Department *of* Health & Human Services

Utah Behavioral Health Workforce Strategic Plan

Developed by the

Utah Health Workforce Advisory Council (HWAC)

In partnership with the Utah Behavioral Health Commission

2026

Working Draft

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Executive Summary

Utah faces significant and growing behavioral health workforce challenges. This Strategic Plan presents a coordinated set of recommendations to strengthen workforce supply, improve data, expand career pathways, and support providers serving Utahns across all communities.

Utah's behavioral health workforce is under significant strain. Severe psychiatrist shortages, geographic maldistribution, growing compensation pressures, and limited pipeline capacity are creating barriers to care for hundreds of thousands of Utahns. Nearly half of Utah adults and more than half of youth who need behavioral health services do not receive them.

In 2025, the Office of the Legislative Auditor General (OLAG) identified behavioral health workforce development as a critical priority and charged the Utah Health Workforce Advisory Council (HWAC) with developing a strategic plan to address it. In response, HWAC conducted a comprehensive landscape analysis, established a dedicated subcommittee, and developed the recommendations presented in this document.

This Strategic Plan is organized around several key priorities:

- Strengthening the clinical supervision and training pipeline
- Developing clear behavioral health career pathways
- Supporting paraprofessional roles including peer support specialists and behavioral health extenders
- Improving Medicaid education resources and aligning with SB0288 implementation
- Developing enhanced guidance for community-level behavioral health needs assessments
- Expanding peer support reimbursement across commercial insurers
- Building a statewide behavioral health provider database
- Enhancing behavioral health workforce data collection and reporting

These recommendations are designed to be actionable, collaborative, and responsive to the real conditions facing behavioral health providers, employers, educators, and the communities they serve. Taken together, they represent a meaningful step forward in building a behavioral health workforce that meets the needs of all Utahns.

Introduction

Utah's behavioral health workforce includes licensed and certified professionals across psychiatry, psychology, social work, counseling, marriage and family therapy, and related paraprofessional roles. Understanding the current state of this workforce, including where shortages exist, where providers are located, and what systemic pressures are shaping the field, is essential to developing effective strategies for the future.

This section summarizes key findings from the landscape analysis conducted by the Health Workforce Information Center (HWIC) and Veritas Health Solutions on behalf of HWAC. The analysis drew on national workforce projection models, state licensure and employment data, stakeholder surveys, and provider feedback collected in 2025 and 2026.

Who Is Utah's Behavioral Health Workforce?

Utah certifies and licenses thousands of behavioral health professionals across a wide range of disciplines. The table below reflects active license and certification counts as of February 2026, drawn from the Division of Professional Licensing (DOPL) and the Utah Department of Health and Human Services (DHHS).

Profession	License / Certification	Count
Social Work	Licensed Clinical Social Worker	7,747
Social Work	Certified Social Worker	2,548
Social Work	Social Service Worker	2,246
Clinical Mental Health	Clinical Mental Health Counselor	3,144
Clinical Mental Health	Assoc. Clinical Mental Health Counselor / Extern	956
Marriage & Family Therapy	Marriage & Family Therapist	1,754
Marriage & Family Therapy	Associate MFT / Extern	434
Psychologist	Psychologist	1,333
Psychologist	Psychology Resident	61
Substance Use Disorder	Licensed SUDC	416

Substance Use Disorder	Licensed Advanced SUDC	199
Case Manager (UDHHS)	Case Manager - Adult Behavioral Health	1,555
Case Manager (UDHHS)	Case Manager - Children Behavioral Health	143
Peer Support (UDHHS)	Peer Support Specialist - Core Training	1,116
Peer Support (UDHHS)	Family Peer Support Specialist - Core Training	134
Crisis Worker (UDHHS)	Certified Crisis Worker	681
Behavioral Health (DOPL)	Behavioral Health Coach	33
Behavioral Health (DOPL)	Behavioral Health Technician	32

Sources: DOPL Active Licensee Count, February 10, 2026; UDHHS Certification Counts as reported in the HWIC Behavioral Health Workforce Report.

Current and Future Workforce Capacity by Profession

The following findings summarize Utah's current and projected behavioral health workforce capacity by profession, drawing on national data sources including HRSA workforce projections, Bureau of Labor Statistics employment data, and the SAMHSA-funded Behavioral Health Workforce Tracker. These sources together provide a multi-perspective view of where Utah stands today and where challenges are likely to intensify.

Table: HRSA Workforce Adequacy Projections for Utah vs. United States, 2026 and 2036

Values below 100% indicate a shortage relative to projected demand. Values above 100% indicate a surplus.

Profession	US 2026	US 2036	Utah 2026	Utah 2036	Utah Status
Adult Psychiatrists	71.9%	51.8%	**52.9%**	**41.0%**	SEVERE SHORTAGE
Child & Adolescent Psychiatrists	76.9%	63.1%	**58.8%**	**63.2%**	SEVERE SHORTAGE
Psychologists	83.2%	52.1%	**54.8%**	**26.2%**	CRITICAL DECLINE
Mental Health Counselors	86.4%	59.2%	**104.6%**	**83.6%**	ADEQUATE / DECLINING
Addiction Counselors (MA)	76.4%	34.9%	**95.2%**	**61.3%**	EMERGING SHORTAGE
Addiction Paraprofessionals	79.4%	42.3%	**121.6%**	**83.8%**	ADEQUATE / DECLINING
Psychiatric NPs	101.5%	108.4%	**119.2%**	**116.7%**	SURPLUS

Psychiatric Physician Assistants	89.3%	79.3%	**150.0%**	**133.3%**	**STRONG SURPLUS**

Source: HRSA Health Workforce Projections Dashboards, 2026 and 2036. Percent Adequacy = Supply as a percentage of projected Demand.

