year time-span, year level data were appended into one file. [750] In years where a state aggregate was not reported, providers were summed across counties in each state.

To calculate Annual NPDB Reports per 1,000 BH Practitioners, the number of reports per license were summed up by state and year and divided by the number of MHPs in the corresponding state and year. These figures were multiplied by 1,000 and then averaged across the 7 year time span. To calculate the rate of repeat offenders, the number of practitioners with 2+ reports was divided by the total number of unique practitioners, per state, with reports between 2010-2022. To ensure that practitioners were not counted twice for the same offense, reports of differing types with the same practitioner in the same year were counted as one event. This inherently assumes that if a practitioner had 2 reports of different types filed against them in one year, they originated from the same incident.

Limitations - NPDB Analysis

The County Health Rankings estimate for MHPs includes professionals, such as psychiatrists and psychiatric nurses, that were not included in the summation of NPDB reports. Therefore, the two do not cover the exact same population of MHPs, which may slightly underestimate the true number of reports per BH professional. Additionally, the filtering method applied to the repeat offenders analysis is not a perfect control for practitioners being double counted. The final figure may double count some reports while removing others that were legitimately unique incidents. Despite this, the estimates from the analysis did not differ substantially whether or not the filter was included.

NPI is also subject to certain limitations, which means that the number of MHPs may be over or under estimating active MHPs in some communities. The limitations are as follows: 1) providers who transmit electronic health records are required to obtain an identification number, but very small providers may not obtain a number, 2) some MHPs included in the list may no longer be practicing or accepting new patients, as they have the option of deactivating their identification number but may not, and 3) MHPs may be registered with an address in one state, while practicing in another state. These limitations are likely unrelated to the registered state, which means the comparative analysis is robust, although the specific estimates may be biased.

It is important to note once more that the NPDB report does not adequately approximate harm, as there are likely many cases of extensive patient harm never reported to NPDB. Therefore, the estimates may underestimate the actual harm caused by BH professionals to their patients.

[750] County Health Rankings & Roadmaps (2010). *Explore Health Rankings* | *Rankings Data & Documentation*. [online] County Health Rankings & Roadmaps. Available at: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

DOPL Complaint Data Analyses

The Division of Professional Licensing (DOPL) receives complaints from aggrieved individuals, other state agencies, co-workers, professional associations, and licensing boards. They are legally required to "investigate unlicensed practice in regulated professions, acts or practices inconsistent with recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of gross negligence or incompetence".[751] Upon submission, complaints are entered into My Licensing Office (MLO) and reviewed by a DOPL investigator who determines if there is 1) no violation of licensing laws, 2) a violation that does not meet the standards of investigation, or 3) a violation that does meet the standards of investigation. A complaint that is a violation but does not meet standards of investigation typically results in referral to another agency, a letter of concern to the licensee, or invitation for the individual to participate in an informal interview. Letters of concern and informal interviews are non-disciplinary and allow for DOPL to proactively address inappropriate behavior before it escalates to the level of public risk and requires action against a license.

Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations may be resolved in a variety of ways, including closing an investigation due to a lack of evidence; referring the case to another agency or to law enforcement if appropriate; carrying out informal or formal administrative sanctions or stipulated agreements;[752] issuing a citation;[753] or denying, suspending, or revoking an individual's license.

To analyze complaints sent to DOPL, OPLR used My License Office (MLO) to access closed complaints investigated by DOPL between 2013-2022. This data contains information on the license name, the complaint type, and the disposition of the complaint, among many other data fields not relevant to this analysis. OPLR then worked with DOPL personnel to code the complaint dispositions as either substantiated or unsubstantiated. Substantiated complaints are those where the disposition includes some type of disciplinary action (e.g., letter of concern, verbal warning, surrender of license), whereas unsubstantiated complaints have dispositions without a disciplinary action (e.g., dismissed, lack of evidence, unfounded). OPLR also used DOPL's pre-existing complaint type variable to categorize the complaint types into 6 primary, consolidated categories: 1) financial/administrative, 2) client harm/abuse, 3) scope/competence, 4) substance use related issues, 5) other criminal conduct, and 6) others.

Complaints were filtered to include only those that were substantiated, and OPLR then calculated the number of complaints per license and per profession. To calculate the number of complaints per 100 licensees, the number of substantiated complaints in each profession was divided by the number of licensees in that profession and multiplied by 100. The complaints

[751] Bureau of Investigation, Division of Professional Licensing (n.d.). *Complaint Process: An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing.* [online] Utah.gov. Available at: https://www.utah.gov/pmn/files/438013.pdf.
[752] Stipulated agreements consist of a written settlement accepted by both parties
[753] Administrative citations typically result from actions such as unlicensed practice, exceeding the scope of a license, or unprofessional conduct, and are issued by an investigator.

were then summed according to their complaint categorization to determine how many complaints were directly related to each category, with specific attention paid to complaints categorized as client harm/abuse.

A more detailed analysis of historical case notes was conducted on a sample of 100 substantiated complaints closed between 2018-2022. DOPL investigators examined case notes for each complaint to identify additional information on licensees' and clients' characteristics. These characteristics included the licensee's employment setting size (small = fewer than 20 practitioners, large = 20 or more practitioners); setting type (inpatient, outpatient, or other); career stage (early career = less than 5 years since initial licensure, mid-career = 5-20 years, late career = over 20 years) and repeat offender status. Case notes were also analyzed to determine whether the clients involved were vulnerable persons (classified as those clients who were 17 or under, disabled, elderly, or homeless at the time of the complaint). This case data was anonymized and provided to OPLR for further analysis.

Limitations - DOPL Complaint Data Analyses

These analyses cannot be used to estimate the overall harm done by BH professions nor to decisively state which BH professions cause the most harm. Firstly, DOPL data only includes those instances where a complaint was filed, thus DOPL data likely underestimates harm. Substantiated complaints are a rough, biased proxy for harm, as many instances of harm will never be reported or investigated, and there is likely a proportion of unsubstantiated complaints resulting from instances of real client harm where the client was unable to produce the necessary evidence. Additionally, there could be latent factors correlated with both the likelihood of complaint and the profession, systematically biasing the rate. For example, if clients of one profession are wealthier than clients of other professions, and wealthy clients are more likely to afford the legal services to produce necessary evidence of harm, then the "true" complaint rate of that profession would be overestimated in comparison with the other professions. Thus, this analysis should be used to orient policymakers to the current state of the BH field and provide information about common types of complaints in each profession, not to make blanket judgements about or decisions against specific professions.

National Review of Regulation

To better understand the licensing environment for BH care providers, OPLR first conducted an extensive review of state regulation for each of the professions included in the CY 2023 review. For each regulated BH profession and license type offered in Utah, OPLR first determined which states and territories in the United States had an equivalent license or certification. OPLR then collected data regarding each license/certification available to the relevant BH professionals in that jurisdiction, including the structure and governance, entry requirements, and practice requirements of the license. Examples of data collected include protected titles, scopes of practice, entry qualifications (e.g., education, exam, experience), licensure application fees, and

renewal fees.[754] OPLR primarily utilized state websites to access the relevant statutes, rules, and licensing information. Table 5.5 details the professions reviewed, the number of licenses and certifications reviewed for each profession, and the number of states/territories covered[755]

Table 5.7 Summary of National Review of Regulation

Profession	# of Licenses Reviewed	States and Territories Covered
Social Work[756]	197	50 states, D.C., 4 territories
Marriage and Family Therapy (MFT)	104	50 states, D.C., 3 territories
Clinical Mental Health Counseling (CMHC)	105	50 states, D.C., 4 territories
Psychology	109	50 states, D.C., 5 territories
Substance Use Disorder Counseling (SUDC)[757]	191	50 states, D.C.
Clinical Supervision[758]	257	50 states, D.C., 3 territories
Music Therapy	15	15 states
Recreational Therapy	10	6 states, D.C.
Vocational Rehabilitation Counseling	3	3 states

OPLR also conducted ad-hoc national regulation reviews in order to vet proposed recommendations, including a review of state regulation specific to BH boards and recovery assistance programs (e.g., UPHP). For the review of BH boards, OPLR collected information on states with unified boards, determining which professions were included and the composition of the board (i.e., how many members of the public the boards included). The recovery assistance program national review spanned across the 47 states and territories with these programs, examining which professionals they serve, which conditions they monitor, how they are funded, and who runs and oversees them.

[754] Other data fields included the closest Utah parallel license, the authorization type, educational requirements, accreditation, experiential hours (supervision and clinical hours required for licensure), years under supervision, exam requirements, initial and renewal background check requirements, and continuing education hours. There were some data fields specific to certain reviews, like whether or not training was required for supervisors, and some data fields did not apply to every license.
[755] To reiterate, every state and territory was reviewed, but data was only collected on those with at least one parallel license or certification.
[756] Includes Certified Social Workers, Social Service Workers, and Licensed Clinical Social Workers
[757] Includes associates level, bachelors, and masters level licenses.
[758] Review encompassed supervisors of social work, MFT, CMHC, Psychology, and SUDC

With the information collected, OPLR was able to calculate averages and find median, maximum, and minimum values for quantitative data fields (e.g., hours of supervision, initial fees, annual CE hours) as well as determine the percent of states with certain policies (e.g., exam and education requirements). Running simple analyses such as these enabled OPLR to systematically map out the national licensing policy landscape to find patterns in regulation, make cross-state comparisons, and discover outliers. These analyses oriented OPLR as to how Utah compares with the rest of the US and largely informed the "existing approaches" sections of each recommendation summary.

OPLR also wrote a series of key reflections and learnings based on the data collected, which served as supplementary information in drafting the recommendations and final report. These reflections were written to report on common regulation practices, determine the states most similar to Utah, find exceptions with novel regulation that Utah may benefit from adopting, and uncover any other licensing regulation potentially of interest.

As this review depended on manual entry of data fields, it may contain limitations related to normal human error. It is possible that there is slight misreporting of some data due to limited accessible state information or data entry errors. Potential bias or measurement error introduced by these limitations likely did not substantially alter any information, as the review was utilized more to find patterns than to report exact numbers.

RxP Effects on HPSA Designations

To estimate how many prescribing psychologists Utah may expect to license, should RxP legislation pass, OPLR first determined the number of prescribing psychologists in states that have granted prescriptive privileges. Data was collected from Idaho, New Mexico, and Louisiana, as these 3 states have all had at least 5 years since RxP enactment.[759] The sources of data included each states' respective psychology licensing board webpage, including information from licensee lookup tools if available, as well as a policy briefing on RxP legislation and information from the American Psychological Association.[760]

This information was used to create a table that included the total number of prescribing psychologists in each state, the number of prescribing psychologists per 100,000 residents, and the years since enactment of RxP legislation. Recent census data was consulted to calculate the number of prescribing psychologists per 100,000 population.[761] An exponential predictive model was then fit to the data is this table using the scatter plot and trendline tools in Google Sheets, which took the following form:

[759] RxP legislation has been in place for 21 years in New Mexico, 19 years in Louisiana, and 6 years in Idaho.
[760] Singer, J. (2022). *Expand Access to Mental Health Care: Remove Barriers to Psychologists Prescribing Medications*. [online] Cato Institute. Available at: https://www.cato.org/briefing-paper/expand-access-mental-health-care-remove-barriers-psychologists-prescribing?ref=moodfuel-news
[761] Iowa State University (2023). *Decennial Census Population Counts for States | Iowa Community Indicators Program*. [online] www.icip.iastate.edu. Available at: https://www.icip.iastate.edu/tables/population/census-states

$$y = 0.128e^{0.176x}$$

Where y represents the number of prescribing psychologists per 100,000 residents and x represents the years since RxP enactment. 6, 12, and 20 years were input into the model to predict the number of prescribing psychologists per 100,000 residents in these years (2030, 2036, and 2044) as if RxP legislation was enacted in Utah in 2024. This estimate was multiplied by population projections in Utah in 2030, 2036, and 2044 to account for population growth.

Limitations

This analysis is meant to provide a very rough estimate of the number of prescribing psychologists in the future. This model uses only the years after enactment of RxP legislation and the number of prescribing psychologists in other states when there are likely many other omitted factors influencing the number of prescribing psychologists, like the licensing environment in a state, requirements for licensure, and demand for psychiatric care.

Appendix II. Supplemental Information

Contents

Behavioral Health: A Primer

Although we all may experience the impact of behavioral health challenges in our communities, varying cultural, personal, or professional backgrounds can lead us to approach these issues in very different ways. Understanding these various viewpoints is foundational not only to understanding how and whether Utahns are participating in the current mental and behavioral healthcare system, but also to anticipating the effects that potential policy changes may have on providers, consumers, and the community at large.

Definitions

Behavioral health encompasses mental health, substance use disorders, and emotional or physical symptoms related to life stressors and crises.[762]

Mental health can be understood as not only "the absence of mental disorder" but also, "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'"[763] The US Department of Health and Humans Services (HHS) has identified two key components of this understanding of mental health: resilience and recovery.[764]

Current public health definitions of **mental illness** include the presence of mental, behavioral, or emotional disorders that cause individuals to experience distress and impairment,[765,766] and which may "substantially [interfere] with or [limit] one or more major life activities."[767] The severity of these disorders can vary widely. The following definitions from the National Institute of Mental Health describe these differences in severity:

- "**Any mental illness (AMI)** is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below)."[768]
- "**Serious mental illness (SMI)** is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one

[762] BHI Collaborative (2021). *Behavioral Health Integration Compendium.* [online] American Medical Association. Available at: https://www.ama-assn.org/system/files/bhi-compendium.pdf.
[763] Vandiver, V. and Hozack, N. (2011). *Mental Health*. Oxford Bibliographies Online Datasets. doi:10.1093/obo/9780199756797-0112.
[764] Ibid.
[765] National Institute of Mental Health (2022). *Mental Illness*. [online] National Institute of Mental Health. Available at: https://www.nimh.nih.gov/health/statistics/mental-illness
[766]Vandiver, V. and Hozack, N. (2011). *Mental Health*. Oxford Bibliographies Online Datasets. doi:10.1093/obo/9780199756797-0112.
[767] President's New Freedom Commission on Mental Health. 2003. *Achieving the promise: Transforming mental health care in America.* DHHS Publication no. SMA-03-3832. Rockville, MD: President's New Freedom Commission on Mental Health.
[768] National Institute of Mental Health (2022). *Mental Illness*. [online] National Institute of Mental Health. Available at: https://www.nimh.nih.gov/health/statistics/mental-illness

or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI."[769]

Substance use disorders, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), "occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[770]

The Causes of Behavioral Health Disorders

Cultural, philosophical, and scientific perspectives begin to diverge more significantly when it comes to theorizing the sources or underlying causes of mental illness. In the medical model of disease and disorder, "mental illness is conceived as a biomedical condition, so clinically based diagnostic criteria are viewed as appropriate measures, treatment by medical/psychiatric professionals is believed necessary, and hospitalization, psychotherapy, and/or medications will produce remission and improved functioning."[771] From this standpoint, the medical community, including psychiatrists, generally views mental health care as "an extension of physical medicine…."[772] Psychoanalytic theories of mental illness, on the other hand, place more emphasis on the influence of "familial, social, and interpersonal factors that are more amenable to 'talk' therapy rather than medical (physical) interventions."[773]

Medical and psychoanalytic views are not mutually exclusive—many mental health care practitioners now consider the potential interaction of both types of factors in contributing to mental ill health, and combine medical treatment with talk therapy or other interventions. Recent research efforts have also attempted to lay the foundation for a more unified theory of the cause of mental illness that incorporates many possible factors—for example, Syme and Hagen provide a typology of the causes of mental disorders across four groups:

> "We…offer a provisional evolutionary schema for conceptualizing mental disorders that identifies one group as relatively rare disorders of development that are probably caused by *genetic variants*, one widespread group that comprises aversive but probably *adaptive responses to adversity* and therefore are likely not disorders at all, one group that is probably due to *senescence* [aging], and one group that might be caused by *mismatches between ancestral and modern environments*."[774] [emphasis added]

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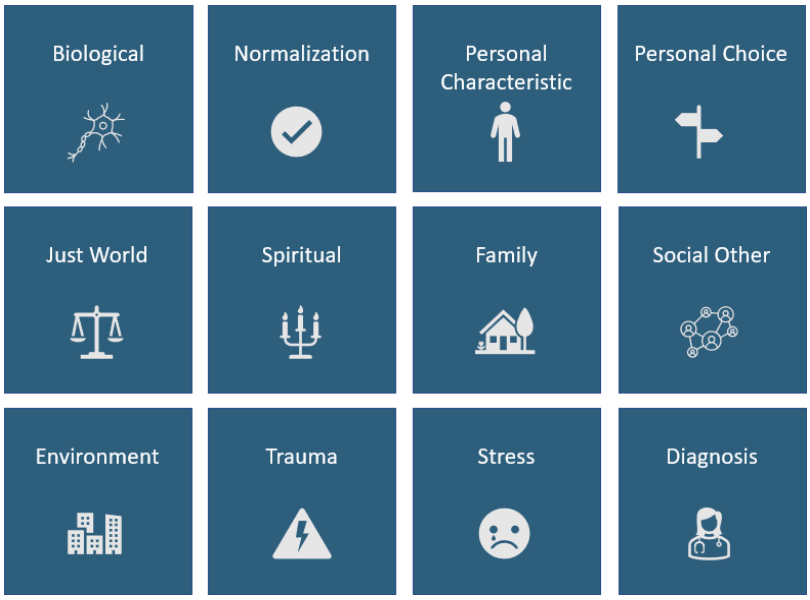
[769] Ibid.
[770] Substance Abuse and Mental Health Services Administration (2019). Mental Health and Substance Use Disorders. [online] Samhsa.gov. Available at: https://www.samhsa.gov/find-help/disorders
[771] Page 495, Thoits, P.A., 2022. Clinical Need, Perceived Need, and Treatment Use: Estimating Unmet Need for Mental Health Services in the Adult Population. *Journal of Health and Social Behavior*, *63*(4), pp.491-507. doi: https://doi.org/10.1177/00221465221114487
[772] Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *Google Books*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.
[773] Ibid.
[774] Syme, K.L. and Hagen, E.H. (2019). Mental health is biological health: Why tackling 'diseases of the mind' is an imperative for biological anthropology in the 21st century. American Journal of Physical Anthropology, 171(S70), pp.87–117. doi:10.1002/ajpa.23965.