Psychiatrists

Multiple data sources consistently indicate a severe shortage of psychiatrists in Utah, both today and in the coming years. HRSA projects only 52.9% adequacy among Adult Psychiatrists and 58.8% adequacy for Child and Adolescent Psychiatrists in 2026. Adult psychiatrists are expected to worsen to just 41.0% adequacy by 2036, meaning Utah will have less than half the psychiatrists needed to meet projected demand. BLS employment data shows Utah has 47.9% fewer filled psychiatrist positions per capita than the national average, and Utah has 13 Mental Health Professional Shortage Areas, all of which are partially or fully rural, requiring an estimated additional 50 FTE of psychiatrists to alleviate these shortages.

Psychologists

Data sources present a conflicting picture of Utah's psychologist workforce. HRSA projects severe shortages with only 54.8% adequacy in 2026 declining dramatically to 26.2% by 2036, the worst projected shortage of any behavioral health profession analyzed. However, the American Psychological Association's workforce projections forecast a surplus of 50 FTE in 2026 growing to 110 FTE by 2030, and BLS employment data shows Utah has 36.2% more clinical and counseling psychologist jobs per capita than the national average. The most likely explanation for this discrepancy is differing demand assumptions, as HRSA may be projecting significant increases in mental health service utilization. Regardless of the source, psychologists show concerning stability signals, with higher rates of plans to decrease hours (5.5%) or retire (3.3%) and lower interest in increasing hours (5.8%) compared to other behavioral health professions.

Psychiatric Advanced Practice Providers

Utah demonstrates notable strength in psychiatric advanced practice providers. HRSA projects 119.2% adequacy for Psychiatric Nurse Practitioners in 2026, maintaining 116.7% through 2036. Psychiatric Physician Assistants show even stronger capacity at 150.0% adequacy in 2026 and 133.3% in 2036. This surplus represents a critical strategic asset that may help offset physician and other behavioral health workforce shortages, particularly in rural communities with telehealth infrastructure.

Social Workers

Social worker data reveals a complex picture. Overall BLS data shows Utah has 21.2% fewer total social worker jobs per capita than the national average. However, this masks significant variation by specialty. Mental Health and Substance Abuse Social Workers show 31.2% higher employment than

the national average, and licensing data from the Association of Social Work Boards shows Utah has 89% more licensed social workers per capita than the national average (2.65 vs. 1.4 per 1,000 population). In contrast, Child, Family, and School Social Workers employment is 53.0% below the national average. The discrepancy between high licensing rates and lower overall employment may reflect that many licensed professionals work in private practice, non-social work roles, or are currently inactive.

Mental Health Counselors

Mental health counselors currently show adequate capacity at 104.6% adequacy in 2026, meaning Utah slightly exceeds current demand. However, this adequacy is projected to decline to 83.6% by 2036. Without proactive intervention, Utah risks falling into shortage territory within the next decade. BLS data shows Utah only 5.4% above the national average for employment per capita in this occupation category.

Marriage and Family Therapists

Marriage and family therapists represent an exceptional workforce strength. BLS data shows Utah has 196.4% more marriage and family therapist jobs per capita than the national average, nearly triple the national rate. SAMHSA state rankings confirm this leadership position, with Utah ranked in the top tier of states nationally. Given Utah's employment rate is triple the national average, the state likely has substantial buffer capacity even if national trends toward shortage materialize locally.

Addiction Counselors and Paraprofessionals

HRSA projects Utah will have near-adequate addiction counseling capacity in 2026 at 95.2% adequacy, but this is expected to decline sharply to 61.3% by 2036. Addiction Paraprofessionals show current strength at 121.6% adequacy but are also projected to decline to 83.8% by 2036. These trajectories represent meaningful future risks that warrant proactive pipeline investment.

Table: behavioral health employment per capita: Utah vs. United States (2024)

Filled employment per 100,000 population. Note: BLS figures exclude self-employed workers, which may significantly undercount professions where private practice is common.

Profession	US per 100k	Utah per 100k	Variance
Marriage and Family Therapists	19.4	**57.5**	**+196.4%**
Clinical & Counseling Psychologists	21.3	**29.0**	**+36.2%**
Mental Health & Substance Abuse SW	37.2	**48.8**	**+31.2%**

Psychiatric Technicians	40.2	**54.6**	**+35.8%**
Substance Abuse/BH/MH Counselors	130.0	**137.0**	**+5.4%**
Healthcare Social Workers	54.9	**56.0**	**+2.0%**
Social Workers (Total)	224.2	**176.7**	**-21.2%**
Child, Family & School Social Workers	113.0	**53.1**	**-53.0%**
Psychiatrists	7.3	**3.8**	**-47.9%**
Psychiatric Aides	10.3	**3.8**	**-63.1%**

Source: U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics, May 2024.

Workforce challenges and contributing factors

While profession-specific analyses reveal distinct challenges across each workforce segment, several cross-cutting factors drive Utah's behavioral health workforce challenges. These systemic issues compound one another and must be addressed holistically to achieve sustainable improvements.

Geographic maldistribution

Utah's behavioral health workforce is concentrated in urban corridors, creating significant access challenges for rural and frontier communities. Utah has 13 designated Mental Health Professional Shortage Areas, all of which are partially or fully rural, requiring an estimated additional 50 FTE of psychiatrists to address identified gaps. For other behavioral health professions, comprehensive geographic distribution data is limited, meaning the full extent of rural workforce gaps remains underdocumented.

Stakeholder surveys identified rural-specific barriers including housing shortages, limited supervision access for licensure progression, travel burden, smaller applicant pools, and competition from higher-paying urban employers. Rural and frontier respondents identified psychiatrists, licensed clinical social workers, and psychologists as the top-priority unfilled roles in their communities. Telehealth offers partial mitigation, with approximately 70% of DOPL survey respondents reporting they utilize telehealth in their practice.

Education and training pipeline

Utah's behavioral health training pipeline shows mixed capacity with critical bottlenecks at the graduate level and in clinical supervision. Total behavioral health program completions have grown substantially, from 937 graduates in 2021 to 1,566 in 2025, an average annual growth rate of 14.2%. However, this growth is driven almost entirely by associate and bachelor's degree completions, which

grew from 471 in 2022 to 1,022 in 2025. Master's and doctoral program graduates, who are required for most licensed clinical professions, have remained largely flat (435 in 2021 vs. 423 in 2025).

Clinical supervision capacity represents a significant pipeline constraint. Only 31.8% of licensed professional respondents report that they currently supervise students or associates, with psychologists showing the highest rate (49.6%) and most other professions at one-third or fewer. The most common reported barrier was feeling they would not meet the necessary requirements (22.2%). Stakeholder feedback emphasized particularly limited supervision capacity for Licensed Clinical Social Work, Clinical Mental Health Counseling, and Psychiatric Mental Health Nurse Practitioner programs.

Stakeholder feedback also raised concerns about graduate preparedness, with employers noting that master's programs are not consistently providing adequate training in foundational clinical skills such as diagnosis justification, case conceptualization, suicide assessment, and understanding psychological dysfunction. These quality concerns compound the volume challenges facing the pipeline.

Employment plans and workforce stability

Overall, 76.8% of DOPL behavioral health workforce survey respondents plan to continue working the same hours over the next two years, with 12.6% planning to increase hours, a rate higher than the registered nurse workforce (11%) and the physician workforce (7%). However, psychologists show more concerning patterns, with higher rates of plans to decrease hours (5.5%) or retire (3.3%) and lower interest in increasing hours (5.8%) compared to other professions, potentially signaling impending constriction in psychologist workforce capacity.

Private practice migration and insurance acceptance

Independent solo or group practice has become a major setting for licensed behavioral health providers in Utah. According to the 2024 DOPL workforce survey, 22% of respondents reported independent solo or group practice as their primary setting, with rates highest among Marriage and Family Therapists (38.9%), Psychologists (29.2%), and Clinical Mental Health Counselors (29.2%). Additionally, 32.1% of all DOPL respondents reported self-employment or consultant arrangements at their primary practice location.

This migration toward private practice has significant implications for access to care. Among independent solo practitioners, fewer than 15% report accepting Medicaid, compared to 85.3% of community health center-based practitioners and 82% of those in public hospital settings. Medicare acceptance among the total workforce stands at just 28.6%. When providers who do not accept insurance were asked why, administrative burden was cited by 68.3%, inadequate reimbursement rates by 48.3%, and insurance policies and restrictions by 26.9%.

"We do not have a workforce shortage as much as we have burdensome hurdles to getting on insurance panels, problems with filing claims, and low compensation reimbursement. Thus, many mental health therapists do only private pay." - Stakeholder Survey Respondent

Compensation and wage pressures

Low wages relative to competing sectors represent a cross-cutting challenge affecting recruitment, retention, geographic distribution, insurance acceptance, and private practice migration. Community-based behavioral health providers frequently face wage disadvantages compared to K-12 school systems, health systems and hospitals, private practice and telehealth platforms, and out-of-state employers who can recruit Utah-trained providers for remote positions.

Table: annual mean wages - Utah behavioral health professions vs. U.S. Average

Utah's cost of living is estimated at 2.2% above the national average. Professions earning below the U.S. average face compounded economic disadvantage in Utah.

Profession	U.S. mean annual wage	Utah mean annual wage	vs. US
Psychiatrists	$269,120	**$310,080**	**Higher**
Marriage and Family Therapists	$72,720	**$85,550**	**Higher**
Healthcare Social Workers	$72,030	**$74,820**	**Higher**
Substance Abuse/BH/MH Counselors	$65,100	**$71,890**	**Higher**
Social Workers, All Other	$74,680	**$70,120**	**Lower**
Child, Family & School Social Workers	$62,920	**$56,410**	**Lower**
Clinical & Counseling Psychologists	$106,850	**$94,070**	**Lower**
Psychiatric Technicians	$45,000	**$41,070**	**Lower**
Psychiatric Aides	$43,610	**$35,670**	**Lower**

Source: U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics, May 2024. Note: BLS wage data excludes self-employed workers.