Researchers have also identified numerous biological, emotional, and environmental risk factors that can predict an individual's likelihood of developing behavioral health disorders, including both mental and substance use disorders. Some of these factors include trauma, stress, personality traits, childhood adversity, genetic influences, economic deprivation, family dysfunction, academic difficulties, and social exclusion.[775]

Finally, it is also important to recognize that individuals' beliefs about the cause of behavioral health disorders may be influenced by their cultural, ethnic, and religious backgrounds. For example, some groups may be more likely to attribute these issues to personal choices or spiritual causes. Figure 5.1 illustrates the wide variety of causes to which people may attribute behavioral health disorders. Because populations differ in their views regarding the origins of behavioral health challenges, and whether and where they seek help likewise differs, it is important for policymakers and healthcare providers to identify culturally responsive approaches to mental health education and service delivery.[776]

Figure 6.1 Themes of Mental Illness Attribution[777]



Categorization of Behavioral Health Disorders

When diagnosing mental illnesses, mental health practitioners and healthcare providers in the United States rely on the standard criteria and definitions laid out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is published and maintained by the

[775] Commission on Narcotic Drugs (2022). *Comorbidities in drug use disorders*. [online] United Nations Office on Drugs and Crime. Available at: https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC_Comorbidities_in_drug_use_disorders.pdf
[776] Bignall, W.J.R., Jacquez, F. and Vaughn, L.M. (2014). *Attributions of Mental Illness: An Ethnically Diverse Community Perspective.* Community Mental Health Journal, [online] 51(5), pp.540–545. doi:10.1007/s10597-014-9820-x.
[777] Ibid.

American Psychiatric Association.[778] While there is ongoing debate about the DSM diagnostic criterias and its categorization of disorders,[779] it is undeniable that the DSM has an enormous influence on research and data collection, as well as on diagnostic and treatment practices in the United States, due in large part to the US healthcare system's reliance on DSM diagnoses for insurance billing purposes. Internationally, groups such as the World Health Organization (WHO) utilize the International Classification of Diseases (ICD-11) to establish common definitions and criteria. The most common mental disorders experienced by populations worldwide, as described by the WHO, are listed in Table 5.6 below.

Table 6.1 Common Mental Health Disorders[780]

Anxiety disorders	• Excessive fear, worry, and related behavioral disturbances • Includes generalized anxiety disorder, panic disorder, social anxiety disorder, and separation anxiety disorder
Depression	• Depressed mood or a loss of pleasure or interest in activities • Feelings of guilt, low self-worth, hopelessness, or suicidality • Changes in sleep, eating habits, or energy
Bipolar disorder	• Alternating depressive episodes with periods of manic symptoms. • Other symptoms such as increased talkativeness, racing thoughts, increased self-esteem, decreased need for sleep, distractibility, and impulsive reckless behavior
Post-traumatic stress disorder (PTSD)	• Re-experiencing a traumatic event or events in the present (intrusive memories, flashbacks, or nightmares) • Avoidance of thoughts and memories of the event(s), or avoidance of activities, situations, or people reminiscent of the event(s) • Persistent perceptions of heightened current threat
Schizophrenia	• Significant impairments in perception and changes in behavior. • Persistent delusions, hallucinations, or disorganized thinking • Extreme agitation
Eating disorders	• Abnormal eating and preoccupation with food • Prominent body weight and shape concerns.
Disruptive behavior and dissocial disorders	• Persistent behavior problems such as defiant or disobedient behaviors that persistently violate the basic rights of others or major age-appropriate societal norms, rules, or laws

[778] American Psychiatric Association (2013). *DSM-5*. [online] Psychiatry.org. Available at: https://www.psychiatry.org/psychiatrists/practice/dsm
[779] Syme, K.L. and Hagen, E.H. (2019). Mental health is biological health: Why tackling 'diseases of the mind' is an imperative for biological anthropology in the 21st century. *American Journal of Physical Anthropology*, 171(S70), pp.87–117. doi:10.1002/ajpa.23965.
[780] World Health Organization (2022). *Mental disorders.* [online] World Health Organization. Available at: https://www.who.int/news-room/fact-sheets/detail/mental-disorders.

Neurodevelopmental disorders	• Developmental behavioral and cognitive disorders • Significant difficulties in the acquisition and execution of specific intellectual, motor, language, or social functions. • Includes autism spectrum disorder and ADHD

The DSM-5 also provides diagnostic criteria for substance use disorders, including defining 10 drug classes that can cause these disorders, symptoms of substance use disorders, levels of severity, and several types of substance-induced disorders, as described in Table 5.7.

Table 6.2 DSM-5 Substance Use Disorder Classification[781,782]	
Drug Classes	Alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics or anxiolytics, stimulants, and tobacco
Symptom Categories	Physical dependence, risky use, social problems, and impaired control
Levels of Severity	• Mild: 2-3 symptoms • Moderate: 4-5 symptoms • Severe: 6+ symptoms
Substance-Induced Disorders	• Mental disorders (psychosis, bipolar, depression, anxiety, OCD, sleep disorders, sexual dysfunction, delirium, and neurocognitive disorders) • Intoxication: symptoms experienced when “high” from drugs • Withdrawal: symptoms experienced as a result of reducing or stopping substance use

Prevention and Treatment in Behavioral Health

The treatment of behavioral disorders has progressed significantly over the past two centuries. As theories of psychology and behavioral health developed, new approaches to classification, diagnosis, and treatment emerged.[783] Psychotherapeutic and pharmacologic interventions were developed during the 20th century as the United States moved towards deinstitutionalization and a greater focus on medical models of behavioral health.[784] Many once-common practices are now seen as cruel or unethical and have become obsolete (for example, the practice of lobotomies, the pathologization of homosexuality, and eugenic policies targeted at disabled and

[781] Substance-Related and Addictive Disorders. (2022). Diagnostic and Statistical Manual of Mental Disorders. doi:10.1176/appi.books.9780890425787.x16_substance_related_disorders.
[782] Hartney, E. (2022). DSM 5 Criteria for Substance Use Disorders. [online] Verywell Mind. Available at: https://www.verywellmind.com/dsm-5-criteria-for-substance-use-disorders-21926.
[783] Jutras, M. (2017). Historical perspectives on the theories, diagnosis, and treatment of mental illness | British Columbia Medical Journal. [online] BC Medical Journal. Available at: https://bcmj.org/mds-be/historical-perspectives-theories-diagnosis-and-treatment-mental-illness
[784] Ibid.

mentally ill populations).[785] Treatment methods have continued to develop into the 21st century, and the definition of behavioral health care has expanded to include the treatment of not only mental disorders, but also substance use disorders.[786]

Currently, the most common treatment methods for both mental and substance use disorders fall into two broad categories: (1) counseling and behavioral interventions and (2) medication.[787] Other approaches, such as psychosocial treatments, complementary health approaches, and brain stimulation therapies, have also gained popularity in recent decades.[788] Many of these treatment methods are used in conjunction with one another, such as the common combination of talk therapy and the prescription of anti-anxiety or antidepressant medications.

Mental Health Treatment Approaches

Psychotherapy, also commonly known as "talk therapy," is usually delivered in one-on-one, family, or group sessions with a therapist. These therapies can be delivered in both inpatient and outpatient settings. Multiple modalities have been developed to suit different mental health conditions, personalities, and situations. Cognitive behavioral therapy (CBT) is one of the most commonly used modalities, where a therapist works with an individual to identify unhealthy thought patterns that have resulted in maladaptive behaviors and help the individual develop more constructive thought patterns. It is used to treat depression, anxiety, and other mental health disorders.[789] Other common psychotherapeutic modalities include Eye Movement Desensitization and Reprocessing Therapy (EMDR)[790] and psychodynamic therapy.[791,792]

Psychosocial treatments are a broad category of treatments designed to strengthen individuals' community support and improve quality of life, encompassing psychotherapy as well as other treatments delivered in community settings or that take the form of added support in individuals' day-to-day activities. Examples include psychoeducation, support groups, multidisciplinary psychosocial rehabilitation following in-patient treatment, supported employment and vocational rehabilitation, or case management services.[793]

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[785] Purtle, J., Nelson, K.L., Counts, N.Z. and Yudell, M. (2020). Population-Based Approaches to Mental Health: History, Strategies, and Evidence. Annual Review of Public Health, 41(1), pp.201–221. doi:10.1146/annurev-publhealth-040119-094247

[786] Substance Abuse and Mental Health Services Administration. *Behavioral Health Integration.* (n.d.) [online] Available at: https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf

[787] Substance Abuse and Mental Health Services Administration (2023). *Medications for Substance Use Disorders.* [online] www.samhsa.gov. Available at: https://www.samhsa.gov/medications-substance-use-disorders

[788] National Alliance on Mental Illness (2020). *Mental health treatments*. [online] Nami.org. Available at: https://nami.org/About-Mental-Illness/Treatments

[789] Also used to treat bipolar disorder, eating disorders, schizophrenia, etc

[790] EMDR treatment pairs bi-lateral stimulation inducing repetitive eye movement with recollection of traumatic events, to "replaces negative emotional reactions to difficult memories with less-charged or positive reactions or beliefs." It is often used to treat PTSD and emotional distress

[791] Psychodynamic therapy teaches people to "recognize negative patterns of behavior and feeling that are rooted in past experiences and resolve them" to treat depression, anxiety, bi-polar disorder, among others.

[792] National Alliance on Mental Illness (2020). *Mental health treatments*. [online] Nami.org. Available at: https://nami.org/About-Mental-Illness/Treatments

[793] Ibid.

An increasing proportion of the U.S. population takes **prescription medication** to manage mental health conditions.[794] These medications must be prescribed by a medical professional such as a psychiatrist, general practitioner, or advanced nurse practitioner. In most U.S. jurisdictions, psychologists, counselors, and other non-medical mental health workers cannot prescribe these medications.

Substance Use Treatment Approaches

Substance use treatments include a variety of interventions designed to help individuals reduce or cease the misuse of alcohol, opioids, and other addictive substances. Many individuals with substance use disorders also have co-occurring mental health disorders, and as such often simultaneously receive mental health treatments as described above in addition to treatments for their substance use disorder.

Medically supervised withdrawal (detoxification). Depending on the severity of substance misuse, individuals may experience intense physical withdrawal symptoms when ceasing substance use, including hallucinations, convulsions, or other symptoms. In these cases, medically supervised withdrawal to ensure the individual's safety may be necessary before other treatment interventions can take place.[795]

Counseling and behavioral support. Most treatment programs include a combination of group and individual counseling, individual assignments and goal-setting, substance use disorder education, life skills training, drug and alcohol testing, relapse prevention training, and orientation to self-help groups.[796] Individuals with unstable living or working conditions, serious disorders, and co-occurring mental health disorders are most likely to receive in-patient treatment, where distance from their usual environment and social interactions, as well as close monitoring and support from providers, can increase their likelihood of recovery.[797]

Medication-assisted treatment (MAT). Certain medications can be helpful in reducing the urge to resume substance use and thereby reduce an individual's likelihood of relapsing or overdosing. For example, there are medications for alcohol use disorder[798] and opioid use disorder[799] which decrease cravings, reduce euphoric effects of substance use, and may even

[794] Some common classes of prescription medication for mental health conditions include: antipsychotics (used to treat schizophrenia and schizoaffective disorder, as well as acute mania, bipolar disorder, and treatment-resistant depression by affecting dopamine levels), antidepressants (used to improve symptoms of depression by affecting brain chemical such as serotonin, norepinephrine and dopamine), and anti-anxiety medications (used to treat social phobias, generalized anxiety disorders, and panic disorders).
[795] Center for Substance Abuse Treatment (2014). What is substance abuse treatment? A booklet for families. [online] Substance Abuse and Mental Health Services Administration. Available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4126.pdf
[796] Ibid.
[797] Ibid.
[798] Medications include acamprosate, disulfiram, and naltrexone
[799] Medications include buprenorphine, methadone, and naltrexone

prevent metabolism of alcohol in the body. Other medications, like Naloxone and Narcan, can reverse the life-threatening effects of an opioid overdose.[800]

Prevention Approaches

While delivering treatment for mental illness is crucial to improving individuals' quality of life, the promotion of positive mental health and prevention of behavioral disorders must be delivered in conjunction with treatment efforts.[801] Widespread behavioral health disorders result in enormous social and economic burdens. For example, suicide and other self-harm events were estimated to cost the U.S. $58.4 billion in 2013, 97% of which were non-healthcare-related costs.[802] By reducing the overall prevalence and incidence of behavioral health disorders, promotion and prevention interventions can lighten the burdens on our health care systems and many other aspects of society and daily life.[803]

Health promotion "aims to keep people healthy or become even healthier" and "aims at enhancing individuals' ability to achieve psychosocial well-being and at coping with adversity."[804] Prevention, on the other hand, "focuses on the causes of risk factors to avoid illness."[805] These efforts can include reducing risk factors for entire populations or groups, early screening and detection, supporting recovery, and preventing relapse.[806] Effective promotion and prevention efforts are targeted at strengthening protective factors and reducing risk factors for mental illness (e.g. family stability, societal and family acceptance or rejection, barriers to economic resources, etc.).[807,808,809]

Promotion and prevention interventions have been shown to be very effective in reducing not only the costs of providing mental health care, but also the costs of other government and societal spending used to address issues related to or caused by mental illness.[810,811] There are

[800] Substance Abuse and Mental Health Services Administration (2023). *Medications for Substance Use Disorders.* [online] www.samhsa.gov. Available at: https://www.samhsa.gov/medications-substance-use-disorders
[801] Min, J.-A., Lee, C.-U. and Lee, C. (2013). Mental Health Promotion and Illness Prevention: A Challenge for Psychiatrists. *Psychiatry Investigation*, [online] 10(4), p.307. doi:10.4306/pi.2013.10.4.307.
[802] Costello, E.J. (2016). Early Detection and Prevention of Mental Health Problems: Developmental Epidemiology and Systems of Support. *Journal of Clinical Child & Adolescent Psychology*, 45(6), pp.710–717. doi:10.1080/15374416.2016.1236728.
[803] Jané-Llopis, E., Barry, M., Hosman, C. and Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education*, 12(2_suppl), pp.9–25. doi:10.1177/10253823050120020103x.
[804] Barry, M.M., Clarke, A.M., Petersen, I. and Jenkins, R. eds., (2019). *Implementing Mental Health Promotion*. Cham: Springer International Publishing. doi:10.1007/978-3-030-23455-3.
[805] Ibid.
[806] Ibid.
[807] Steinhausen, H.-C. and Metzke, C.W. (2001). Risk, Compensatory, Vulnerability, and Protective Factors Influencing Mental Health in Adolescence. *Journal of Youth and Adolescence*, 30(3), pp.259–280. doi:10.1023/a:1010471210790.
[808] Heinsch, M., Wells, H., Sampson, D., Wootten, A., Cupples, M., Sutton, C. and Kay-Lambkin, F. (2020). Protective factors for mental and psychological wellbeing in Australian adults: A review. *Mental Health & Prevention*, 25, p.200192. doi:10.1016/j.mhp.2020.200192.
[809] Pirkola, S., Isometsä, E., Aro, H., Kestilä, L., Hämäläinen, J., Veijola, J., Kiviruusu, O. and Lönnqvist, J. (2005). Childhood adversities as risk factors for adult mental disorders. *Social Psychiatry and Psychiatric Epidemiology*, 40(10), pp.769–777. doi:10.1007/s00127-005-0950-x.
[810] McDaid, D., Park, A-La. and Wahlbeck, K. (2019). The Economic Case for the Prevention of Mental Illness. *Annual Review of Public Health*, 40(1), pp.373–389. doi: 10.1146/annurev-publhealth-040617-013629
[811] Ibid.

a wide range of promotion and prevention strategies that can be employed to improve mental health outcomes. Many of these strategies must be implemented as multi-sector, multi-disciplinary efforts, which can make the initial stages of coordination and collaboration difficult.[812] Selected examples of evidence-based promotion and prevention strategies are included in Table 5.8.

Table 6.3 Evidence-Based Mental Health Promotion and Prevention Strategies

Intervention	Results
Societal Strategies	
Improved macroeconomic and labor policies[813]	Decreased socioeconomic inequalities; improved standards of living and employment
Improved nutrition for socio-economically disadvantaged children[814]	Healthy cognitive development; improved educational outcomes
Improved urban planning and housing conditions[815]	Improvements in self-reported physical and mental health, perceptions of safety, crime reduction and social and community participation
Adult literacy programs[816]	Tangible benefits in promoting mental health; Sense of pride, self-worth, and purpose experienced by participants
Taxation of addictive substances[817]	Reduction of traffic accidents; reduction of other intentional and unintentional injuries, such as suicide or domestic violence; reduction of the associated negative mental health impacts of the consequences attributed to alcohol consumption
Mental health media campaigns[818]	Decrease in stigma; increase in public knowledge and awareness
Healthcare Strategies	
Early interventions for expectant mothers[819]	Reduction in risk factors such as substance use, premature births, and perinatal depression

[812] Ibid.
[813] Whitehead, M. (2007). A typology of actions to tackle social inequalities in health. *Journal of Epidemiology & Community Health*, 61(6), pp.473–478. doi:https://doi.org/10.1136/jech.2005.037242.
[814] Jané-Llopis, E., Barry, M., Hosman, C. and Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education*, 12(2_suppl), pp.9–25. doi:https://doi.org/10.1177/10253823050120020103x.
[815] Ibid.
[816] Ibid.
[817] Ibid.
[818] Ibid.
[819] Jané-Llopis, E., Barry, M., Hosman, C. and Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education*, 12(2_suppl), pp.9–25. doi:https://doi.org/10.1177/10253823050120020103x.