Educational debt compounds these wage pressures. Nearly a third of DOPL licensee respondents reported debt between $20,000 and $60,000, with about 10% reporting more than $100,000 in educational debt. Debt burden was highest among psychologists, with 11% reporting over $200,000 in educational debt. Notably, 50% of professionals who completed their education between 1970 and 1979 reported no debt, compared to just 7.7% of those who completed their education in 2020 or later. Educational debt relief was the single highest-priority intervention identified by stakeholders, with

every respondent indicating that loan repayment or scholarship programs would represent a high-impact strategy.

"We can recruit bachelor's and master's level staff without difficulty. Our problem is retention - we cannot compete with hospital systems, schools, and private practice on compensation." - Local Mental Health Authority Stakeholder

Language access

Approximately 6.5% of Utah's behavioral health workforce speaks Spanish at home, compared to 11.0% of the general Utah population. This gap in language capacity has real consequences for access to care. Stakeholders reported that the average wait time for non-crisis care is 3 to 7 days for English speakers, compared to 6 to 8 weeks for Spanish speakers. Language barriers may compound existing geographic isolation, particularly for communities in rural Utah with significant Spanish-speaking populations.

Paraprofessional roles

Utah has invested in developing new paraprofessional roles, including behavioral health technicians and behavioral health coaches (established in Utah Code 58-60-600 in 2024), complementing existing roles such as peer support specialists and case managers. However, awareness of these newer roles among employers remains limited, and their integration into behavioral health care teams is still developing. Several stakeholders cited a general lack of awareness of the coach and technician credentials and a corresponding lack of integration into behavioral health workflows. Career pathways from paraprofessional roles into licensed clinical practice were also described as opaque, particularly in rural areas where growing the local workforce from within is seen as a higher priority.

Top priorities identified by stakeholders

Stakeholders consistently identified three interconnected priority areas: recruiting qualified behavioral health professionals, retaining experienced staff, and addressing compensation disparities. These challenges are fundamentally linked and addressing them in coordination rather than in isolation is essential to achieving sustainable workforce improvement.

- Recruitment: Providers reported difficulty filling roles across the workforce, with extended vacancy periods and intensified challenges in rural communities due to smaller applicant pools, housing limitations, limited supervision access, and competition from urban employers.
- Retention: High clinical workloads, administrative documentation burden (estimated at 30-50% of clinician time for Medicaid billing), billable hour pressures, and the emotional toll of behavioral health work are driving turnover. The 'train and lose' pattern, where organizations lose clinicians to private practice shortly after they achieve independent licensure, was frequently described by Local Mental Health Authority stakeholders.

- Compensation: Wage gaps with schools, hospitals, private practice, and out-of-state employers create persistent recruitment and retention disadvantages for community-based providers. Educational debt compounds these pressures for early-career professionals.

The recommendations in this Strategic Plan address many of the structural and systemic factors underlying these three priorities, including strengthening the clinical supervision and training pipeline, developing clearer career pathways, supporting paraprofessional roles, improving data infrastructure, and expanding access to peer support reimbursement. Taken together, these actions are intended to reduce barriers to entering and advancing in the behavioral health workforce, improve conditions that drive retention, and strengthen the systems that support providers serving Medicaid-enrolled and underserved populations.

Compensation and financial incentives were identified by stakeholders as the single highest-impact lever for addressing recruitment and retention challenges, with every stakeholder respondent citing loan repayment or scholarship programs as a high-impact strategy. Recommendation 6 addresses one dimension of compensation directly: by expanding peer support reimbursement to commercial insurers, it would broaden the compensation base available to peer support workers and strengthen the financial viability of peer support as a career. Utah also administers workforce financial incentive programs through the Health Care Workforce Financial Assistance Program, the Rural Physicians Loan Repayment Program, and the Behavioral Health Tax Credit, which are addressed in Recommendation 11. Expanding the scope and funding of these financial incentive strategies more broadly represents an area of continued need that warrants attention in future planning cycles and legislative discussions beyond the scope of this plan's initial recommendations.

Approach

The recommendations presented in this Strategic Plan were developed through a structured, multi-stage process grounded in data, stakeholder engagement, and expert deliberation.

Legislative mandate

In 2025, the Office of the Legislative Auditor General (OLAG) released a report identifying behavioral health workforce development as a critical unmet priority for the State of Utah. The report specifically charged the Utah Health Workforce Advisory Council (HWAC) with developing a comprehensive behavioral health workforce strategic plan to guide state action. This mandate established the foundation for the work reflected in this document.

Landscape review

In response to the OLAG charge, HWAC commissioned and conducted a comprehensive landscape analysis of Utah's behavioral health workforce. This analysis drew on a wide range of data sources, including:

- Licensure and certification data from the Division of Professional Licensing (DOPL) and the Utah Department of Health and Human Services (UDHHS)
- Workforce supply and demand projections from the Health Resources and Services Administration (HRSA)
- Employment and wage data from the Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics
- State ranking data from the SAMHSA-funded Behavioral Health Workforce Tracker
- Degree completion data from the Utah System of Higher Education (USHE)
- Behavioral health workforce survey data collected by the Health Workforce Information Center (HWIC) through the DOPL license renewal process
- A survey of Utah mental health professionals conducted by Utah Valley University (UVU)
- Stakeholder pulse surveys administered to the USAAV+ Behavioral Health Workforce Workgroup and Utah Local Mental Health Authorities and their networks

The landscape analysis provided a detailed, multi-source picture of workforce supply, demand, distribution, compensation, training pipeline, and provider practice characteristics across Utah's behavioral health professions.

Subcommittee formation and recommendation development

Following the completion of the landscape review, HWAC established a dedicated Behavioral Health Workforce Subcommittee to review the findings and develop draft recommendations for the full Council's consideration. The Subcommittee included representatives with expertise in behavioral health clinical practice, workforce data and analytics, Medicaid and payer policy, rural health, higher education, and professional licensing.

The Subcommittee engaged in a structured deliberative process that included:

1. Reviewing landscape analysis findings and identifying priority workforce challenges
2. Examining examples and evidence from other states that have implemented similar workforce strategies
3. Developing draft recommendations aligned with HWAC's mandate and the operational realities of Utah's behavioral health system
4. Soliciting feedback from partner agencies, provider associations, and workforce stakeholders on draft recommendations
5. Refining recommendations based on stakeholder input and presenting finalized recommendations to the full HWAC for review and approval

Scope and priorities

This Strategic Plan focuses on the behavioral health workforce needs that remain unaddressed through existing statewide initiatives and require coordinated, system-wide strategy. Several areas identified in the OLAG report, including school behavioral health workforce initiatives and licensing and regulatory streamlining, are being advanced through separate efforts led by other agencies and

are not duplicated here. The recommendations in this plan are designed to complement those parallel efforts while addressing the gaps that remain.

The plan gives particular attention to:

- Strengthening the training and supervision pipeline that feeds the licensed behavioral health workforce
- Improving the quality and accessibility of behavioral health career information for prospective workers
- Clarifying and supporting paraprofessional roles that serve as important entry points into the behavioral health field
- Improving data infrastructure to support more informed workforce planning over time
- Addressing access and coverage gaps, particularly for rural communities and Medicaid-enrolled populations

Recommendations

The following recommendations were developed by the HWAC Behavioral Health Workforce Subcommittee [and are pending approval by the full Utah Health Workforce Advisory Council]. Each recommendation includes a summary of its purpose, the entities responsible for implementation, background context, key considerations, potential metrics for measuring progress, specific recommended actions, and a phased implementation timeline.

These recommendations are organized to collectively address the structural factors underlying Utah's top stakeholder-identified workforce priorities. Recommendations 1, 2, and 10 target the training pipeline and supervision capacity that are foundational to long-term recruitment. Recommendations 3, 4, and 6 support paraprofessional roles, Medicaid systems, and reimbursement structures that affect day-to-day provider conditions and retention. Recommendation 6 also speaks directly to compensation, as expanding peer support reimbursement to commercial insurers would broaden the compensation base available to peer support workers and strengthen peer support as a financially viable career. Recommendations 5 and 7 improve the data and community-level information needed to plan and allocate the workforce more effectively. Recommendations 8, 9, and 11 strengthen the data infrastructure and incentive program transparency that support informed decision-making over time. While broader wage and financial incentive strategies fall outside the scope of this plan's recommendations, several recommendations create conditions that reduce financial barriers, improve practice environments, and support providers in the settings where workforce need is greatest.

Recommendation 1: identify opportunities for free or low-cost clinical supervisor training and continuing education

This recommendation encourages the Utah Health Workforce Advisory Council (HWAC), in coordination with DOPL, to identify and promote free or low-cost clinical supervisor training and continuing education opportunities for behavioral health professionals. Utah requires formal training and ongoing continuing education for clinicians who supervise associate-level practitioners, yet access to affordable, supervision-specific training remains inconsistently documented and promoted. By improving visibility and coordination around existing training options and clarifying which offerings may satisfy supervision-related education requirements subject to DOPL approval, Utah can reduce barriers to supervision participation and strengthen the behavioral health workforce pipeline.

Lead entities:

Utah Health Workforce Advisory Council (HWAC); Division of Professional Licensing (DOPL)

Background

Clinical supervision is a foundational component of the behavioral health workforce pipeline for professionals classified in statute as mental health therapists, including certified psychology residents, certified social workers, and associate-level licensees in marriage and family therapy, clinical mental health counseling, and master addiction counseling (Utah Code 58-60-102(15)). Utah law requires formal supervision for individuals pursuing licensure within these professions, and supervised clinical experience is a prerequisite for licensure and continued practice.

To supervise mental health therapists in Utah, law requires clinical supervisors to meet statutory and regulatory requirements, including holding an eligible license in good standing, being approved or certified as a supervisor by a national professional organization, completing required clinical supervision training (eight or more hours of instruction meeting division standards or completing a graduate course in supervision), and completing supervision-related continuing education (Utah Code 58-60-102(4)). These requirements go into effect January 1, 2027.

Several supervisor trainings have been identified which may in part satisfy the upcoming DOPL initial or continuing education requirements for supervisors:

- National Association of Social Work - Utah & Utah Mental Health Counselors Association: Introduction to Clinical Supervision, Ethical Code & Decision-Making Models, Ethical Issues in Supervision, Models of Clinical Supervision, Best Practices in Supervision (free for members)
- Utah Association for Marriage and Family Therapy: Clinical Supervisor Training ($500)
- American Association for Marriage and Family Therapy: Fundamentals of Supervision (free)
- NAADAC (Association for Addiction Professionals): Clinical Supervision in the Addiction Profession Specialty Online Training (free for members, $50 for non-members)

Key considerations

Any effort to promote supervisor training must respect existing licensure authority to ensure that promoted training would satisfy DOPL standards. Training acceptability may vary by license type, renewal cycle, and supervision role. The goal of this recommendation is not to create new training requirements, but to reduce friction and cost associated with meeting existing ones.