Interventions for first-episode psychosis[820]	Reduced morbidity, more rapid recovery, and better prognosis; Preservation of psychosocial skills; preservation of family and social supports; decreased need for hospitalization
School Strategies	
Developmentally appropriate preschool curriculum paired with home visits[821]	Short-term improved cognitive development, decreased learning disability, improved social adjustment; Increased high school completed; deduction in lifetime arrests; Increase in literacy and employment; decreased welfare dependence and improved social responsibility
Whole-school programs that target multiple health outcomes[822,823]	Increases in mental well being, competence and social skills; decreases in anxiety and depressive symptomatology; deductions in aggression and bullying Increases in school achievement
Skill-oriented programs for university students[824]	Improvements in social and emotional skills and self-perception; deductions in emotional distress
Community Strategies	
Community member-led substance use education programs[825]	Reductions in gateway drug use; Increased parent-child communication; decreased self-reported alcohol use
Community-developed plans to prevent violence and aggression[826]	Improvements in youth cognitive skills, parental skills, and community relations; decreases in school problems, burglary, drug offenses, and assault charges
Workplace Strategies	
Job search skill programs emphasizing self-efficacy, self-esteem, and resilience[827]	Improved confidence, self-efficacy, and re-employment
Workplace improvements such as manager training	Returns on investment both to employers and publicly funded health care systems

[820] Ibid.
[821] Ibid.
[822] Ibid.
[823] Barry, M.M., Clarke, A.M., Petersen, I. and Jenkins, R. eds., (2019). *Implementing Mental Health Promotion*. Cham: Springer International Publishing. doi:https://doi.org/10.1007/978-3-030-23455-3.
[824] Conley, C.S., Durlak, J.A. and Dickson, D.A. (2013). An Evaluative Review of Outcome Research on Universal Mental Health Promotion and Prevention Programs for Higher Education Students. Journal of American College Health, 61(5), pp.286–301. doi:https://doi.org/10.1080/07448481.2013.802237
[825] Jané-Llopis, E., Barry, M., Hosman, C. and Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education*, 12(2_suppl), pp.9–25. doi:https://doi.org/10.1177/10253823050120020103x.
[826] Ibid.
[827] Jané-Llopis, E., Barry, M., Hosman, C. and Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education*, 12(2_suppl), pp.9–25. doi:https://doi.org/10.1177/10253823050120020103x.

and provision of mental health resources to employees[828]	
Home and Family Strategies	
Screening for and management of mental health during pregnancy[829]	Reductions in anxiety, psychosis, and post-traumatic stress disorders in new mothers, as well as depression and anxiety in new fathers
Cognitive-behavioral and rational emotive therapy programs for parents[830]	Relieved guilt and improved parental moods
Behavioral and multi-modal parenting programs[831]	Improved parenting competence and social support
Strategies for Old Age	
Stepped-care approaches (monitoring, guided self-help, and referral to primary care)[832]	Reduced anxiety and depressive disorders
Physical exercise, skill training, reminiscence, social activities, group support, and multi-component activities[833]	Positive effects on quality of life and mental health; reduction in depressive symptoms
Increased access to hearing aids[834]	Improvements in social, emotions, communication, and cognitive functions Reduction in depression scores

[828] McDaid, D., Park, A-La. and Wahlbeck, K. (2019). The Economic Case for the Prevention of Mental Illness. Annual Review of Public Health, 40(1), pp.373–389. doi:https://doi.org/10.1146/annurev-publhealth-040617-013629
[829] Ibid.
[830] Barry, M.M., Clarke, A.M., Petersen, I. and Jenkins, R. eds., (2019). *Implementing Mental Health Promotion*. Cham: Springer International Publishing. doi:https://doi.org/10.1007/978-3-030-23455-3.
[831] Ibid.
[832] McDaid, D., Park, A-La. and Wahlbeck, K. (2019). The Economic Case for the Prevention of Mental Illness. Annual Review of Public Health, 40(1), pp.373–389. doi:https://doi.org/10.1146/annurev-publhealth-040617-013629
[833] Barry, M.M., Clarke, A.M., Petersen, I. and Jenkins, R. eds., (2019). *Implementing Mental Health Promotion*. Cham: Springer International Publishing. doi:https://doi.org/10.1007/978-3-030-23455-3.
[834] Jané-Llopis, E., Barry, M., Hosman, C. and Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education*, 12(2_suppl), pp.9–25. doi:https://doi.org/10.1177/10253823050120020103x.

The Behavioral Health Care System

Settings of Care

The settings in which behavioral health care is delivered can generally be categorized as in-patient, out-patient, or informal settings.[835] The 2020 National Mental Health Services Survey found that the vast majority of mental health facilities in the US are outpatient facilities, followed by approximately equal proportions of 24-hour inpatient, 24-hour residential, and partial hospitalization or day treatment facilities.[836] That survey also found that mental health facilities are operated by private non-profits, with a minority operated by private for-profit companies and various government entities.

In-patient settings include specialized mental health clinics or hospitals, nursing homes and skilled nursing facilities, hospital emergency departments, and residential programs (such as those for substance use or eating disorders). This type of care is "generally reserved for acute situations when individual[s are] perceived to be a threat to [themselves] or others around [them]."[837] **Out-patient** settings include mental health offices and primary care settings (such as general practitioners' or pediatrics offices). The conditions most commonly treated in these settings include anxiety, mood, and substance use disorders, and a vast majority of individuals with mental health conditions are diagnosed and treated in outpatient settings.[838] *Informal* settings include schools, prisons,[839] public meeting spaces, and private homes. Non-clinical services provided by criminal justice and educational human service workers are usually provided in these settings, as well as community- or volunteer-based services such as support groups, peer counseling, and pastoral counseling services.[840]

Paths to Care

There is no single path to receiving behavioral health care—a combination of many factors, such as economic resources, social milieu, cultural background, and societal structures affecting access to care, results in multiple paths that a person might take on their way to finally receiving treatment. Treatment seeking may be initiated by the individual, by someone in that individual's

[835] Sundararaman, R. (2009). The U.S. Mental Health Delivery System Infrastructure: A Primer. [online] Congressional Research Service. Available at: https://sgp.fas.org/crs/misc/R40536.pdf
[836] Substance Abuse and Mental Health Services Administration (2021). *National Mental Health Services Survey (N-MHSS): 2020 Data on Mental Health Treatment Facilities*. [online] Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt35336/2020_NMHSS_final.pdf.
[837] Sundararaman, R. (2009). The U.S. Mental Health Delivery System Infrastructure: A Primer. [online] Congressional Research Service. Available at: https://sgp.fas.org/crs/misc/R40536.pdf
[838] Goodrich, D.E., Kilbourne, A.M., Nord, K.M. and Bauer, M.S. (2013). Mental health collaborative care and its role in primary care settings. Current Psychiatry Reports, 15(8). doi:10.1007/s11920-013-0383-2.
[839] Approximately 40% of the United States' incarcerated population has been diagnosed with a mental illness, so it is important to note that a significant amount of clinical care is also provided in criminal justice contexts. Purtle, J., Nelson, K.L., Counts, N.Z. and Yudell, M. (2020). Population-Based Approaches to Mental Health: History, Strategies, and Evidence. Annual Review of Public Health, 41(1), pp.201–221. doi:10.1146/annurev-publhealth-040119-094247.
[840] Sundararaman, R. (2009). The U.S. Mental Health Delivery System Infrastructure: A Primer. [online] Congressional Research Service. Available at: https://sgp.fas.org/crs/misc/R40536.pdf

social network, or by someone they encounter who is in a position of authority (such as a judge or police officer), and these paths to care may be either voluntary or involuntary.[841]

Voluntary Treatment Seeking. A survey of consumers voluntarily seeking behavioral health services found that most people rely on "internet searches and recommendations of family, friends and physicians to find mental health providers."[842] Although practitioners report that "a large percentage of patients stem from a self-performed internet search," consumers who select providers in this way are more likely to report lower satisfaction with the provider, as compared to those who are connected to their provider via external referrals."[843] Mental health professionals' efforts to establish and maintain their professional identities are closely related to the need to differentiate themselves to treatment-seeking consumers. Research has shown that the public's perception and knowledge of a mental health profession may influence consumers' confidence in providers' abilities and ultimately their choice of provider when seeking help.[844]

Consumers' searches for a behavioral health provider are sometimes impeded by organizational or cultural barriers. For example, searches conducted through insurers' provider directories can be difficult due to "ghost networks"—large numbers of directory entries for providers who are not actually in-network, are non-responsive, or who are no longer practicing. One study found that "between forty-five and fifty-two percent of [Medicare Advantage] provider directory listings had errors…." This disconnect may result in people receiving "huge, unexpected medical bills [from out-of-network providers]", "giving up on finding an in-network provider at all and pay more money to see someone who is out-of-network"; or "delay[ing] needed care or choos[ing] to not seek care at all."[845] Another common barrier to successful care seeking is stigma around mental illness or substance use. Stigma may affect an individual's willingness to seek care in the first place or the resources available to them, and is the result of complex factors. However, some of these barriers can be reduced through "mental health literacy, cultural competence, and family engagement campaigns," as well as additional education for providers.[846]

Involuntary Receipt of Treatment. In some cases, individuals may be involuntarily committed to inpatient treatment or ordered to complete assisted outpatient treatment by a judge or other

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[841] Pescosolido, B.A. and Olafsdottir, S., 2013. Beyond dichotomies: confronting the complexity of how and why individuals come or do not come to mental health care. World Psychiatry, 12(3),p.269. doi: https://doi.org/10.1002/wps.20072

[842] Ward-Ciesielski, E.F. and Rizvi, S.L., 2021. Finding mental health providers in the United States: a national survey and implications for policy and practice. Journal of Mental Health, 30(5), pp.578-584. doi: https://doi.org/10.1080/09638237.2019.1677867

[843] Larson, L.R. and Bock, D.E., 2016. Consumer search and satisfaction with mental health services. Journal of Services Marketing. doi:https://doi.org/10.1108/JSM-09-2015-0281

[844] Fall, K.A., Levitov, J.E., Jennings, M. and Eberts, S. (2000). The Public Perception of Mental Health Professions: An Empirical Examination. Journal of Mental Health Counseling, 22(2). [online] Available at: https://www.researchgate.net/profile/Kevin-Fall/publication/234755928_The_Public_Perception_of_Mental_Health_Professions_An_Empirical_Examination/links/5c8e62dd92851c1df94803e9/The-Public-Perception-of-Mental-Health-Professions-An-Empirical-Examination.pdf

[845] Burman, A. (2021). Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories. Yale Law & Policy Review, 40(1), p.78. [online] Available at: https://yalelawandpolicy.org/laying-ghost-networks-rest-combatting-deceptive-health-plan-provider-directories

[846] Corrigan, P.W., Druss, B.G. and Perlick, D.A., 2014. The impact of mental illness stigma on seeking and participating in mental health care. Psychological Science in the Public Interest, 15(2), pp.37-70. doi: https://doi.org/10.1177/152910061453139

individual with judicial authority.[847] Involuntary, coerced, or pressured paths to treatment are surprisingly common, as "just under half of those who had their first major contact with the public mental health system made any kind of decision to do so," whether as a result of contact with the criminal justice system or familial pressure.[848] The issue of involuntary treatment is complicated and controversial, involving legal and ethical issues of individuals' autonomy, dignity, and human rights, individual and public safety, and the role of the state. Currently, most U.S. states' laws require the following three criteria to be satisfied for involuntary commitment: *dangerousness, grave disability* or *serious deterioration*, and *incompetency*.[849] In 2015, an estimated 9 in 1,000 individuals with SMI were involuntarily committed in the United States, although state-by-state averages varied widely.[850] Regarding involuntary commitment for substance use disorder treatment, practices differ from state to state—a 2014 review found that some states explicitly allow for involuntary commitment for substance use disorders, some do not reference these disorders and thus "passively permit" involuntary commitment, and others explicitly exclude substance use disorders from the definition of mental illness for the purpose of involuntary commitment.[851] Also particularly relevant to Utah (as one of the largest providers of adolescent residential treatment programs in the country) are issues surrounding involuntary youth transport (IYT). IYT, during which adolescents are involuntarily admitted to residential programs with their legal guardians' consent, is a controversial practice that has attracted attention in recent years due to various ethical concerns and the potential for negative long-term psychological effects on the adolescents involved.[852]

Paying for Behavioral Health Care Services in Utah

Utahns access regulated behavioral health care services through two distinct markets: public and private. Behavioral health facilities and providers are then reimbursed for their services by these public and private payors (e.g., Medicare, Medicaid, and private plans, which in Utah includes plans such as Aetna, SelectHealth, or University of Utah insurance plans). Some clients also pay providers directly ("self-pay" or "out-of-pocket" pay). The majority of Utah's population is insured through the private insurance market—the Utah Insurance Department estimated that in 2020, 66.3% of the population was covered by commercial or self-funded

[847] Substance Abuse and Mental Health Services Administration (2019). *Civil commitment and the mental health care continuum: Historical trends and principles for law and practice*. [online] Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf
[848] Pescosolido, B.A. and Olafsdottir, S., 2013. Beyond dichotomies: confronting the complexity of how and why individuals come or do not come to mental health care. World Psychiatry, 12(3), p.269. doi: https://doi.org/10.1002/wps.20072
[849] Substance Abuse and Mental Health Services Administration (2019). *Civil commitment and the mental health care continuum: Historical trends and principles for law and practice*. [online] Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf
[850] Ibid.
[851] Williams, A.R., Cohen, S. and Ford, E.B. (2014). Statutory Definitions of Mental Illness for Involuntary Hospitalization as Related to Substance Use Disorders. Psychiatric Services, 65(5), pp.634–640. doi:10.1176/appi.ps.201300175
[852] Gass, M., Hardy, C., Norton, C. and Priest, S. (2021). Involuntary Youth Transport (IYT) to Treatment Programs: Best Practices, Research, Ethics, and Future Directions. Child and Adolescent Social Work Journal, 39. doi:10.1007/s10560-021-00801-9

insurers and 24.3% were covered by government insurers.[853] As for the uninsured, it can be estimated that as of 2019, between 8.6% and 9.7% of Utah's population had no health insurance coverage.[854] The Utah Medical Education Council reported in 2016 that the reimbursement methods most commonly accepted by masters-level providers were private insurance (51.5%), followed by Medicaid (35.7%) and full self-pay (35.6%). Providers were less likely to accept sliding-scale self-pay, Medicare, Tricare, managed care, or workers compensation, or to offer charitable services free of charge.[855]

Utah's Public System. Appropriations from the Utah General Fund and Medicaid funding goes to two state divisions responsible for delivering behavioral health services: the Division of Substance Use and Mental Health and the Division of Medicaid and Health Financing, both within the Department of Health and Human Services. A system of complex funding flows between these agencies result in the provision of mental health services by Prepaid Mental Health Plans and other government-contracted providers of mental health services.[856] These programs serve "Medicaid enrollees, uninsured individuals, and other underinsured populations."[857] In Utah, behavioral health providers must be licensed in order to receive Medicaid reimbursement for services within their scope of licensure, whether they are employed by a provider facility or are self-employed. These licensing requirements, along with Medicaid reimbursement rates, have a direct influence on public providers' hiring, staffing, and service delivery patterns. Licensed providers can be made ineligible for Medicaid reimbursement in the event they are found guilty of committing fraud, or if DOPL or another state board has imposed a license limitation as part of a disciplinary action..[858]

Public system reimbursement payments come with significant documentation and reporting requirements.[859] For example, Utah behavioral health providers serving Medicaid clients must adhere to the Centers for Medicare and Medicaid Services (CMS) *Evaluation and Management Documentation Guidelines*, which require providers to keep detailed records of assessments, care plans, rationales for ordering additional services, treatment progress, and any changes to treatment plans. Record-keeping and disclosure, confidentiality, and access requirements are also in place.

Utah's public system is also funded in part by federal block grants, such as the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block

[853] Utah Insurance Commissioner (2021). 2021 Utah Health Insurance Market Report. [online] Utah Insurance Department. Available at: https://insurance.utah.gov/wp-content/uploads/2021HealthMarketReport.pdf
[854] Division of Data, Systems, and Evaluation (2022). *IBIS-PH - Health Indicator Report - Health Insurance Coverage.* [online] Available at: https://ibis.health.utah.gov/ibisph-view/indicator/view/HlthIns.UT_US_ACS.html
[855] Christensen, J. (2016). *Utah's Mental Health Workforce, 2016: A Study on the Supply and Distribution of Clinical Mental Health Counselors, Social Workers, Marriage and Family Therapists, and Psychologists in Utah.* [online] Utah Medical Education Council, State of Utah. Available at: https://umec.utah.gov/wp-content/uploads/Mental-Health-Workforce-2016-1.pdf
[856] This public network also includes the Utah State Hospital, Local Mental Health Authorities, CHIP, Accountable Care Organizations, Medicaid Fee-for Service, and the Healthy Outcomes, Medical Excellent (HOME) Program.
[857]Utah Hospital Association (2019). *Utah's Mental Health System*. [online] Kem C. Gardner Policy Institute. Available at: https://gardner.utah.edu/wp-content/uploads/MentalHealthReportAug2019.pdf
[858] Utah Division of Medicaid and Health Financing (2022). *Utah Medicaid Provider Manual: Section 1 General Information.* [online] Available at: https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf
[859] Ibid.

Grant. These block grants are administered by SAMHSA, and while they are non-competitive grants, Utah must demonstrate adherence to statutory and regulatory requirements in order to receive funding.[860,861]

Utah's Private System. For the majority of Utahns who are privately insured, coverage of behavioral health services can vary quite widely between plans, and private insurance will rarely cover the full cost of care. As reported by the Gardner Policy Institute,[862] some private plans, such as large group plans and ACA-compliant individual and small group plans, are required to offer mental health and substance use disorder benefits under the Mental Health Parity and Addiction Equity Act (MHPAEA). However, in discussion groups conducted by the Gardner Policy Institute, Utah mental health professionals noted that "not all employer-sponsored or commercial health plans are subject to the federal MHPAEA law and the law is not always enforced." This situation can limit even insured individuals' ability to access mental health services due to lack of coverage or plans that charge high co-pays and deductibles for behavioral health services. Those clients who are uninsured or whose insurance does not cover behavioral health services can directly reimburse providers through self-pay, or out-of-pocket payments, which can range from $50-$240 per session.[863] Some providers choose to operate solely as an out-of-network "cash-only" provider to avoid the complications associated with working with managed care organizations or insurance panels.[864] Some will also set sliding fee scales for self-pay clients, often based on the U.S. Federal Poverty guidelines.[865]

[860] Substance Abuse and Mental Health Services Administration (2019). *Substance Use and Mental Health Block Grants | What Is a Block Grant?* [online] Samhsa.gov. Available at: https://www.samhsa.gov/grants/block-grants
[861] For example, the 2020-2021 SABG funding agreement requires states to report the recipients of block grant funding and the purpose of any expenditures, submit to federal audits, and make records available to both public agencies and the general public. United States Code (2023). §300x–52. *Requirement of reports and audits by States.*
[862] Utah Hospital Association (2019). *Utah's Mental Health System*. [online] Kem C. Gardner Policy Institute. Available at: https://gardner.utah.edu/wp-content/uploads/MentalHealthReportAug2019.pdf
[863] Ibid.
[864] Fang, M. (2019). *Why I Have a Cash Only Therapy Practice.* [online] Private Practice Skills. Available at: https://privatepracticeskills.com/cash-only-therapy-practice/
[865] APA Legal and Regulatory Affairs (2018). *Using a Sliding Fee Scale: Some Do's and Don'ts*. [online] American Psychological Association. Available at: https://www.apaservices.org/practice/business/legal/professional/sliding-fees

Table 6.4 Occupational Oversight Menu of Alternatives—Structure & Governance Levers			
Category	Lever	Description	Examples
Oversight	Entities	*Groups involved in overseeing and/or regulating the occupation*	Professional associations, employers, executive branch agencies, boards
	Powers & Duties	*Responsibilities of those groups*	Law-making, rule-making, administration, discipline
	Relationships	*Ties/Hierarchy of those groups*	Reporting & communication, levels of authority & autonomy within areas of responsibility, oversight by other entities
	Size & Composition	*Membership of those groups*	Practitioners, administrators, other experts, members of the public; their characteristics
	Appointment Process	*How members are selected*	By the entity vs. by another entity, by vote, by appointment
Model of Occupational Regulation	Authorized Party	*Who is authorized to practice*	Individual or entity (i.e., occupational vs. business licenses)
	Authorization Type	*What type of authorization is used*	Self-regulation, co-regulation, negative licensing, registration, certification, licensure (authorization may offer title protection, scope of practice protection, neither, or both)
	Authorization Structure	*How the selected authorization type is structured*	Number, levels, and interdependencies of authorizations granted (e.g., licenses levels)
Parameters of Occupational Regulation	Definitions	*How terms are defined*	List of terms used and their meaning; whether those meanings are distinct or shared
	Scope of Practice	*What licensees are authorized to do*	Activities for which authorization is provided (may be granted as exclusive or non-exclusive practice authority)
	Authorization Limitations	*Limitations to authorization provided*	Level of authority/autonomy (e.g., needs supervision), license duration & renewability (e.g., temporary/provisional), license applicability (e.g., only authorized in certain settings)
	Unauthorized Practice	*What unauthorized practitioners are not authorized to do*	Falsely advertising oneself as an authorized professional; performing protected activities; exempted practice

Table 6.5 Occupational Oversight Menu of Alternatives—Entry Levers			
Category	Lever	Lever Definition	Examples
Pathways & Portability	Intrastate Alternative Pathways	*Pathways for entering a profession within one state*	Traditional pathways vs. alternative pathways with substitutions or alterations to requirements
	Interstate Portability	*Pathways governing portability of authorization between states*	Interstate licensure compacts; licensure by endorsement
	International Portability	*Pathways governing portability of authorization between countries*	Foreign credential endorsement for immigrant professionals
Professional Preparation & Entry Qualifications	Educational	*Degrees & courses*	Degrees (high school, bachelors, masters, doctorate, etc.), coursework, and training certifications
	Experiential	*Practicum & supervised hours*	Internships, apprenticeships, directly or indirectly supervised practice
	Exam	*Formal assessments*	State-created assessments; private examinations recognized by the state
	Other	*Entry requirements not related to education, experience, or exams*	SSN, criminal background checks, fingerprinting, mandatory insurance or bonding, professional association membership
Application Process & Logistics	Initial Application Fees	*State-levied administrative fees*	Fee amounts; reductions or exemptions from fees for certain applicant groups
	Initial Application Format	*Content, style, and form of application materials*	Digital vs. print applications, available languages, length and detail, deadlines, accommodations for disability, military, or other special status

Table 6.6 Occupational Oversight Menu of Alternatives—Practice Levers			
Category	Lever	Lever Definition	Examples
Compliance, Discipline, & Enforcement	Accountable Party	*Who is liable in the event of unprofessional conduct*	Individual-level, employer-level, or entity-level liability, third-party insurance company or bonding company
	Practice Standards & Unprofessional Conduct	*Actions not in accordance with state-defined standards for practice*	Ethical violations, boundary violations, professional code violations, deceptive or unfair practices, out of scope practice
	Monitoring Method(s)	*Methods of discovering instances of unprofessional or unlawful conduct*	Consumer complaints, reporting and paperwork, peer complaints, investigations, inspections, audits, mandatory disclosures about service(s) and/or provider(s) to consumers, oversight by supervisors or other professionals
	Disciplinary Method(s)	*The range of potential disciplinary actions & consequences*	Letter of concern, stipulation, sanction, suspension, revocation, civil or criminal charge, negative licensure
Professional Development & Renewal Requirements	Interprofessional Development	*Methods of ensuring professional competence post-authorization*	Peer consultation requirements, supervision requirements, collaboration requirements
	Continuing Education	*Content and amount of continuing education required for renewal*	Training in new technologies, best practices, ethics and legal compliance; number of required credits or hours of training
	Other Requirements	*Other requirements that must be completed before renewal*	SSN, criminal background checks, fingerprinting, mandatory insurance or bonding, professional association membership
Renewal Process & Logistics	Renewal Application Fees	*State-levied administrative fees*	Fee amounts; reductions or exemptions from fees for certain applicant groups
	Renewal Application Format	*Content, style, and form of application renewal materials*	Questions, deadlines, length, available languages, digital vs. print, accommodations (e.g., for disability, military, other)
	Renewal Cycle	*How often authorization must be renewed*	Length of renewal cycle (e.g., in months or years)

Background: The Regulation of BH Professionals

Authorization Types

Currently, behavioral health (BH) care professionals in Utah operate under two primary forms of authorization: 1) mandatory licensure, and 2) voluntary certification. These authorizations are overseen and administered by the Division of Professional Licensing (DOPL) and by the Department of Health & Human Services (DHHS). The BH workforce also includes exempted and unregulated practitioners. Beyond regulating individual professionals, the entity-level licensure of healthcare and human service facilities and programs through DHHS provides an added layer of oversight for members of the workforce who are employed within these contexts.

Mandatory Licensure. Mandatory licensure includes both title protection—meaning unauthorized individuals cannot refer to themselves by the title designated for only licensed practitioners—as well as scope-of-practice protection—meaning unauthorized individuals cannot conduct activities or provide services designated for only licensed practitioners (or exempted parties). In other words, no one is allowed to carry out specified acts unless they are licensed or exempt, and no one may call themselves by a specific title unless they are licensed.

Voluntary Certification. Voluntary certification, on the other hand, typically includes only title protection, not scope-of-practice protection. In other words, anyone may carry out specified acts regardless of whether or not they are state certified, but not everyone may refer to themselves using the protected professional title.

Exempted Practice. Others may also be authorized to perform certain functions that fall within a licensed profession's scope of practice, provided that they are exempt from licensure. For example, medical professionals (e.g., physicians, advanced practice registered nurses, physician assistants), clergy members, friends and relatives, and students in a degree program may all engage in acts that fall within the definition of the practice of mental health therapy.[866]

Unregulated Practice. Importantly, Utah's BH workforce also includes unregulated or self-regulated practitioners (e.g., psychiatric technicians, life coaches). These individuals may work in BH settings, interact with BH clients, and provide BH services, as long as these services are not within the exclusive scopes of practice of authorized (i.e., licensed or exempted) parties. They may even hold private industry certifications or credentials, but these do not interact with the state regulatory apparatus in terms of authorizing or certifying their qualifications to perform their work activities. A common example of this approach from the broader healthcare workforce is certified nursing assistants (CNA), who hold a private industry certification rather than a state license or certification, but who nevertheless provide services in the healthcare field.

[866] UCA 58-60-107 Mental Health Professional Practice Act - Exemptions from licensure.

Facility & Program Licensure. Finally, Utah's regulatory oversight of BH practitioners extends beyond professional-level licensure, to the licensure of health care[867] and human services[868] facilities and programs. Much of the BH workforce operates within these settings, which are licensed and overseen by DHHS. Currently, DOPL is not authorized to obtain information regarding a licensed professional's place of work, so which practitioners operate within these regulated contexts may not be known by relevant regulators.

Table 6.7 Current Regulation of Utah's Behavioral Health Workforce

Authorization Type	Current Professions & License Types
Mandatory Licensure	• Social Workers (LCSW, CSW, SSW) • Marriage & Family Therapists (MFT, AMFT) • Clinical Mental Health Counselors (CMHC, ACMHC) • Substance Use Disorder Counselors (LA-SUDC, CA-SUDC, L-SUDC, C-SUDC) • Psychologists & Certified Psychology Residents • Behavior Analysts & Assistant Behavior Analysts • Recreation Therapists (MTRS, TRS, TRT)* • Licensed Vocational Rehabilitation Counselors*
Voluntary Certification	• State Certified Music Therapists* • Certified Peer Support Specialists • Certified Crisis Workers • Certified Case Managers
Exempted Practice *(List not exhaustive)*	• Medical Professionals • Clergy Members • Friends and Relatives • Students in Training
Unregulated Practice *(List not exhaustive)*	• Psychiatric Technicians • Art Therapists • Dance Therapists • Life Coaches

[867] UCA 26B-2-201(13)(a) "'Health care facility' means general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, residential-assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, abortion clinics, a clinic that meets the definition of hospital under Section 76-7-301 or 76-71-201, facilities owned or operated by health maintenance organizations, end stage renal disease facilities, and any other health care facility which the committee designates by rule."

[868] UCA 26B-2-101(23)(a) "'Human services program' means: (i) a foster home; (ii) a therapeutic school; (iii) a youth program; (iv) an outdoor youth program; (v) a residential treatment program; (vi) a residential support program; (vii) a resource family home; (viii) a recovery residence; or (ix) a facility or program that provides: (A) adult day care; (B) day treatment; (C) outpatient treatment; (D) domestic violence treatment; (E) child-placing services; (F) social detoxification; or (G) any other human services that are required by contract with the department to be licensed with the department."

Facility & Program Licensure	• Health Care Facilities • Human Services Facilities & Programs

* Comparatively rare license or certification type; regulated in 15 or fewer U.S. states and territories.[869]

Within the United States, the regulation of BH occupations is not uniform both in terms of which professions are regulated and in terms of which forms of authorization are used (e.g., mandatory licensure, voluntary certification). Data compiled by the Knee Center for the Study of Occupational Regulation (CSOR) on 29 types of behavioral health occupational licenses in all 50 states, as well as the District of Columbia and Puerto Rico, shows a wide range of approaches to classifying and regulating these occupations.[870,871] The most consistently regulated BH practitioners include psychologists and clinical social workers (52 jurisdictions), marriage and family therapists (51 jurisdictions), social workers (47 jurisdictions), peer recovery support specialists (43 jurisdictions), prevention specialists (43 jurisdictions), and drug and alcohol addictions counselors (42 jurisdictions).[872] Less commonly regulated BH practitioners include hypnotherapists (8 jurisdictions), recreational therapists (7 jurisdictions), psychiatric technicians (4 jurisdictions), vocational rehabilitation counselors (3 jurisdictions), and dance/movement therapists (2 jurisdictions).

Mandatory licensure and voluntary certification are by far the most common approaches to regulating the BH workforce in the U.S., yet substantial variation exists in terms of both whether and how the various BH occupations are regulated. Other authorization types that may be used to regulate this workforce include registration[873] and negative licensure.[874]

Registration. Registration requires individuals to register their details with the government if they wish to use a professional title or if they wish to provide certain types of goods or services, but does not stipulate any specific entry requirements or prerequisites to become registered.[875] In this way, registration allows anyone to use a title or to engage in specific work, as long as

[869] By contract, common BH license/certification types not offered in Utah include: Certified Prevention Specialists, Master Addiction Counselors, and Certified Clinical Supervisors.
[870] The Knee Center for the Study of Occupational Regulation (n.d.). *CSOR Occupational Regulation Database*. [online] Available at: https://csorwvu.com/find-occupations/
[871] Note from CSOR Occupational Regulation Database webpage: "Information is subject to change as state laws change. Please visit our Legislation Page to access each state's most up-to-date occupational laws." Although the data collected by CSOR and referenced here may not be current for all states as of the writing of this report, OPLR is using this data to describe the general variation of occupational regulation in the United States.
[872] It should be noted that some areas of practice are regulated under a variety of titles that are counted separately in CSOR's data. (CSOR reports at least 7 license types related to substance use or addiction treatment.) So, for example, although only 42 of 52 jurisdictions regulate "Drug and Alcohol Addictions Counselors," this does not necessarily mean that the remaining 10 jurisdictions do not have some type of occupational regulation in this specialty area—instead, they may use titles like "Substance Use Disorder Counselor" (as in Utah) or "Addictions and Chemical Dependency Counselor."
[873] Carollo, N.A. (2021). *Essays in Labor Economics*. [online] escholarship.org. Available at: https://escholarship.org/uc/item/18g5d9kv.
[874] Macleod, A. and Mcsherry, B. (2007). Regulating Mental Healthcare Practitioners: Towards a Standardised and Workable Framework. *Psychiatry, Psychology and Law*, 14(1), pp.45–55. doi:https://doi.org/10.1375/pplt.14.1.45.
[875] Ibid.

they provide certain information (e.g., name, contact) to the state. Registered practitioners can be investigated and removed from the registry if they engage in unprofessional conduct.[876]

Negative Licensure. With negative licensure, anyone may engage in a pre-specified set of work practices and activities, but this authorization may be selectively revoked—for example, when sufficient evidence is present to suggest that a practitioner is harming consumers. Using negative licensure involves creating a registry of persons who are *not* authorized to perform certain work activities, whereas mandatory licensure and registration involve creating a registry of those who *are* authorized to perform them. This approach reduces barriers to entry while still allowing for ongoing oversight and so may be appropriate in instances where risks of harm to consumers are present, but are not especially severe, probable, and permanent.[877] New South Wales has adopted this approach, allowing regulators to investigate and discipline unregistered health practitioners for unprofessional conduct and violations of practice standards.[878]

From most to least restrictive then, authorization types include:

- Licensure (Title and Scope of Practice; Required Qualifications)
- Certification (Title; Required Qualifications)
- Registration (Title and/or Scope of Practice; No Required Qualifications)
- Negative Licensure (Scope of Practice; No Required Qualifications)
- Unregulated / Self-Regulated Practice (No Protection)

Table 6.8 Authorization Types in Behavioral Health Occupational Regulation

Authorization Type	Qualifications	Title Protection	Scope Protection
Licensure	✔	✔	✔
Certification	✔	✔	
Registration		✔*	✔*
Negative Licensure			✔
Unregulated/Self-Regulated			

* Registration may provide a protected professional title and/or a protected scope of practice.

Looking beyond the United States to include other common-law nations (i.e., Australia, Canada, New Zealand, and the United Kingdom), there is "little consistency as to how the different classes of categories of mental health care providers across the five jurisdictions are regulated."[879] Psychologists are licensed in at least some states or provinces within all five

[876] Hogan, D.B. (1999b). *PROTECTION NOT CONTROL*. IPNOSIS [online] ipnosis.postle.net. Available at: http://ipnosis.postle.net/pages/hogantext01.htm

[877] Macleod, A. and Mcsherry, B. (2007). *Regulating Mental Healthcare Practitioners: Towards a Standardised and Workable Framework*. *Psychiatry, Psychology and Law,* 14(1), pp.45–55. doi:https://doi.org/10.1375/pplt.14.1.45.

[878] Ibid.

[879] Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *Google Books*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.

countries, but social workers, marriage and family therapists, mental health counselors, and substance use counselors are much less consistently licensed or even certified, and the United States' regulatory requirements tend to be the most restrictive.[880] Importantly, many of these countries' regulatory approaches only provide title protection, rather than scope-of-practice protection, due in part to the extensive overlaps, ongoing evolution, and inherent ambiguity that currently exist in the professional activities of BH providers.[881]

Scopes of Practice

Purpose of Scope. Scopes of practice for BH practitioners outline the professional tasks, services, and activities that only authorized parties are allowed to perform. Additionally, scopes of practice may help insurers to determine which BH practitioners they will reimburse for which services and activities. For instance, in addition to designating protected practices that may only be performed by authorized BH professionals, scope language may be used by Medicaid and other payers to inform and determine which professionals may be compensated for providing which services. Given this dual purpose, scopes of practice are currently provided both for those who hold both mandatory licenses, and for those who hold voluntary certifications (for purposes of reimbursement) in BH. In the case of mandatory licensure, the scope of practice is exclusive—meaning that no party may engage in the specified job activities unless duly licensed (or exempted) by the state. With voluntary certification, scopes of practice are non-exclusive—meaning that anyone may engage in the specified job activities, regardless of whether they are state certified. In practice, typically only those who are state certified may be reimbursed by Medicaid and other payers for the delivery of those services. In this case, outlining their scope of practice is useful insofar as it enables payors to verify the appropriateness of reimbursing certified workers for certain activities, but does not exclude unauthorized parties from performing the same work.

Content of Scope. Across the occupations, BH practitioners practicing at the same level (e.g., clinicians, extenders) perform many of the same core tasks, despite apparent differences in approach.[882] For example, licensed clinical social workers, marriage and family therapists, clinical mental health counselors, and psychologists are all allowed to provide psychotherapy, although they may do so building upon distinct theoretical traditions and a diverse set of modalities. The scopes of practice of Utah's BH workforce include the following types of tasks:

- Assessment and monitoring tasks, which include observing/analyzing a client's condition
- Care planning and authorization tasks, which include setting goals and defining strategies to achieve them
- Intervention and treatment tasks, which include providing care and services to clients
- Administration and coordination tasks, which include documenting care and conducting other organizational services

[880] Trebilcock, M.J. (2022). *Paradoxes of Professional Regulation: In Search of Regulatory Principles*. [online] *Google Books*. University of Toronto Press. Available at: https://www.jstor.org/stable/10.3138/j.ctv2sm3bgh.
[881] Ibid.
[882] Ibid.

Mental health therapists (i.e., clinicians) tend to provide higher-risk, more complex, and higher-cost services, while other non-clinician BH professionals (i.e., extenders) tend to provide lower-risk, less intensive, and lower-cost services. Both clinicians and extenders provide care that is directed toward treating BH disorders. In this way, the nature of clinicians' and extenders' work is interconnected and mutually supportive, though distinct.

Table 6.9 Common Clinician & Extender Task Types in Behavioral Health Care

Task Category	Clinician Task Types	Extender Task Types
Assessment & Monitoring	• Psychological testing • Diagnostic evaluation	• Intake screening • Information gathering to inform diagnostic evaluation
Care Planning & Authorization	• Treatment planning to establish medical necessity to trigger reimbursement for services • Treatment planning that includes psychotherapy and other intensive treatments	• Information gathering and progress tracking to inform treatment planning & updates • Planning that includes goal setting and non-clinical care (i.e., not psychotherapy)
Intervention & Treatment	• Individual psychotherapy • Family psychotherapy • Group psychotherapy • Psychotherapy for crisis	• Activity-based therapies (e.g., recreation, art, music) • Support groups • Skills training • Psychoeducation • Habilitation services • Coaching • Motivational interviewing
Administration & Coordination	• Patient referrals • Case notes / progress notes • Clinical documentation • Authorizing billing	• Targeted case management • Care navigation • Scheduling & office tasks • Benefits-related tasks

The scope-of-practice protections granted to BH practitioners vary widely both across U.S. jurisdictions, as well as in other nations around the world. Broadly speaking, scopes of practice for BH practitioners include activities related to assessing and monitoring patients' progress, planning and authorizing strategies for their care, providing therapeutic interventions and other forms of care, and performing administrative and care-coordination-oriented tasks. Further, practice authority for BH practitioners is often differentiated by independent versus supervised status. That is, some practitioners are allowed to perform tasks without supervision, while others require direct or general supervision to be authorized to perform their work. Typically there is also a divide between the scopes of practice of more advanced providers such as psychologists and clinical therapists, who are authorized to diagnose and treat using interventions such as psychotherapy, versus non-clinician providers who are not allowed to provide these services.

Protected scopes of practice, the granularity of occupational classifications, and required years of training all vary widely in common-law nations and within the European Union.[883] Importantly, the international health community does not necessarily see total uniformity in mental health provider regulation as an ideal outcome. For example, the World Health Organization recommends that countries adjust scope-of-practice regulations based on their unique circumstances: "Which professional group may make a judgment about the presence or absence of a mental disorder must be determined within countries, and must be linked to questions of availability, accessibility, affordability, training and competence of various professional groups."[884] These recommendations may indicate that in low-income countries or areas with a scarcity of highly trained BH professionals such as psychiatrists and psychologists, the benefits of allowing other practitioners to diagnose and treat BH conditions to increase overall access may outweigh the risks of extending these privileges to those with less training.

Taken together, differences in authorization types and scopes of practice reflect a 2x2 matrix for the regulation of BH providers, where those who are authorized to perform higher-risk tasks and/or to work independently without supervision must hold a license, while those who are authorized to perform only lower-risks, and in particular those who do so while under supervision, may be overseen through less restrictive forms of regulation.