Potential metrics

- Number of free or low-cost supervisor training opportunities identified and promoted
- Clicks or access indicators to trainings from state government website or state-promoted marketing
- Increase in number of individuals participating in supervision (per DOPL/HWIC survey data)

Recommended actions

- Scan national professional associations, federally funded training and technical assistance centers, and interdisciplinary supervision forums for relevant free or low-cost supervisor training and continuing education offerings
- Coordinate with DOPL and licensing boards to clarify which types of training may be eligible to satisfy supervision education or continuing education requirements
- Develop a centralized repository or guidance resource on DOPL's website listing identified training opportunities with disclaimers regarding licensure acceptance
- Promote awareness among licensees, current supervisors, employers, and training programs through provider associations, higher education partners, and workforce communication channels
- Gather feedback from supervisors and training programs on usefulness and accessibility and update listings periodically based on training availability and regulatory updates

Timeline

0-3 months

- Begin identification of national free or low-cost training opportunities.

3-6 months

- Coordinate with DOPL and boards to clarify guidance on training acceptability.
- Develop and disseminate a preliminary resource or training catalog.

6-12 months

- Expand promotion efforts statewide.
- Evaluate early impact on supervision engagement and workforce pipeline capacity.
- Refine approach based on feedback and regulatory changes.

Recommendation 2: develop and promote clear behavioral health career resources and pathways

This recommendation calls for the coordinated development and promotion of Utah-specific behavioral health career resources that clearly explain behavioral health roles, career pathways, and entry points, particularly pathways that support progression from paraprofessional and entry-level roles into licensed clinical behavioral health professions. Organizing and promoting accessible, plain-language career resources that illustrate both individual roles and advancement pathways can strengthen recruitment, retention, and long-term workforce supply across Utah's behavioral health system.

Lead entities:

Utah Area Health Education Centers (AHEC); Utah Health Workforce Advisory Council (HWAC); Utah Behavioral Health Commission; Utah Center for Rural Health

Consulting partners:

Utah Department of Workforce Services (DWS); Utah State Board of Education (USBE); Utah System of Higher Education (USHE); Division of Professional Licensing (DOPL); behavioral health employers and professional associations

Background

Utah's behavioral health system relies on a broad range of licensed, certified, and entry-level professionals. Many individuals enter the field through paraprofessional or entry-level roles with interest in long-term behavioral health careers. However, prospective workers frequently lack clear, accessible information about what behavioral health professionals do, how roles differ, and how to enter or advance within the field.

Utah already has numerous resources relevant to career exploration, but no coordinated behavioral-health-focused view. Utah AHEC promotes health career awareness through Explore Utah Health Careers, but these resources do not currently include behavioral-health-specific role descriptions or career ladder information. The Department of Workforce Services provides statewide career tools and labor market data, but these resources are primarily targeted toward entry- and middle-skills job matching rather than explaining professional roles, licensure pathways, or progression within behavioral health careers. At the same time, Utah has expanded paraprofessional entry points through licensing reforms and workforce initiatives, creating roles such as behavioral health technicians and behavioral health coaches, but pathways from these positions into licensed clinical practice are often perceived as opaque or disconnected.

Key considerations

Career resources and pathways should organize and amplify existing information, not duplicate it. Materials should be written in plain language for students, career-seekers, and entry-level workers, while accurately reflecting Utah-specific licensure, education, and supervision requirements. Pathways should accommodate multiple entry points and avoid presenting a single linear route. Given ongoing behavioral health licensing reforms and evolving workforce roles, resources should be adaptable and reviewed periodically.

Potential metrics

- Number of behavioral health roles with Utah-specific, plain-language descriptions and pathway context
- Number of articulated career pathways linking paraprofessional, postsecondary, and clinical roles
- Utilization of resources by AHEC programming, workforce counselors, schools, and employers
- Increased awareness or reported understanding of behavioral health career pathways
- Improved retention and advancement of paraprofessional staff within behavioral health organizations

Recommended actions

- Inventory existing behavioral health career and pathway resources across DWS, AHEC, professional associations, DOPL, and higher education partners
- Define priority behavioral health roles and pathways, including high-demand paraprofessional roles, associate-level licensees, and licensed clinical professions, aligned with current Utah licensure and certification structures
- Develop standardized, plain-language role descriptions and pathway visuals that describe core job functions, education requirements, licensure steps, and typical work settings
- Illustrate progression from entry-level and paraprofessional roles into licensed clinical practice, incorporating early on-ramps including Career and Technical Education
- Coordinate dissemination through existing platforms including AHEC career portals, DWS career tools, DHHS workforce communications, and education advising systems
- Establish a process for ongoing maintenance and refinement with a designated steward entity or interagency process to review materials regularly

Timeline

0-6 months

- Inventory existing career and pathway resources.
- Identify priority roles, pathways, and target audiences.

6-12 months

- Develop standardized behavioral health role descriptions and pathway materials.

- Coordinate dissemination across existing platforms.

12-24 months

- Expand marketing and outreach.
- Evaluate usage and refine materials based on feedback and workforce trends.