Table 6.10 Practice Authority Scope, Independence, & Type

	Supervised Practice	Independent Practice
Higher-Risk Acts	**Mandatory Licensure** *Supervised Clinicians*	**Mandatory Licensure** *Independent Clinicians*
Lower-Risk Acts	**Voluntary Certification or Less (e.g., Negative Licensure)** *Supervised Non-Clinicians*	**Mandatory Licensure or Less (e.g., Voluntary Certification)** *Independent Non-Clinicians*

[883] European Commission (2016). Mutual evaluation of regulated professions: Overview of the regulatory framework in the health services sector - psychologists and related professions. [online] Available at: https://ec.europa.eu/docsroom/documents/16683?locale=en.
[884] World Health Organization. 2005. WHO resource book on mental health, human rights, and legislation. Geneva, Switzerland: World Health Organization.

Table 6.11 Prescribing Psychologist Regulation in RxP States—Structure & Governance			
State/Territory	Oversight Body/Bodies	Scope of Practice	Other
Guam (1999)	Board of allied health examiners, medical board, and pharmacy board	Administer, prescribe, and dispense any licensed drug, as delegated by a Collaborative Practice Agreement (CPA) with a physician	
New Mexico (2002)	Psychology board, medical board, and pharmacy board	Administer and prescribe psychotropic medications, and order and review laboratory tests in conjunction with the prescription, for the treatment of mental disorders.	Psychology board provides updates to medical and pharmacy boards with lists of certified prescribing psychologists
Louisiana (2004)	Medical board, Medical Psychology Advisory committee	Administer and prescribe only those drugs customarily used for the management of mental, nervous, emotional, behavioral, substance abuse, and cognitive diseases or disorders (excluding narcotics); order and interpret laboratory and diagnostic tests	
Illinois (2014)	Secretary of Financial and Professional Regulation, advisory board	Prescribe medications including Schedule III through V controlled substances as delegated by a CPA with a physician (excluding narcotics and injected controlled substances)	
Iowa (2016)	Psychology board, medical board	Administer and prescribe psychotropic medications, and order and review laboratory tests in conjunction with the prescription, for the treatment of mental disorders.	
Idaho (2017)	Psychology board, advisory panel	Administer and prescribe only those drugs customarily used in the diagnosis, treatment and management of individuals with psychiatric, mental, cognitive, nervous, emotional or behavioral disorders.	
Colorado (2023)	Psychology board, medical board	Administer and prescribe psychotropic medications, and order and review laboratory tests in conjunction with the prescription, for the treatment of mental disorders.	Licensing department required to collect information on prescribing psychologists and report annually to the office responsible for sunset reviews

Table 6.12 Prescribing Psychologist Regulation in RxP States—Entry Requirements				
State	Education	Exam	Experience	Other
Guam (1999)	Completion of a nationally and professionally accepted pharmaceutical curriculum	Passing score on a national certification exam		State and federal controlled substance permits
New Mexico (2002)	Master's degree in psychopharmacology	Passing score on a national certification exam; independent peer review by the psychology and medical boards	2 years of supervised experience under the supervision of a trained physician	
Louisiana (2004)	Master's degree in psychopharmacology	Passing score on a national certification exam	3 years of supervised experience under the supervision of a trained physician	Recommendation of 2 collaborating physicians and the Medical Psychology Advisory Committee; state and federal controlled substance permits
Illinois (2014)	Undergraduate biomedical prerequisites and 60 credits of additional didactic coursework in psychopharmacology	Passing score on a national certification exam	14 month full-time practicum with clinical rotations; must be equivalent to training for either physician assistant education, advanced practice nurse education, or medical education	
Iowa (2016)	Master's degree in psychopharmacology	Passing score on a national certification exam	2 years of supervised experience under the supervision of a trained physician	
Idaho (2017)	Master's degree in psychopharmacology (substantially equivalent to psychiatric APRN)	Passing score on a national certification exam	2 years of supervised experience under the supervision of a trained physician	
Colorado (2023)	Master's degree in psychopharmacology	Passing score on a national certification exam		

Table 6.13 Prescribing Psychologist Regulation in RxP States—Practice Requirements			
State	Malpractice Insurance	Collaboration	Continuing Education
Guam (1999)		Written collaborative practice agreement (CPA) with a physician	20 hours annually
New Mexico (2002)	Required in statute for both conditional/provisional and full certification	Maintain an ongoing collaborative relationship with patients' health general practitioners; provide written notice of prescriptions to patients' HCP within 24 hours of issuance	20 hours annually
Louisiana (2004)		Provide summaries of treatment plans, follow up reports, and annual reports to patients' established primary, attending, or referring physician	20 hours annually
Illinois (2014)		Written CPA with a physician; physicians may enter into no more than three CPAs with prescribing psychologists	10 hours annually
Iowa (2016)	Required in statute for both conditional/provisional and full certification	Written collaborative practice agreement (CPA) with a physician	20 hours annually
Idaho (2017)		Collaborative relationship with the patient's licensed medical provider	15 hours annually
Colorado (2023)		Ongoing collaborative relationship with the patient's physician; must receive written agreement from the physician before prescribing medication and document the collaborative relationship	20 hours annually

Appendix III: Additional OPLR Review Materials

Contents

UTAH DEPARTMENT OF COMMERCE
Office of Professional Licensure Review

Periodic Review

Behavioral Health

August 9, 2023

PRELIMINARY

Executive Summary

- This review examines the regulation of behavioral health (BH) professionals. BH includes both mental health and substance use disorders.
- Utah has a behavioral health care **access problem.** Between 210-515K Utahns who need BH care are not currently receiving it.
  - Utah's unmet need for care leads to higher suicidal ideation & attempts, as well as significant societal & economic consequences.
  - The access problem may be worsened by 1) workforce capacity constraints 2) shortage of extenders 3) misaligned education & career paths
- Utah has a behavioral health care **safety problem.** Utah ranks 12th worst for NPDB reports per BH practitioner, and 4th worst for repeat offenders.
  - Unsafe care includes boundary violations (e.g., sexual misconduct), billing fraud, and confidentiality and other violations.
  - The safety problem may be worsened by: 1) inconsistent supervision & support for clinicians 2) siloed info on safety/quality 3) reactive monitoring
- In order to improve behavioral health care access and safety, OPLR recommends that Utah:
  1. **Train Smarter, Not Harder**
     a. Eliminate generic supervision hours, while raising direct client contact and direct clinical supervision hours, and requiring direct observation
     b. Require supervisors to be trained and clearly define a minimum standard for supervision, while implementing capacity-building measures
     c. Count ongoing case consultation and direct-observation toward required continuing education hours
  2. **Expand Pathways & Portability**
     a. Provide an alternate pathway around clinical exam requirements for licensure, using added supervision and sign-offs
     b. Preserve both single- and multi-state pathways in all interstate compact language
     c. Form a pathway for Master's level addiction counselors to become licensed to practice in Utah
  3. **Strengthen Upstream Monitoring**
     a. Expand the Utah Professionals Health Program to include BH professionals and to cover BH conditions
     b. Require additional proactive safety measures including safety checks for past offenders and licensing-related client disclosures.
  4. **Fill Gaps in Career Ladders & Care**
     a. Create a new 1-year BH Technician voluntary certification and a 4-year generalist behavioral health license.
     b. Grant prescriptive authority for psychotropic medications to psychologists who complete training & supervision in psychopharmacology
  5. **Streamline Regulatory Structure & Governance**
     a. Align scopes of practice and authorization types by level of provider training and by level of risk to consumers
     b. Create a multi-profession BH oversight board with sub-committees, including stakeholders from across the BH care system

PRELIMINARY

Agenda

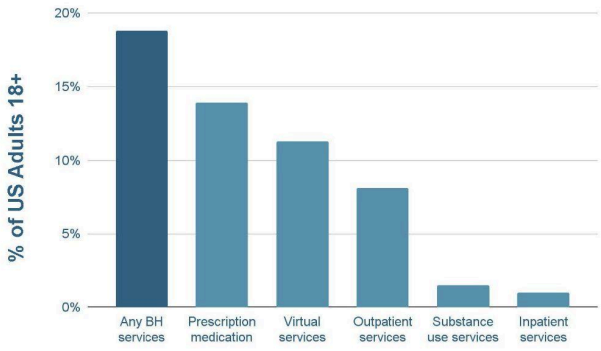
1. **Background & Methodology**
2. Findings
3. Recommendations
4. Discussion

UTAH | COMMERCE

PRELIMINARY

Behavioral Health: Overview

BH Services Received (2021)[1]



- **Behavioral Health (BH)[2]**
  Encompasses mental health & substance use disorders
- **Common Disorders[3]**
  Anxiety, depression, bipolar, post-traumatic stress, schizophrenia, eating disorders, disruptive behaviors & dissocial disorders, neurodevelopmental disorders, & substance use disorders (e.g., alcohol, opioid)
- **Common Treatments[4]**
  Psychotherapy, psychotropic medication, psychosocial support services – e.g., therapy, case management
- **Treatment Settings[5]**
  Outpatient, inpatient, and informal – e.g., clinics, hospitals, residential programs, support groups

In the U.S., the most commonly used form of treatment for BH is prescription medication. These medications are most often prescribed by a primary care provider without specialized training in BH.[6-9]

1. Center for Behavioral Health Statistics and Quality, 2022. 2. BHI Collaborative, 2021 3. World Health Organization, 2022 4. National Alliance on Mental Illness, 2020 5. Center for Behavioral Health Statistics and Quality, 2022 6. Jetty, Petterson, Westfall, & Jabbarpour, 2021 7. Mark, Levit, & Buck, 2009 8. DeLeon & Wiggins, 1996 9. Beardsley, 1988

PRELIMINARY

Behavioral Health: System Overview

- The behavioral health (BH) system has **multiple actors** working in coordination
- The BH system operates within a regulatory framework which includes **professional licensure**
- OPLR's objective is the '**health, safety, [and] financial welfare of the public**'[1]
- OPLR balances input from all actors in the system…but we **preference the needs of the Utah public**

[1] Utah Code 13-1b

PRELIMINARY

Behavioral Health: Licenses Under Review

Department of Commerce

- Social Worker *(~9,800 active licensees)*
- Clinical Mental Health Counselor *(2,900)*
- Psychologist *(1,300)*
- Marriage & Family Therapist *(1,500)*
- Recreational Therapist *(500)*
- Behavior Analyst *(800)*
- Substance Use Disorder Counselor *(500)*
- Vocational Rehabilitation Counselor *(200)*
- State Certified Music Therapist *(80)*

Department of Health & Human Services

- Certified Case Manager (1,000)
- Certified Peer Support Specialist (600)
- Child/Family Peer Support Specialist/ Family Resource Facilitator (25)
- Certified Crisis Worker (350)
- Behavioral Emergency Services Technician (0)
- Advanced Behavioral Emergency Services Technician (0)

Source: Department of Commerce data retrieved June 15, 2023 from Division of Professional Licensing, MLO Database. Department of Health & Human Services data shared by administrators in July, 2022.

PRELIMINARY

Why Review Behavioral Health?

Utah's high rates of BH disorders[1,2] have serious consequences

3rd
Worst in Nation

- Adult Serious Mental Illness (SMI)
- Youth Severe Major Depressive Episodes

2x higher mortality risk
for individuals with SMI[3]

~75,200 years
lived with disability in Utah due to mental disorders in 2022[4]

~$5.5 billion
lost to mental disorder disability-adjusted life years (DALYs) in Utah in 2022[5]

1. 2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates 2. 2022 State of Mental Health in America 3. Chang, Hayes, Broadbent, Fernandes, Lee, Hotopf, & Stewart, 2010. 4,5. Estimates based on research and data drawn from GBD 2019 Mental Disorders Collaborators, 2022. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019; PAHO, 2021 The Burden of Mental Disorders - PAHO/WHO | Pan American Health Organization.

PRELIMINARY

OPLR Statutory Mandate & Research Questions

Utah Code 13-1b review criteria…

- Supply of qualified BH practitioners
- Unnecessary barriers to entry
- Portability & alternative paths to licensure

Does Utah regulation provide sufficient **access to behavioral health care?**[1]

Access refers to whether people receive the care they need, based on its availability, affordability, accessibility, acceptability, and adequacy, and their awareness of options for their care.[2-6]

- Need for regulation to reduce risk of harm
- Severity, probability, permanence of harm
- What policies best prevent & reduce harm

Does Utah regulation provide sufficient **safety in behavioral health care?**

Safety reflects the incidence of adverse events, and refers to the extent to which receiving care exposes consumers to risks of harm to their health, safety, and/or financial welfare.[7-14]

1. Utah Code Section 13-1b; 2. Penchansky & Thomas, 1981; 3. Saurman, 2016; 4. Andersen & Aday, 1978; 5. Andersen & Davidson, 2007; 6. McLaughlin & Wyszewianski, 2002; 7. Mental Health Patient Safety: A Rapid Literature Review, 2019; 8. Averill, Vincent, Reen, Henderson, & Sevdalis, 2023; 9. Berzins, Baker, Brown, & Lawton, 2018; 10. Brickell, Nicholls, Procyshyn, McLean, Dempster, Lavoie, Sahlstrom, Tomita, & Wang, 2009; 11. Briner & Manser, 2013; 12. Cuomo, Koukouna, Macchiarini, & Fagiolini, 2021; 13. D'Lima, Crawford, Darzi, & Archer, 2017; 14. Quinlivan, Littlewood, Webb, & Kapur, 2020.

PRELIMINARY

Data & Methods

Primary Data Collection

Behavioral Health Workforce Survey[1]
- ~4,000 total respondents
- ~1,100 open-ended comments

Stakeholder Listening Tour

Industry Focus Groups (10)
- 68 total attendees
- 90 minutes avg.

Board Chair Interviews (8)
- 60 minutes avg.

Expert & Leader Interviews (150+)

Stakeholder Vetting Tour
- 35 sessions w/200+ participants
- e.g., HMHI, USH, UHIA, LMHAs, IHC, DHHS, USHE, DOI

Secondary Data Analyses

Access to Care
- National Survey of Children's Health (NSCH)
- National Survey on Drug Use & Health (NSDUH)

Safety of Care
- National Practitioner Data Bank (NPDB) adverse action & malpractice data
- Division of Professional Licensing (DOPL) data on complaints & dispositions

Academic & Policy Review

Interstate Law Review
- Policy data on 500+ BH license types across U.S. jurisdictions

Policy Landscape Review
- Legislative history, international approaches, case studies

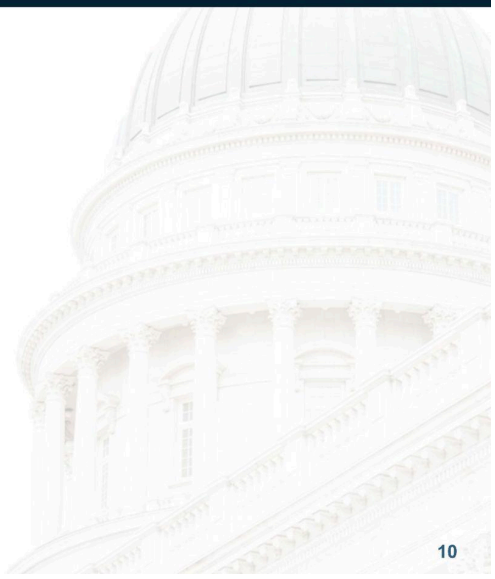
Literature Review
- 800+ relevant resources (e.g., articles) identified
- Evidence on the impact of various regulations on consumer access & safety
- Research on behavioral health systems, workforce, & policies

1. This survey used the core questions from the Cross Profession Minimum Data Set (CPMDS), developed by Dr. Hanna Maxey, Director of the Bowen Center for Health Workforce Research and Policy in collaboration with multiple national health professions' regulatory associations. The survey was distributed to all active DOPL behavioral health licensees (16,236 individuals) and achieved a response rate of 24.8%.

PRELIMINARY

Agenda

1. Background & Methodology
2. **Findings: Access**
3. Recommendations
4. Discussion



UTAH | COMMERCE

PRELIMINARY

Utah Has an Access Problem

Utahns **receiving** behavioral health care	Utahns with an **unmet need** for behavioral health care
~530k	**~210k-515k**
Even among those children in Utah who do access care, **40% of parents report that it is difficult or impossible** to obtain this care for their children.	From 2020-2021, **58% of children** aged 3-17 in Utah with a clinically diagnosed mental or behavioral health condition **did not receive treatment** or counseling.

~750K-1 million Utahns need access to behavioral health care

Source: All data drawn from 1) the 2020-2021 National Survey of Children's Health and 2) the 2018-2019 National Survey on Drug Use and Health. For detailed calculations and limitations, see Appendix.

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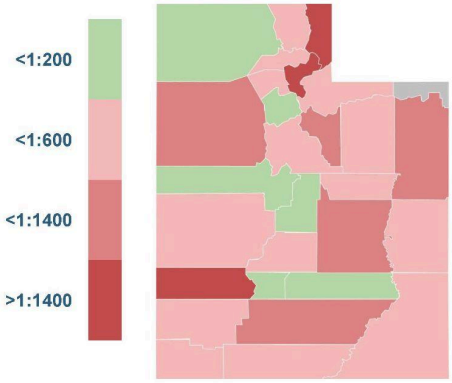
PRELIMINARY

The Access Problem May Be Worse in Rural Utah

BH Provider to Population Ratios, by County[1]

All BH Provider Types



Rural counties struggle to attract & retain psychiatrists[2]

- All Utah counties with more than 600 residents per BH practitioner are rural
- Rich County and Morgan County have one provider for every 2,600 and 4,220 residents, respectively

1. County Health Rankings, University of Wisconsin Population Health Institute. Number of BH Providers drawn from NPI estimates for Psychiatrists, Psychologists, Licensed Clinical Social Workers, Counselors, Marriage & Family Therapists, Mental Health Providers that treat alcohol/drug abuse, Advanced Practice Nurses specializing in BH. 2. Behavioral Health Workforce Research Center, University of Michigan.

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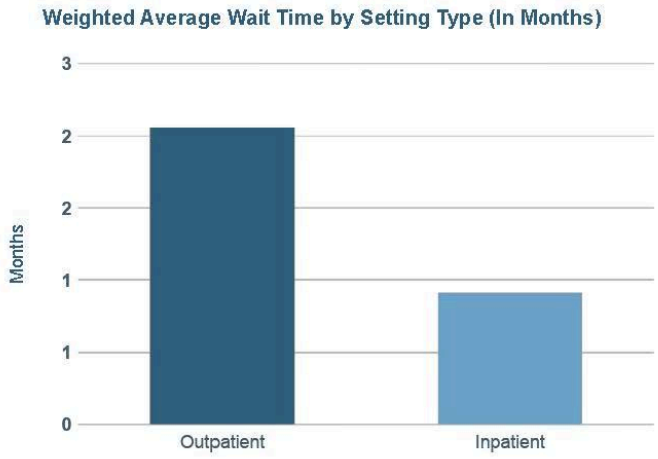
PRELIMINARY

Access is Poor for Outpatient BH Services



Proposed federal guideline for behavioral health outpatient wait time is **10 calendar days**[1]

Based on data from the Behavioral Health Workforce Survey, distributed by OPLR from Feb 27-Mar 6, 2023.
1. 2023 Draft Letter to Issuers in the Federally-facilitated Exchanges (CMS).