Recommendation 3: supporting and strengthening behavioral health paraprofessional roles

This recommendation calls for structured engagement with behavioral health stakeholders to clarify next-step strategies for paraprofessional roles, with distinct attention to peer support professionals and behavioral health extenders, including behavioral health technicians and behavioral health coaches. Utah has made meaningful progress in establishing, funding, and training these roles through reimbursement policy, licensure and certification, education pathways, and workforce initiatives. Additional engagement is needed to understand how these roles are being utilized in practice, what challenges remain, and what policy or operational adjustments are warranted moving forward.

Lead entities:

Utah Behavioral Health Commission; Utah Health Workforce Advisory Council (HWAC)

Consulting partners:

Talent Ready Utah (TRU); DHHS; DOPL; Medicaid and payer policy stakeholders; USHE and training providers; behavioral health employers; professional associations and workforce intermediaries

Background

Utah has taken deliberate steps to expand its behavioral health workforce through two distinct paraprofessional pathways. Peer support roles have been supported through certification and reimbursement models designed to center lived experience and recovery-oriented services. More recently, Utah established behavioral health technician and behavioral health coach roles (Utah Code 58-60-600, established in 2024), creating new entry points intended to support licensed clinicians, improve care coordination, and expand service capacity under supervision.

While this groundwork represents progress, stakeholders across the behavioral health system report uncertainty about what should come next. Employers continue to raise questions about role clarity, supervision, billing, career progression, and specifically how or whether these roles should be integrated into care teams. This recommendation emphasizes intentional stakeholder engagement to interpret existing conditions, assess how prior investments are functioning, and collaboratively determine appropriate next steps.

Key considerations

Engagement should be role-specific, context-sensitive, and solution-neutral. Peer support professionals and behavioral health extenders operate under different philosophies, scopes, and workforce goals, and should not be treated interchangeably. Discussions should prioritize qualitative understanding, shared problem definition, and trust-building.

Potential outcomes

- Clearer shared understanding of how peer support and extender roles are functioning in practice
- Identification of role-specific challenges and opportunities
- Increased alignment across employers, educators, and policymakers
- Informed determination of whether future policy action is needed, and if so, where

Recommended actions

- Convene role-specific stakeholder discussions for peer support professionals and behavioral health extenders separately, including employers, training providers, professional associations, and individuals working in these roles
- Use stakeholder input to understand how current policies, reimbursement models, state certification structures, and training pathways are being implemented on the ground
- Draw on workforce data and insights from related recommendations to inform stakeholder conversations
- Determine whether peer support roles and extender roles face distinct challenges requiring different responses
- Synthesize insights to inform future workforce strategy for consideration by HWAC, the Behavioral Health Commission, and partner agencies

Timeline

0-6 months | Stakeholder engagement

- Identify priority stakeholder groups.
- Design and convene role-specific discussions.

6-9 months | Synthesis and sense-making

- Summarize insights for peer and extender roles separately.
- Share findings with workforce and behavioral health leadership.

9-12 months | Strategic alignment

- Use synthesized insights to inform future workforce planning conversations.
- Determine whether additional action, refinement, or continued monitoring is warranted.

Recommendation 4: gather provider feedback on medicaid education resources and provide workforce considerations to DHHS for SB0288 implementation

This recommendation positions the Utah Behavioral Health Commission to contribute to two closely related efforts: gathering feedback from behavioral health providers on gaps in Medicaid provider education resources and delivering guidance to the State Office of Medicaid; and providing workforce-informed considerations to DHHS as it implements SB0288 (2026 General Session). Both efforts share a common foundation, ensuring that Medicaid administrative systems and quality reform are grounded in the real operational conditions facing behavioral health providers, particularly those in smaller agencies, rural areas, and emerging workforce roles.

Lead entity:

Utah Behavioral Health Commission

Collaborators:

Utah Health Workforce Advisory Council (HWAC); DHHS Division of Integrated Healthcare (Utah Medicaid); behavioral health provider associations; Local Mental Health Authorities (LMHAs) and Local Substance Use Authorities (LSAs); Managed Care Organizations (MCOs); behavioral health workforce stakeholders

Background

Utah Medicaid offers a wide range of provider education materials, including online training webinars, annual statewide provider trainings, PRISM system e-learning modules, coverage and reimbursement tools, and behavioral health-specific policy training. The State Office of Medicaid has indicated openness to guidance on where gaps may exist and how resources could be better tailored to behavioral health providers. However, the specific nature and extent of those gaps has not yet been systematically documented from the provider perspective.

SB0288 requires DHHS to establish performance metrics for Medicaid providers, evaluate provider performance, and annually report findings to the Social Services Appropriations Subcommittee. It also authorizes use of Medicaid ACA Fund interest to support quality-based incentive payments for providers who meet performance expectations. The implementation of SB0288 creates a meaningful opportunity for workforce stakeholders to engage with DHHS on how performance metrics and incentive structures interact with workforce realities.

It is also worth noting that Utah Medicaid has recently conducted a review of reimbursement rates for behavioral health services, and behavioral health services currently receive a 2% annual rate increase. While broad reimbursement rate reform is not the primary focus of this recommendation, this context

is relevant to understanding the financial environment in which behavioral health providers operate and the extent to which Medicaid reimbursement levels may affect provider participation, workforce retention in community-based settings, and willingness to accept Medicaid-enrolled clients. HWAC and the Behavioral Health Commission should remain attentive to how reimbursement rate trends interact with workforce conditions as SB0288 implementation proceeds.