PRELIMINARY

Unmet Need for Care Has Serious Consequences

Impact on Human Life	• **15-23K more adults (18+) in Utah will suffer from suicidal ideation** in any given year because they have an unmet need for BH care.[1,2] • **7-10K more youth (11-17) in Utah will suffer from suicidal ideation** in any given year because they have an unmet need for BH care.[1,3]
Societal & Economic Consequences	• Unaddressed BH issues lead to **2-10x increase in burdens of healthcare & criminal justice spending** and decreased economic productivity.[4] • **Utahns will earn $2.8 billion less** in any given year because they have an unmet need for BH care.[5]

1. Ali, Lackey, Mutter, & McKeon, 2018 2. 2021 National Survey on Drug Use & Health 3. DHHS Student Health & Risk Prevention (SHARP), Prevention Needs Assessment Survey, 2021 4. McDaid, Park, & Wahlbeck, 2019 5. Kessler, Heeringa, Lakoma, Petukhova, Rupp, Schoenbaum, Wang, & Zaslavsky, 2008.

PRELIMINARY

The access problem may be worsened by:

- Workforce Capacity Constraints
- Shortage of BH Care Extenders
- Misaligned Education & Career Paths

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PRELIMINARY

Part-Time Work & Admin Tasks Limit Capacity

Source: Data drawn from OPLR's 2023 Behavioral Health Care Workforce Survey; OPLR Analysis. UMEC's Utah's Mental Health Workforce 2021 report estimates: 10.3K total licensees, 9K actively providing services in Utah, and 7.4K total hour FTEs. Differences in estimates are due to differences in the population sampled; OPLR includes licensees below master's level. Proportion of active licensees to overall workforce FTEs is consistent across both analyses, at 65.7% (OPLR) and 71.9% (UMEC). 1. 38% part time reflects those workforce working part time at their primary practice location. An additional 14% of respondents report working at a secondary practice location. 2. 38% patient care hours subtracts time of those in non-patient facing roles (e.g., administrators), as well as admin burden for those in direct patient care roles.

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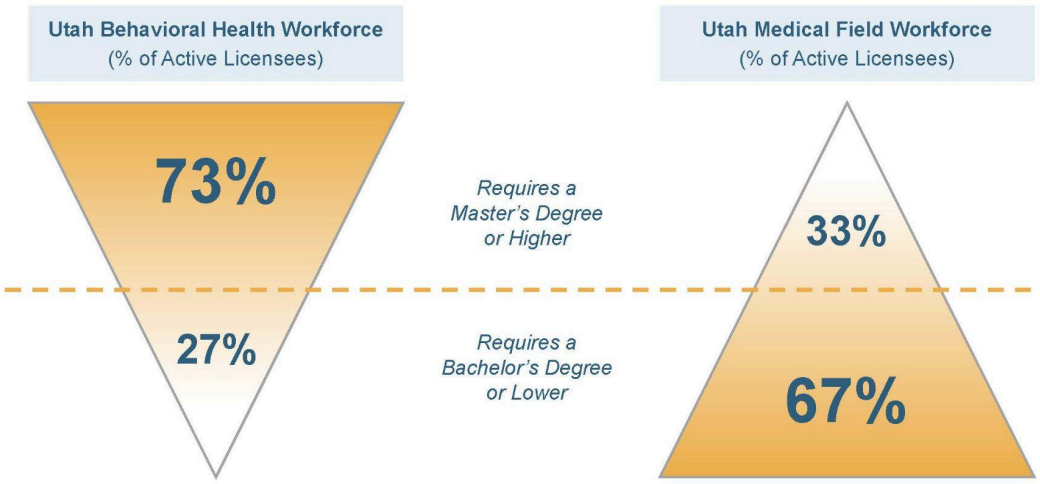
PRELIMINARY

Behavioral Health Care Lacks Extenders



Source: DOPL licensee data obtained from DOPL MLO report "Active License Count," accessed 2/28/2023; data on DHHS licensees provided to OPLR by DHHS administrators in July, 2022. The figures presented do not reflect members of the workforce who hold a private certification (e.g., CNAs) or no certification (e.g., psych techs).

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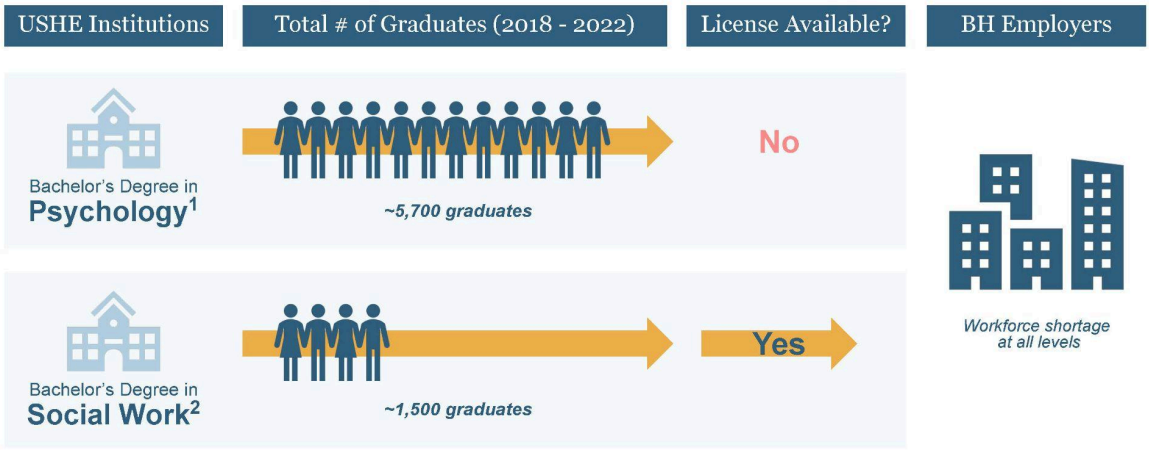
PRELIMINARY

Education & Career Paths Are Misaligned



Source: USHE IPEDS Completions Survey; Graduates from 5 year span of 2017-2018 to 2021-2022 academic years. 1. Psychology undergraduates can work under an Assistant Behavior Analyst, Music Therapist, Therapeutic Recreation Specialist, Certified Advanced Substance Use Disorder Counselor, or Social Service Worker license, but only with additional coursework (like any other undergraduate). In other words, a psychology undergraduate major provides students with no advantage in terms of licensure for any BH license in Utah. 2. Bachelors in Social Work corresponds to the Social Service Worker license.

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PRELIMINARY

Utah Needs More Specialists & More Extenders

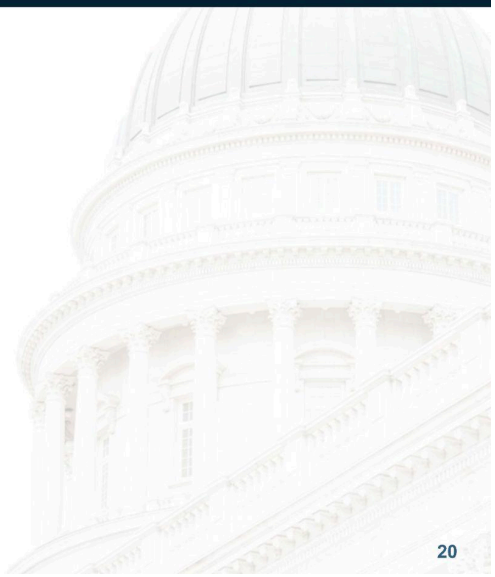
	Current	Target	Gap
Total BH Workforce	20K	28K	+8K (40%)
Advanced BH Specialists *Diagnose & treat severe, recurrent, & complex BH conditions*, e.g., psychologists, psychiatrists, psych nurse practitioners, psych physician assistants	2K	3K	+1K (60%)
Clinical BH Therapists *Diagnose & treat mild to severe BH conditions* e.g., clinical social workers, marriage & family therapists, clinical mental health counselors	12K	16.5K	+4.5K (35%)
BH Support Workforce *Treat or assist in treating mild to severe BH conditions* e.g., substance use disorder counselors, social service workers, crisis workers, peer supports	6K	8.5K	+2.5K (40%)

Values rounded to nearest 5% or to nearest 500. Target uses IAPT guideline of 10% advanced, 60% clinical, & 30% support. Workforce figures based on DOPL MLO report "Active License Count," accessed 2/28/2023; data on DHHS licensees provided to OPLR by DHHS administrators in July, 2022; data on advanced BH specialists from University of Michigan, Behavioral Health Workforce Research Center, 2018 – Mapping Supply of the U.S. Psychiatric Workforce; Unmet need figures based on 2020-2021 National Survey of Children's Health; 2018-2019 National Survey on Drug Use and Health.

PRELIMINARY

Agenda

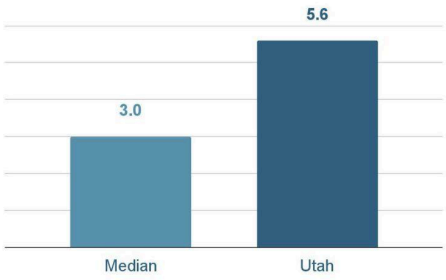
1. Background & Methodology
2. **Findings: Safety**
3. Recommendations
4. Discussion



PRELIMINARY

Utah Has a Safety Problem

Annual[1] NPDB Reports Per 1,000 BH Providers
(2015-2022)



Utah ranks far above the median number of NPDB reports[3] per behavioral health licensee[4] in the US, at **12th** of 51 states.

Utah has a high rate of repeat offenders

- The National Practitioner Data Bank (NPDB) tracks **adverse actions**[2] (e.g., loss of license) and **medical malpractice payments** for BH
- **44.4%** of Utah BH practitioners with an NPDB report will offend again, which is very high relative to the US median (25%).
- **Utah ranks #4** among US states for highest proportion of repeat offenders among BH practitioners with at least one NPDB report.

1. Annual refers to the yearly average number of reports across the given time period. 2. Adverse actions reduce, restrict, suspend, or deny clinical privileges or membership in a healthcare organization or program. This includes actions related to: State Licensure/Certification, Clinical Privileges/Panel Membership, Drug Enforcement Administration, HHS OIG Exclusion, and Professional Society Membership. 3. Analysis includes all 50 states and D.C. and the following NPDB licenses: Clinical Social Worker, Psychologist, Mental Health Counselor, Professional Counselor, Addictions Counselor, Marriage and Family Therapist, Prof. Cnslrs. of Family/Marriage and Alcohol. 4. Number of BH practitioners from County Health Rankings number of Mental Health Providers, drawn from NPI estimates. Includes: Psychiatrists, Psychologists, Licensed Clinical Social Workers, Counselors, Marriage and Family Therapists, Mental Health Providers that treat alcohol and other drug abuse, and Advanced Practice Nurses specializing in mental health.

PRELIMINARY

Unsafe Care Has Serious Consequences

Common **Substantiated Complaints** Against BH Practitioners

1. **Boundary Violations**
   (e.g., sexual relationships, harassment, or assault)
2. **Billing Fraud**
   (e.g., billing for sessions that did not occur)
3. **Confidentiality & Other Violations**
   (e.g., failure to keep confidentiality; inappropriate involvement in custody proceedings)

→

- **Worsening of symptoms**[1]
- **Additional harms to health, safety, & welfare**[2,3]
- **Reduced willingness to access care in the future**[4-6]

1. Martin & Beaulieu, 2023 2. Reamer, 2003 3. Frueh, Dalton, Johnson, Hiers, Gold, Magruder, & Santos, 2000 4. Martin & Beaulieu, 2023 5. Feldman-Summers & Jones, 1984 6. Robins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005

PRELIMINARY

The safety problem may be worsened by:

Inconsistent supervision & support for clinicians

Siloed data on safety/quality of care

Reactive rather than proactive monitoring

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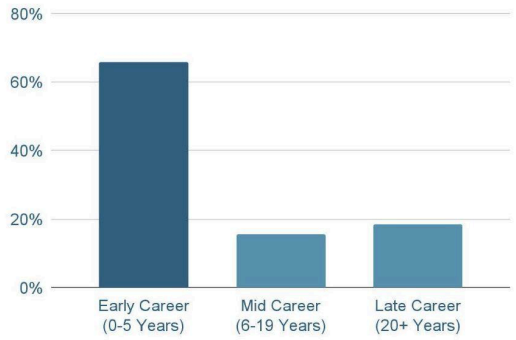
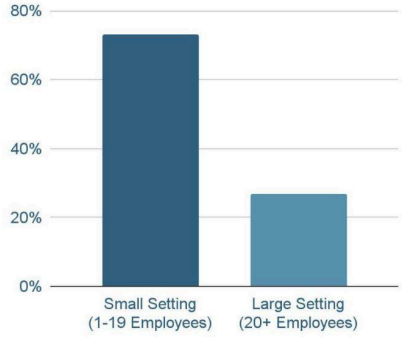
PRELIMINARY

Career Stage & Setting Are Linked to Safety Issues

DOPL Substantiated Complaints by Career Stage



DOPL Substantiated Complaints by Setting Size



Utah BH providers report that **supervised training** for early career providers **lacks consistency** and that many providers have **insufficient access to ongoing support** (e.g., via case consultation)

Based on a random sampling of 2018-2022 data from the Division of Professional Licensing, Utah Department of Commerce

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PRELIMINARY

Agenda

1. Background & Methodology
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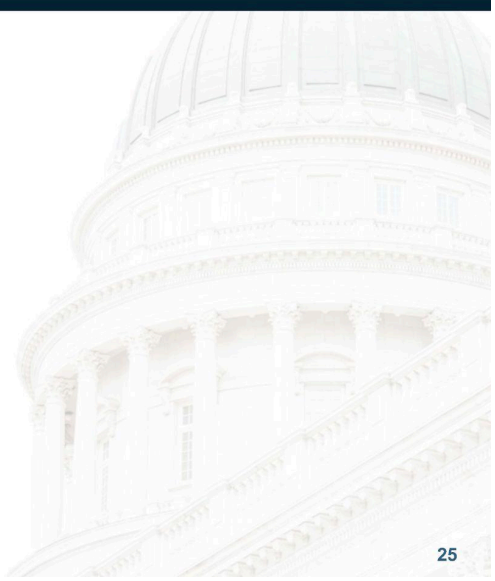

Utah | Commerce

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PRELIMINARY

Recommendations Address Both Access & Safety

Increase Access to BH Care

- **Grow the Workforce**
  More providers overall
- **Optimize Providers' Time**
  More time at highest and best use
- **Meet High-Need Consumer Demand**
  More specialists & extenders

Increase Safety of BH Care

- **Prevent Harm to Consumers**
  More effective safeguards
- **Detect Harm to Consumers**
  More proactive monitoring methods
- **Course Correct When Harm Occurs**
  More coordinated oversight efforts

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PRELIMINARY

Recommendation Summary

Train Smarter, Not Harder	• Supervision Hours • Supervision Quality • Continuing Education
Expand Pathways & Portability	• Exam Alternatives • Interstate Compacts • Addiction Counseling
Strengthen Upstream Monitoring	• Proactive Measures • UPHP Expansion
Streamline Governance Structure	• Scopes & Authorization • Multi-Profession Board
Fill Gaps in Career Ladders & Care	• Extender Roles • Psychology Rx

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PRELIMINARY

Train Smarter, Not Harder – Supervision Hours*

For master's-level clinical therapists:

General Experience
Non-clinical experiential hours (e.g., study & research, administrative tasks)

Direct Client Contact
Direct contact with patients; performing mental health therapy and clinical tasks

Direct Clinical Supervision
Direct contact between supervisor and supervisee; may include case consultation or observation of actual practice

* This recommendation is only in reference to MA-level clinical therapists, meaning LCSW, CMHC, MFT licenses

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PRELIMINARY

Train Smarter, Not Harder – Supervisor Reqs*

For master's-level clinical therapists:

Current

1. Unclear Definition of Supervision
2. No Training Required
3. Max Limit of 6 Supervisees

Future

1. Clear Definition of Supervision
2. Training Required
3. No Limit on Supervisees

* This recommendation is only in reference to MA-level clinical therapists, meaning LCSW, CMHC, MFT licenses

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PRELIMINARY

Train Smarter, Not Harder – Continuing Ed

Current

Future

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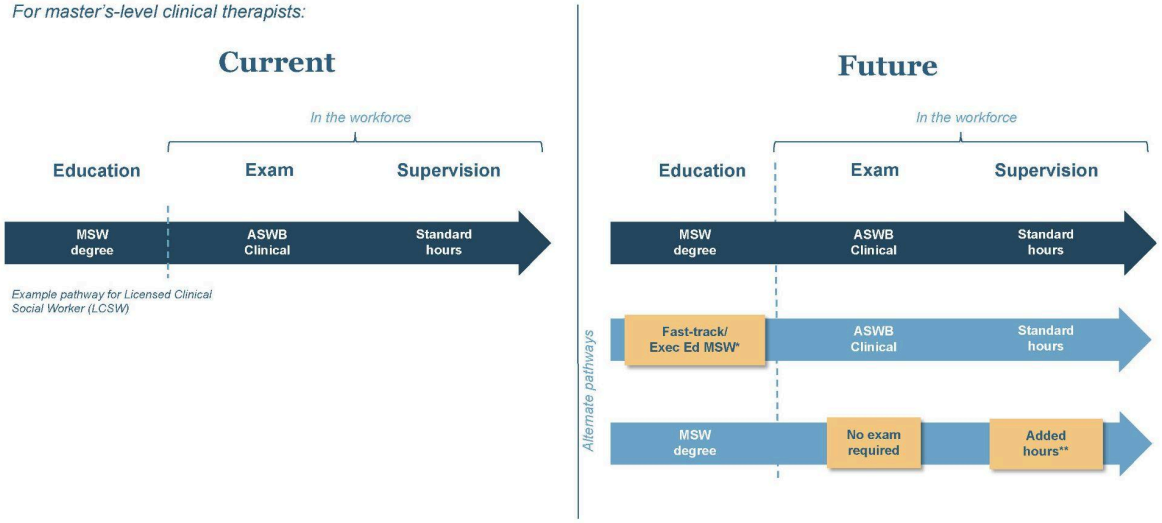
PRELIMINARY

Expand Paths & Portability – Clinical Exams

For master's-level clinical therapists:



*Exploring in conjunction with USHE/Talent Ready Utah **See previous slides for other changes to supervision/clinical training requirements

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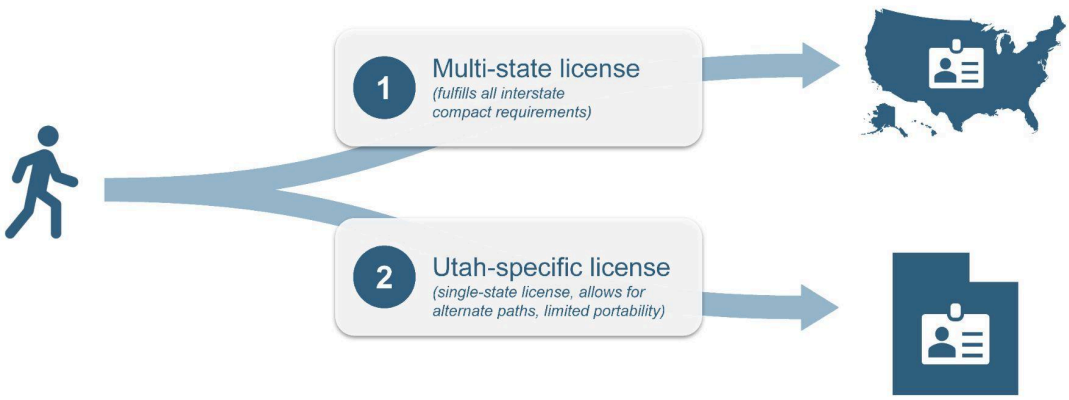
PRELIMINARY

Expand Paths & Portability – Compacts



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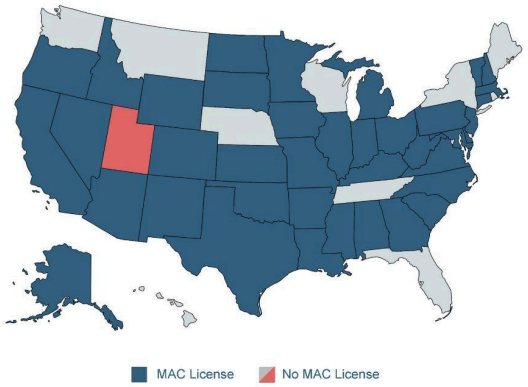
PRELIMINARY

Expand Paths & Portability – Addiction Specialty

Current



Future

Master Addiction Counselor

Source: According to the Knee Center for the Study of Occupational Regulation, csorwvu.com/find-occupations/, 38 other states have a Master Addiction Counselor (MAC) license or certification.

PRELIMINARY

Strengthen Monitoring – Proactive Measures

Current

No Safety Checks at Initial Licensure / Renewal

Consumers Not Provided Safety Information

→ Higher Risk of Harm to Consumers

→ Lower Rates of Reporting Harm

Future

Safety Check(s) at Initial Licensure / Renewal
(e.g., criminal background, National Practitioner Data Bank)

Consumers Provided Safety Information
(e.g., what is never appropriate, how to file a complaint)

→ Reduced Risk of Harm to Consumers

→ Higher Rates of Reporting Harm

PRELIMINARY

Strengthen Monitoring – UPHP Expansion

The Utah Professionals Health Program (UPHP) is an alternative to public disciplinary action for licensed professionals who have substance use disorders. It enables individuals to confidentially seek & receive help.

Current	Future
Professionals Served	**Professionals Served**
• Medical Professionals (80.5K) • Dental Professional (7.5K) • Veterinary Professionals (1.3K)	• Medical Professionals (80.5K) • Dental Professional (7.5K) • Veterinary Professionals (1.3K)
Not Served	+
• BH Professionals (18.6K active licensees)	• Behavioral Health Professionals (18.6K)
~89K professionals **~90 participants (current)**	**~108K professionals** **~110 participants (estimate)**

Source: DOPL licensee data obtained from Department of Commerce annual reports and DOPL MLO report "Active License Count," accessed 6/15/2023

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PRELIMINARY

The Duties of DOPL Boards

Utah Code 58-1-201: "…the duties, functions, and responsibilities of each board include…" [selected]

Policy functions

- Recommending **rules and statutory changes**
- Recommending **policy and budgetary matters**
- …may **recommend to the appropriate legislative committee** re: changes to a licensing act
- Assisting in establishing **standards of supervision** for students in training

Licensing functions

- **Screening applicants & recommending licensing**, renewal, reinstatement, & re-licensure actions
- …acting as **presiding officer** in conducting hearings associated with **adjudicative proceedings** when so designated by the director.

The ideal board composition differs for **policy functions** versus **licensing administrative functions**

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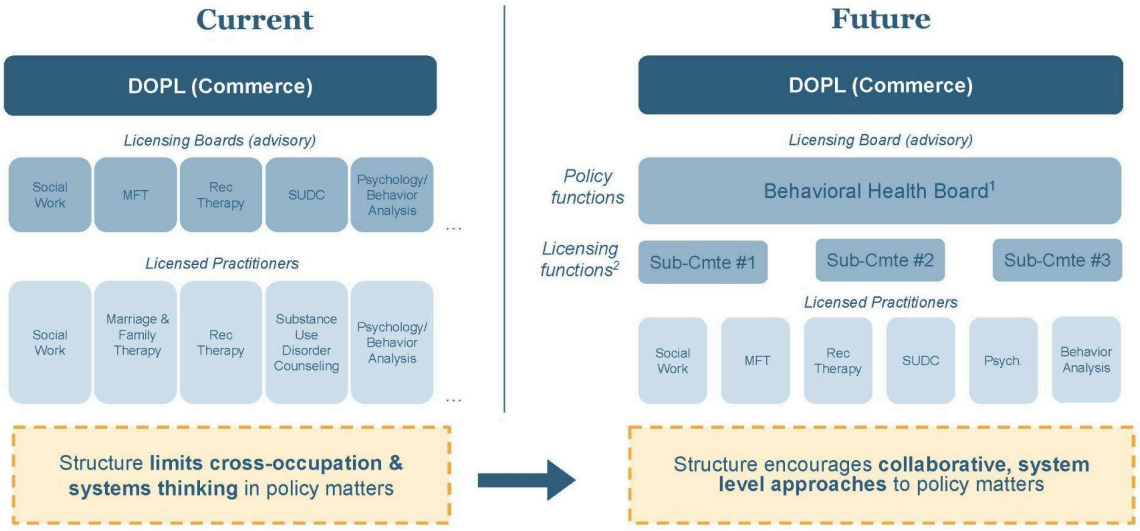
PRELIMINARY

Streamline Governance – Multi-Profession Board



1 We also recommend expanding the expertise of the boards to include DHHS officials, population health experts, payors, employers, medical professionals, consumer advocates, and others to give a broad view of the behavioral health system; 2 Sub committees would execute licensing functions (like enforcement) with separate sub committees by scope of practice (e.g., clinical therapists, sub-clinical, etc…); committee composition TBD, but would be made up of primarily those licensed to perform the relevant scope of practice.

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PRELIMINARY

Streamline Governance – Scopes of Practice

Profession-exclusive scopes create "**barriers to interprofessional collaboration**, practice, and respect."[1]

1. See pg. 325, Safriet, 2002; see also Trebilcock, 2022.

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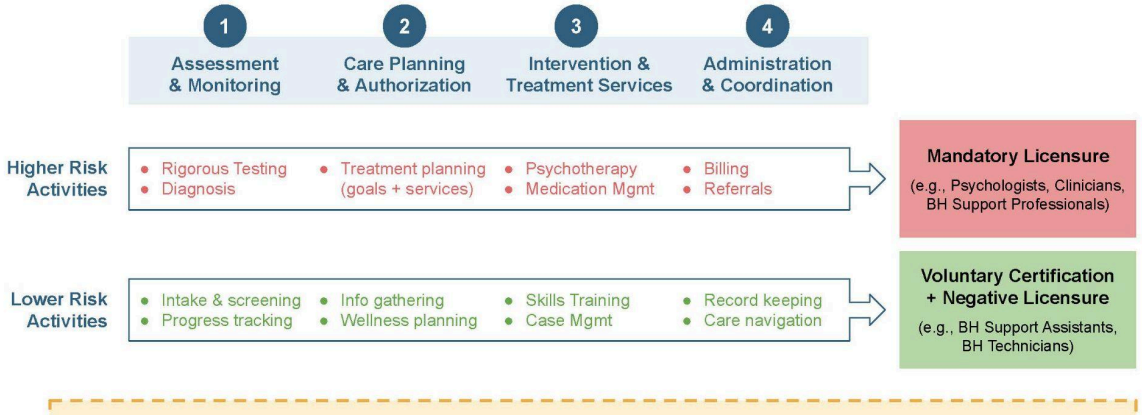
PRELIMINARY

Streamline Governance – Authorization Types



Higher-risk activities create **more opportunities for more serious harm**, and so should require a license.
Lower-risk activities **still pose some risk of harm**, and so may be regulated via negative licensure.

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PRELIMINARY

Fill Gaps in Careers & Care – Extender Roles

Current

Education	Psychology	Social Work	Counseling & Therapy	Substance Counseling
Doctorate + Supervision	Psychologist			
Masters + Supervision		LCSW	CMHC/ MFT	
Bachelors		SSW		Advanced SUDC
Associates		GAP		SUDC*
Stand-alone Academic Certificate (1yr)				
DHHS Certificate (1 week)	Case Manager, Crisis Worker			Peer Support

Future

Education	Psychology	Social Work	Counseling & Therapy	Substance Counseling
Doctorate + Supervision	Psychologist			
Masters + Supervision		LCSW	CMHC/ MFT	
Bachelors	[Generalist Behavioral Health License]			
Associates	Behavioral Health Technician			
Stand-alone Academic Certificate (1yr)				
DHHS Certificate (1 week)	Case Manager, Crisis Worker			Peer Support

Clinical licenses | Existing sub-clinical licenses | NEW sub-clinical licenses

*There are ~280 Associate's-level SUDCs licensed in the state, as opposed to 7,000 clinical social workers, or 2,700 Clinical Mental Health Counselors;

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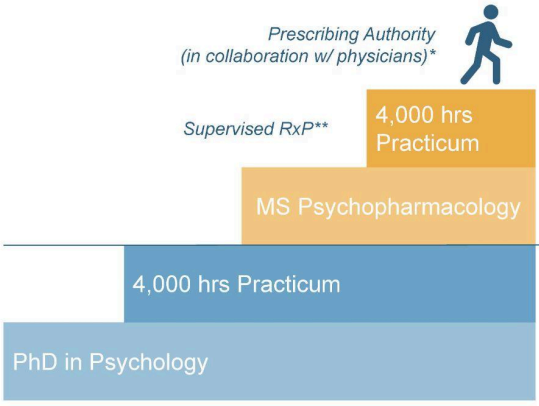
PRELIMINARY

Fill Gaps in Careers & Care – RxP Specialty



RxP refers to prescriptive authority for psychologists

- Prescribing psychologists receive **4x-6x more pharmacology training** than physicians & psych APRNs[1]
- RxP legislation **increases access** to care, especially **in rural areas**[2,3]
- RxP legislation is associated with **decreased suicide rates** & deaths attributable to mental illness[3,4]
- RxP may be a **cost-effective** strategy for reducing suicide rates[5]
- From 2005-2021, prescribing psychologists had a slightly **lower malpractice claim rate than psychiatrists**—at 2.1% vs. 2.6%[6]

*RxP allows a limited formulary of medications relevant to BH disorders **Under supervision of a physician (in most states). 1. Muse & McGrath, 2009 2. Shoulders & Plemmons, 2022 3. Nebraska Psychology Prescribing Technical Review Committee, 2017 3. Hughes, McGrath, & Thomas, 2023 4. Choudhury & Plemmons, 2023 5. Hughes, Phillips, McGrath, & Thomas, 2023 6. Curtis, Hoffman, & O'Leary Sloan, 2022

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PRELIMINARY

Recommendation Summary

Train Smarter, Not Harder
- Supervision Hours
- Supervision Quality
- Continuing Education

Expand Pathways & Portability
- Exam Alternatives
- Interstate Compacts
- Addiction Counseling

Strengthen Upstream Monitoring
- Proactive Measures
- UPHP Expansion

Streamline Governance Structure
- Scopes & Authorization
- Multi-Profession Board

Fill Gaps in Career Ladders & Care
- Extender Roles
- Psychology Rx

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PRELIMINARY

Licensure is Only One Part of the Solution

- Behavioral health (BH) **educational pathways are underdeveloped** at all levels
- Workforce shortages also relate to the **expense** of post-secondary training/education relative to compensation

- The market for BH services (most often covered by insurance) is **highly regulated and constrained**
- BH providers feel **reimbursement rates are low** and stagnant, and insurance may not reimburse **team-based approaches**

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PRELIMINARY

Agenda

1. Background & Methodology
2. Findings
3. Recommendations
4. **Discussion**

Utah | Commerce

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PRELIMINARY

Next Steps

1. Integrate feedback from Business & Labor
2. Circulate field-level report for stakeholder comment
3. Submit field-level report to Business & Labor
4. Circulate occupation-level reports for stakeholder comment
5. Submit occupation-level reports to Business & Labor

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PRELIMINARY

Agencies Coordinating On System-Wide Solutions

Commerce

- Fill gaps in **entry-level licensing / certifications**
- Expand **alternative pathways** and portability
- Strengthen & **streamline supervision** hour requirements
- **Merge** DOPL licensing boards

USHE & TRU

- Create **statewide 1- and 2- year** BH educational programs
- Create **clinical psychology** track for undergrads
- Consider policies and targeted funds **for growth of programs** and to encourage **BH workforce participation** (programmatic growth and scholarships)

DHHS

- Evaluate whether **new Medicaid services** are needed to match new proposed paraprofessional certifications
- Emphasize subclinical practitioners in **public agency staffing** (DCFS, LMHAs)
- Create **inter-agency communication** around facility licensing & DOPL licensing
- Seek ways to reduce practitioners' **reporting and administrative burdens**

Insurance

- **Convene private insurers, public payors, and other key stakeholders** to identify & address root causes of access issues (e.g., paneling, credentialing, & reimbursement)
- Investigate and identify **network adequacy requirements** for behavioral health

GOAL: Aligned, inter-agency reform package

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UTAH | COMMERCE
Office of Professional Licensure Review

Proposed List of Regulated Occupations for CY 2023 Periodic Review

*The Office of Professional Licensure Review within the Department of Commerce submits this list in compliance with **Title 13-1b-303** of the Utah Code.*

Introduction

Created by SB 16 (2022 General Session), the Office of Professional Licensure Review (OPLR), Department of Commerce is directed to provide the Utah Legislature with objective review and recommendations related to occupational licenses, both new and existing. To ensure that OPLR's periodic reviews of existing occupational licenses are aligned with legislative priorities, Title 13-1b requires that the office submit by October 1st each year "a list of each periodic review that the office proposes to conduct during the upcoming year." This list is reviewed by the Business and Labor Interim Committee and approved, with or without modification, then submitted to the Legislative Management Committee for approval, with or without modification.

The Office also proposes below a framework for prioritizing for review the many occupational licenses within the State of Utah. We share this framework in hopes of creating a multi-year approach—jointly with the legislature—for addressing those areas where occupational licensing reform can have the greatest impact on public well-being.

The next sections present the prioritized list of occupations proposed for review during CY 2023 with notes related to the rationale and scope of the review. The proposed review methodology is available in Appendix I.

Prioritization of Reviews

In proposing a list of occupations for periodic review each year, OPLR will prioritize reviews of multiple related occupations. Reviewing a set of closely related occupations simultaneously allows for a deeper understanding of the occupations and avoids redundant effort. Beyond efficiency, OPLR will propose occupations based on:

- **Overlapping or interrelated scopes of practice**. Many occupations have overlapping scopes of practice (e.g., licensed practical nurses and advanced practice registered nurses). In these cases, addressing one occupation without reference to the scope of practice of the related occupations could result in poor policy recommendations.

- **Large impact on the Utah public**. Regulated occupations with higher numbers of licensees, and those operating in critical functions have more impact on Utah's public than occupations with fewer licensees, and those operating in less critical areas.

Future reviews, then, may include groupings of occupations like trades (e.g., contractors, plumbers, electricians, engineers/land surveyors, interior design), doctors (e.g., physician/surgeons, osteopathic physicians, dentists, chiropractors), nursing (e.g., advanced practice registered nurses, registered nurses, licensed registered nurses, midwives), real estate (e.g., brokers, sales agents, mortgage originators, appraisers), cosmetology (e.g., barbers, estheticians, nail technicians), teachers (e.g., elementary teachers, special education teachers, school psychologists), and many others.

In the absence of other legislative direction, OPLR plans to review occupations with fewer licensees or lower impact on the public later in the 10-year review cycle.

Proposed List of Occupations & Licenses for Review

For CY 2023, OPLR proposes a focus on regulated mental and behavioral health occupations (comprising ~17,900 currently active licensees in Utah). See Appendix II for the comprehensive list of occupations and licenses for CY 2023 review.

Department of Commerce

• Social Worker (9,200 active licensees)	Section 58-60-204
• Clinical Mental Health Counselor (2,600)	Section 58-60-404
• Psychologist (1,200)	Section 58-61-703
• Marriage & Family Therapist (1,400)	Section 58-60-304
• Therapeutic Recreation Specialist (700)	Section 58-40-301
• Behavior Analyst (700)	Section 58-61-703
• Substance Use Disorder Counselor (500)	Section 58-60-504
• Vocational Rehabilitation Counselor (200)	Section 58-78-301
• State Certified Music Therapist (70)	Section 58-84-201

Department of Health and Human Services

• Certified Case Manager (1043)	Section R523-7-4
• Certified Peer Support Specialist (109)	Section R523-5-4
• Child/Family Peer Support Specialist/ Family Resource Facilitator (23)	Section R523-6-2
• Certified Crisis Worker (128)	Section R523-17-62
• Behavioral Emergency Services Technician (0)	Section 26-8a-302
• Advanced Behavioral Emergency Services Technician (0)	Section 26-8a-302

Additional regulated occupations relate to mental and behavioral health, for instance, primary care medicine, psychiatry, and school psychology. While the scopes of practice for these other occupations will inform the reviews undertaken in CY 2023, they will be reviewed separately (e.g., with physicians or educators in an upcoming review) and not during the current periodic review.

Rationale

The rationale for addressing licensure for mental and behavioral health occupations in CY 2023 rests on three elements:

- First, ***mental health needs*** are surging within Utah.
- Second, Utah has a ***shortage of mental health professionals.***
- Third, some mental health occupations receive ***higher rates of substantiated complaints***[1], indicating that there may be potential to better target licensing requirements to prevent harm to the public.

Utah is in the midst of a mental health crisis. Suicide is the leading cause of death in Utah for youth and young adults (aged 15-24), and the second- and third-leading cause of death for adults aged 25-34 and 35-44 respectively, placing Utah 9th in the nation for highest rate of suicide per capita.[2] Utah has consistently higher rates of self-reported lifetime depression than the U.S. rate (23.1% vs. 18.8% in 2020).[3] The organization Mental Health America ranks Utah 47th among states (51st being the worst) for prevalence of mental illness in 2022.[4]

Mental health professionals are essential to confronting this crisis. However, according to the federal Health Resources and Services Administration (HRSA), Utah has a shortage of mental health professionals in all 29 counties.[5] This shortage of mental health professionals existed pre-COVID-19 and has grown worse since March 2020.[6]

Utahns experience this shortage in several ways. Utah's Division of Child and Family Services (DCFS) struggles to fill its roughly 500 caseworker spots with licensed social service workers–a bachelor's level license–and thus must underfill those spots with non-licensed employees.[7] Similarly, the new Youth Behavioral Health Receiving Center in Provo is currently short 35 clinicians.[8] For families with children, waitlists to see a child psychiatrist are several weeks to months long throughout the state.[9] Average wait times for veterans' mental health care appointments at Utah VA facilities can range from 25-70 days.[10]

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[1] Compared to all DOPL licenses, based on data retrieved from the MLO database in July 2022.
[2] Utah State Facts, American Foundation for Suicide Prevention. https://afsp.org/facts/utah
[3] *Health Indicator Report of Depression: Adult Prevalence.* (2022, January). Utah Department of Health. https://ibis.health.utah.gov/ibisph-view/indicator/view/Dep.html
[4] *Ranking the States 2022.* Mental Health America. https://mhanational.org/issues/2022/ranking-states
[5] Health Professional Shortage Areas (HPSAs) are determined by the Office of Primary Care and Rural Health and approved by HRSA. https://ruralhealth.health.utah.gov/workforce-development/primary-care-office-pco/shortage-designations/
[6] *TrendWatch: The Impacts of the COVID-19 Pandemic on Behavioral Health*. American Hospital Association. https://www.aha.org/system/files/media/file/2022/05/trendwatch-the-impacts-of-the-covid-19-pandemic-on-behavioral-health.pdf
[7] Email correspondence between DOPL and the Director of DCFS, December 2020.
[8] Communication with Steve Hunter, Utah Association of Counties, September 2022.
[9] Utah Hospital Association. (2019, July). *Utah's Mental Health System*. Kem C. Gardner Policy Institute. https://gardner.utah.edu/wp-content/uploads/MentalHealthReportAug2019.pdf
[10] *VA Overall | Veterans Affairs*. U.S Department of Veteran Affairs. https://www.accesstopwt.va.gov/Healthcare/Overall

Utah's shortage of mental health professionals leaves significant gaps in treatment such that 62% of Utah adults with mild mental illness did not receive treatment in 2020, while one quarter of those with severe mental illness reported unmet need. Perhaps most concerning, almost half of Utah's youth aged 12–17 who have depression did not receive any care in 2020. While the causes of mental health disorders are complex, a shortage of mental health professionals has been shown to contribute to poor health outcomes (mental and physical) and system utilization (e.g., substance use, homelessness, criminal justice).[11]

Leaving mental health issues untreated has not only the many human consequences presented above, but also fiscal consequences. A recent analysis determined that every $1 investment in prevention and early intervention for mental illness and addiction yields between $2 and $10 in savings in healthcare costs, criminal justice costs, and improved productivity.[12] Put another way, the shortage of mental health professionals today will likely lead to higher costs to the state in coming years.

DOPL data also highlights a relatively high number of substantiated complaints against licensed individuals in mental and behavioral health occupations. DOPL's internal data shows that licensees in several of the major mental health occupations receive negative dispositions (e.g., sanctions, referrals, letters of concern, suspensions, revocations) at higher rates than average within the DOPL database (see Figure 1 below). A complete review may surface ways to better target public safety concerns for occupations with higher rates of substantiated complaints.

OPLR is cautious not to give undue weight to these complaint data until further research is done. Each occupation has different patterns of complaints, investigations, and dispositions, meaning that no conclusions should be drawn without the full review.

While licensing policy is not the only determinant of Utahns' access to quality mental health care, it does set the requirements in terms of education, exams, training, and experience required for new entrants into these occupations. Thus, licensing may be an effective lever for influencing the supply of mental health professionals, and thereby the availability of mental health services for Utahns.

In sum, OPLR believes that a review of licensing for mental health occupations can increase availability of services for consumers and improve safety and well-being of the public. Additional information on OPLR's selection process for CY 2023 review is available in Appendix III.

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[11] *Adults with Mental Illness in Past Year Who Did Not Receive Treatment*. (2021, March 10). KFF. https://www.kff.org/other/state-indicator/adults-with-mental-illness-in-past-year-who-did-not-receive-treatment/?currentTimeframe=0&sortModel

[12] *Fact Sheet: The cost benefits of early intervention in mental illness – Steinberg Institute*. www.Steinberg Institute.Org. https://steinberginstitute.org/fact-sheet-cost-benefits-early-intervention-mental-illness/

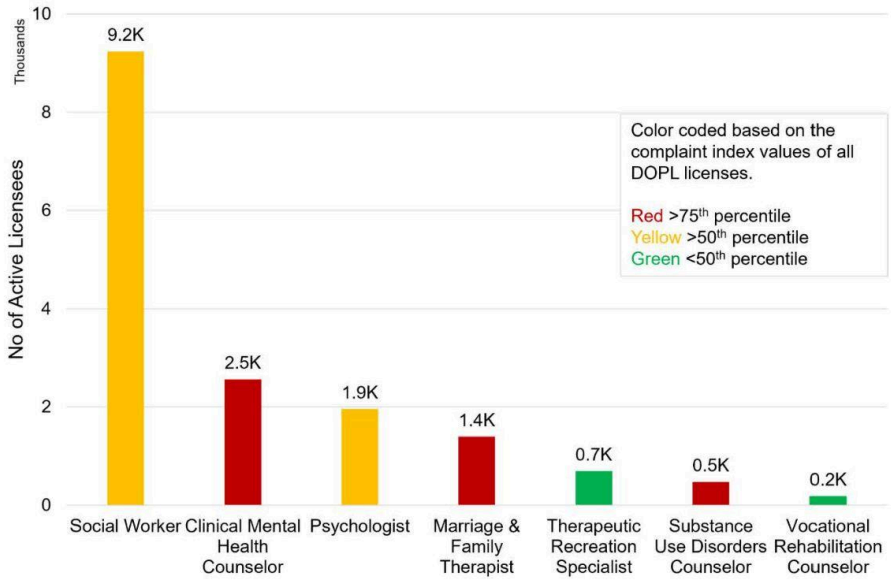


Figure 1. Bar graph showing active licensees by mental & behavioral health profession, color-coded by complaint index.

Scope of Review

As presented above, the proposed review will include multiple related occupations that can have a large impact on Utahns. The review will therefore consider a variety of options related to licensing for the occupations named above. The scope of review thus may include the type of occupational regulation (e.g., registration, certification, licensing), initial qualifications for licensure, continuing education requirements, exemptions from licensing, and scope of practice. The review may also include recommendations for changes to statute, administrative rule, and/or policies of licensing agencies. In all cases, the reviews will be conducted in accordance with Title 13-1b-302.

The comprehensive nature of the review should not, however, be confused with comprehensive recommendations for change. The office may do a comprehensive review whose findings point to modest or no changes to licensing law or practices. The final report for each periodic review will be informed by the proposed review methodology presented in Appendix I.

APPENDIX

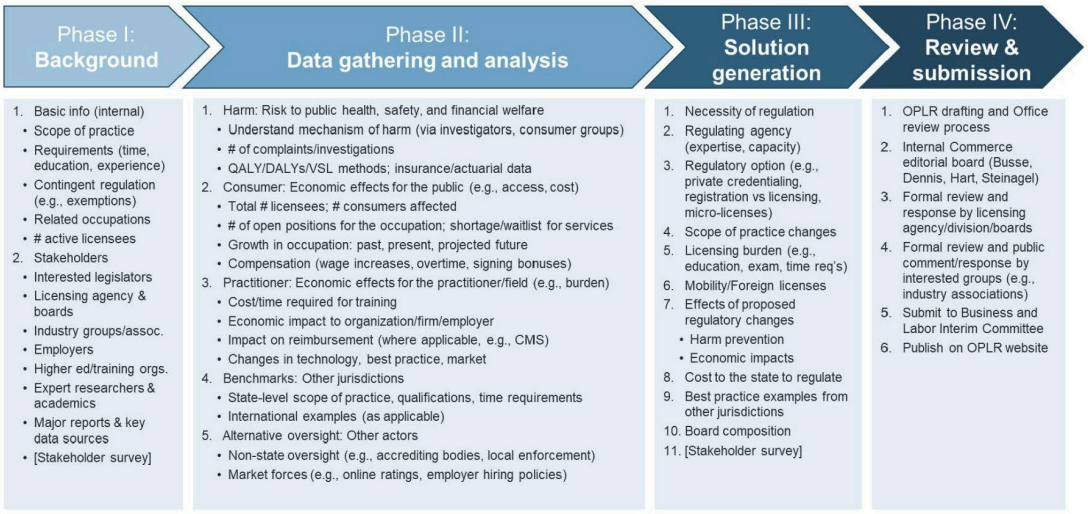
I. Proposed methodology for periodic review

II. Table of proposed occupations, licenses, active licensees, and complaint index

III. Selection process for the proposed list of occupations for CY 2023 periodic review

IV. List of meetings and interviews since July 1, 2022

I. Proposed methodology for periodic review



II. Table of proposed occupations, licenses, active licensees, and complaint index

Occupation	Licenses	Active Licensees (As of July 2022)	Complaint Index* (Justified complaints per 100 active licensees)
Division of Professional Licensure			
Social Worker	Licensed Clinical Social Worker	5,389	3.0
	Social Service Worker	1,896	
	Certified Social Worker	1,814	
	Certified Social Worker Intern	138	
Clinical Mental Health Counselor	Clinical Mental Health Counselor	2,048	7.0
	Associate Clinical Mental Health Counselor	499	
	Associate Clinical Mental Health Counselor Extern	13	
	Volunteer Clinical Mental Health Counselor	1	
Psychologist	Psychologist	1,215	3.9
	Certified Psychology Resident	38	
	Behavior Analyst	642	
	Assistant Behavior Analyst	42	
	Behavior Specialist	11	
	Assistant Behavior Specialist	5	
Marriage and Family Therapist	Marriage & Family Therapist	1,127	5.8
	Associate Marriage & Family Therapist	265	
	Associate MFT Extern	2	

Substance Use Disorder Counselor	Licensed SUDC	252	8.1
	Licensed Advanced SUDC	135	
	Certified Advanced SUDC	54	
	Certified SUDC	27	
	Certified SUDC Intern	3	
	Certified Advanced SUDC Intern	1	
Vocational Rehabilitation Counselor	Licensed Vocational Rehabilitation Counselor	183	1.6
Recreational Therapy	Therapeutic Recreation Specialist	360	1.6
	Therapeutic Recreation Technician	291	
	Master Therapeutic Recreation Specialist	42	
State Certified Music Therapist	State Certified Music Therapist	71	0.0
Department of Health and Human Services			
	Case Manager	1,043	0.0
	Certified Peer Support Specialist	109	0.6
	Child/Family Peer Support Specialist and Family Resource Facilitator	23	0.0
	Certified Crisis Worker	128	0.0
	Behavioral Emergency Services Technician	0*	No data**
	Advanced Behavioral Emergency Services Technician	0*	No data**

* DOPL median complaint per 100 active licensees is 2.1
** Title 26-8a-302, effective 7/1/2022, directs DHHS to develop training and testing procedures and to issue these licenses, but as of the writing of this report, development and approval of the training has not been finalized and no licenses have been issued.

III. Selection process for the proposed list of occupations for CY 2023 periodic review

OPLR considered potential occupations for this initial review in two avenues: a quantitative exercise using the data and indicators laid out below, and conversations with a broad range of stakeholders to understand the context of licensing and potential reform for each. The goal was to find the set of occupations that will most benefit the Utah public if licensing laws, rules, policies, and processes could be improved.

In proposing mental and behavioral health occupations for the initial periodic review, OPLR has been guided by the criteria set out in Title 13-1b-302. These include (broadly speaking) harm to the public, economic effects for consumers and practitioners, and benchmarks in other jurisdictions.

Specifically, OPLR focused its initial analysis and selection of occupations for review in CY 2023 using the following four quantitative indicators for each regulated occupation:

- **Harm to the public**: substantiated complaints and enforcement action by the licensing agency per 100 active licensees
    - In the case of DOPL, these complaints are those where some action was taken, including fines, citations, letters of concern or warning, suspension or revocation of license, and referral for criminal prosecution

- **Demand:** projected job openings over 2018-2028 from the Department of Workforce Services (DWS)
    - These projections are based on the Federal Bureau of Labor Statistics SOC (Standard Occupational Classification) codes
    - For a limited number of occupations where Utah's licensing scope was different from the SOC definition; OPLR analysts used the number of active licensees and other data to create a 'crosswalk' between the Utah licensed occupations and the BLS/DWS projections

- **Regulation in other jurisdictions:** alignment of Utah's scope of practice with other states
    - Based on the review performed for licensure by endorsement (SB 23, enacted in 58-1-302). See this map for LCSWs as an example.
    - Note that these maps, created by DOPL, are based solely on equivalency of scope of practice, not licensing requirements
    - States that are shown as yellow on these maps may be so because Utah requires applicants to provide additional documentation, and those that are gray may indicate that Utah is licensing an occupation that is unlicensed in those states (e.g., court reporters).

  - After aggregating the equivalency information available from DOPL endorsement maps, OPLR analysts sorted and color-coded each occupation by relative level of equivalency with other states. Occupations with equivalent licenses in many other states are coded green, while occupations that are licensed less frequently or have significant differences in licensing requirements or scope may be coded yellow, orange, or red.

- **Scale:** number of active licensees
  - The number of active licensees approximates the importance of the occupation in Utah's communities and the economy, but not perfectly
  - OPLR considered using average wage multiplied by the number of active licensees to better estimate the impact on the economy, but decided against, so as to avoid conflating earnings with value to Utah's communities

None of these indicators is a perfect proxy for the criteria it represents. For instance, we know that the harm done by one incompetent professional (e.g., plumber) is very different from the harm that might be done by another (e.g., physician). Also, DWS projections for job openings do not include the self-employed, nor are they able to project job openings for current openings that go unfilled–the projections are based only on currently filled positions.

In addition, not every indicator was available for every occupation. OPLR was able to access the Commerce databases for complaint data for many occupations; other agencies have different enforcement regimes, making comparison difficult. Similarly, not every occupation has a clear equivalency finding due to differences in license scope and name.

Despite the limitations, the data clearly indicated a limited set of occupational groupings with a large number of active licensees. These are the areas like trades, cosmetology, nursing, physicians, mental health, real estate, securities, and teaching. Looking at the complaint index, alignment with other states, and projected job openings in this case did not point towards any one of these groups of occupations over another for review. These other data elements did, however, provide contextual information about how we might approach the review for one set of occupations (trades, with very high complaints, high projected openings) versus another (cosmetology with very low complaints, but a high number of projected openings).

After assessing occupations against these criteria, OPLR sought input and information from a broad range of stakeholders (see Appendix IV). These conversations surfaced relevant information: the recent review and change to the licensing pathways for teachers by the Utah State Board of Education (USBE); the relative equivalency of Utah's requirements for physicians and nurses; the expressed need for more mental health professionals in many parts of the state.

The clear response from many stakeholders (legislators, executive branch agencies, others) was that mental health is a serious issue in Utah, and that mental health professionals are in short supply.

While we are proposing mental health occupations for this initial review, OPLR expects to propose a set of such occupational groupings for each calendar year. This focuses OPLR on a related set of occupations where we can become relatively well-informed quickly and work with the same set of stakeholders throughout the year. OPLR will also seek to address those occupations (like mental health and nursing) where shortages may exist, thereby helping to address the most important areas for Utahns as quickly as possible.

IV. List of meetings and interviews since July 1, 2022

Utah Executive Branch

Department of Agriculture and Food	**Craig Buttars**, Commissioner
Department of Environmental Quality	**Kim Shelley**, Executive Director **Ty Howard**, Deputy Director
Department of Health and Human Services	**Tracy Gruber**, Executive Director **Nate Checketts**, Deputy Director **Brent Kelsey**, Director, Division of Substance Abuse and Mental Health **Simon Bolivar**, Director, Office of Licensing
Department of Insurance	**Jon Pike**, Commissioner
Labor Commission	**Jaceson Maughan**, Commissioner
Department of Public Safety	**Kristy Rigby**, Deputy Commissioner
Department of Workforce Services	**Mark Knold**, Chief Economist **Michael Jeanfreau**, Regional Economist
The Office of the Governor	**Brittney Cummins**, Senior Advisor of Education
Governor's Office of Economic Opportunity	**Dane Ishihara**, Director, Office of Regulatory Relief **Natalie El-Deiry**, Director of Immigration and New American Integration
State Board of Education	**Sydnee Dickson**, Superintendent **Malia Hite**, Executive Educator Licensing Coordinator
State Tax Commission	**Scott Smith**, Executive Director **Deanna Herring**, Deputy Executive Director **Alan Shinney**, Director, Motor Vehicle Enforcement Division
Utah Substance Use and Mental Health Advisory Council (USAAV+)	**Elizabeth Klc**, Council Director **Santiago Cortez**, Workforce Subcommittee Chair **Patrick Fleming**, Council Member
Utah System of Higher Education	**Jeremias Solari**, Senior Assistant Commissioner, Research and Data Science **Vic Hockett**, Senior Assistant

	Commissioner for Workforce Development; Director, Talent Ready Utah **Will Pierce**, Assistant Commissioner of Technical Education

Utah State Legislature

Senate	**President Stuart Adams** **Sen. Curtis Bramble** **Sen. Kirk Cullimore** **Sen. Luz Escamilla** **Sen. Mike Kennedy** **Sen. Mike McKell** **Sen. Ann Millner** **Sen. Evan Vickers** **Sen. Todd Weiler**
House of Representatives	**Rep. Walt Brooks** **Rep. Brady Brammer** **Rep. Marsha Judkins** **Rep. Mike Schultz** **Rep. Norm Thurston** **Rep. Raymond Ward** **Speaker Brad Wilson** **Rep. Chris Wilson**
Office of the Legislative Auditor General	**Kade Minchey**, Auditor General

Academia and Research

Kem C. Gardner Policy Institute	**Mallory Bateman**, Director of Demographic Research **Nate Lloyd**, Deputy Director of Economic and Public Policy Research
University of Minnesota	**Dr. Morris Kleiner**, AFL-CIO Chair in Labor Policy
U.S. Census Bureau	**Mark Klee**, Economist
Wasatch Front Research Data Center	**Ken Smith**, Executive Director **Bryce Hannibal**, Administrator

Industry

Holland & Hart	**Kate Bradshaw**, Director of Government Affairs **Billy Hesterman**, Government Affairs Specialist

Utah Medical Association	**Michelle McOmber**, CEO
Capstone Strategies	**David Spatafore**, President **Ashley Spatafore Mirabelli**, Vice President

Advocacy

AARP Utah	**Alan Ormsby**, CEO
Better Business Bureau	**Jane Rupp**, CEO
Consumer Federation of America	**Erin Witte**, Director of Consumer Protection
EDCUtah	**Ze Min Xiao**, Director of Center for Economic Opportunity and Belonging
International Rescue Committee Utah	**Annie Healion**, State Advocacy Officer
Libertas Institute	**Connor Boyack**, Executive Director
R Street	**Shoshanna Weismann**, Director, Digital Media, Communications
Utah Association of Counties	**Brandy Grace**, CEO **Steve Hunter**, Director of Government Affairs
Voices for Utah Children	**Maurice Hickey**, Executive Director