Key considerations

Gathering meaningful feedback on Medicaid provider education gaps requires intentional outreach across provider types, agency sizes, and geographies, with particular attention to rural and frontier communities where administrative burden is greatest. SB0288's performance and incentive framework may affect behavioral health providers differently depending on staffing models, supervision requirements, and geography. Emerging roles often operate with limited or inconsistent Medicaid reimbursement yet are increasingly essential to service delivery.

Potential metrics

- Number of behavioral health providers and organizations engaged in Medicaid education feedback activities
- Number of identified provider education gaps documented and submitted to Medicaid
- Workforce considerations submitted to DHHS related to SB0288 implementation
- Provider participation rates in SB0288 incentive programs by role and geography (longer-term)

Recommended actions

- Develop and administer a survey or structured feedback process targeting behavioral health providers to identify gaps in Medicaid education resources and dissemination
- Convene stakeholder listening sessions or focus groups through provider associations and LMHAs/LSAs
- Compile themes, gaps, and enhancement opportunities into a formal summary and present findings to the State Office of Medicaid
- Work with Medicaid and partner organizations to create a sustainable channel for behavioral health stakeholders to communicate emerging education needs
- Identify stakeholders with expertise in behavioral health workforce roles, supervision requirements, and rural service delivery to inform SB0288 feedback
- Compile and share workforce considerations with DHHS for consideration during SB0288 implementation

Timeline

0-6 Months | Engagement and scoping

- Design and launch the Medicaid provider education needs assessment and survey.
- Identify workforce stakeholders to engage on SB0288 considerations.
- Begin sharing initial workforce feedback with DHHS.

6-9 months | Listening sessions and stakeholder input

- Convene provider education listening sessions through associations and LMHAs/LSAs.
- Facilitate structured stakeholder input on SB0288 workforce intersections.

9-12 months | Synthesis and submission

- Compile and submit formal provider education guidance to the State Office of Medicaid.
- Compile and submit SB0288 workforce considerations to DHHS.

1-3 years | Ongoing advising and refinement

- Review annual SB0288 performance reports and offer ad hoc workforce-informed recommendations.
- Monitor uptake of Medicaid provider education recommendations and assess whether a follow-up feedback cycle is warranted.

Recommendation 5: enhanced guidance for community-level behavioral health needs assessments

This recommendation calls on the Utah Behavioral Health Commission to develop enhanced, standardized guidance for community-level behavioral health needs assessments. While local mental health and substance use authorities routinely assess service needs and develop their workforces accordingly, an opportunity may exists to support more consistent and comprehensive identification of population-level need across communities, ensuring that identified workforce needs are grounded in a full picture of the populations being served.

Lead entity:

Utah Behavioral Health Commission

Supporting entities:

Utah Health Workforce Advisory Council (HWAC); Local Mental Health Authorities (LMHAs) and Local Substance Use Authorities (LSAs); Utah Department of Health and Human Services (DHHS); behavioral health provider associations and community-based organizations

Background

Utah continues to experience significant behavioral health workforce shortages alongside high levels of unmet need. The Behavioral Health Master Plan identifies that nearly half of Utah adults and more than half of youth do not receive necessary behavioral health services, despite Utah ranking among the highest states for adult mental illness and serious mental illness. While these figures capture the statewide picture, they do not fully illuminate where gaps are most acute at the community level, which populations are going unserved, which geographies lack adequate provider capacity, and where workforce shortages are the primary driver of unmet need versus other access barriers.

Local mental health and substance use authorities play a central and jurisdictionally grounded role in assessing community needs and developing their workforces in response. Many authorities have robust processes in place and deep knowledge of their communities. At the same time, questions have been raised at the state level about whether assessment processes consistently capture the full range of population-level service needs, and whether workforce development is reliably anchored to those identified needs. This is not a critique of local authority efforts, but rather a recognition that an opportunity may exist to support enhanced and more standardized approaches to needs identification, so that communities have the tools and frameworks to ensure their assessments are as comprehensive as possible and that workforce planning flows directly from them.

Key considerations

Any guidance developed through this effort must be designed in genuine partnership with local authorities, respecting their jurisdiction and the important relationship between state and local entities. The intent is not to evaluate or audit local assessment practices, but to offer a voluntary, supportive resource that communities can draw on to strengthen existing processes. Rural and frontier communities warrant particular attention, as they face compounding challenges of provider scarcity, geography, and limited local infrastructure.

Potential metrics

- Number of LMHAs and LSAs engaged in the development of enhanced needs assessment guidance
- Completion and dissemination of standardized needs assessment guidance coordinated through the Behavioral Health Commission
- Degree to which guidance is voluntarily adopted or adapted by local authorities
- Number of identified community-level gaps translated into actionable workforce or policy considerations
- Degree to which needs assessment findings inform HWAC workforce planning recommendations

Recommended actions

- Engage LMHAs and LSAs early as co-developers of the guidance, ensuring their experience and perspective shapes the framework from the outset
- Clarify HWAC's contributing role, specifically providing workforce data, provider perspectives, and analytical support to the Behavioral Health Commission's leadership of this effort
- Through structured dialogue with local authorities, explore what elements of needs assessment could benefit from additional guidance, tools, or standardization
- Surface gaps between identified service needs and the populations that may not yet be captured through existing assessment approaches, particularly in rural and frontier communities
- Draft guidance that supports local authorities in comprehensively identifying population-level behavioral health service needs and connects needs identification to workforce planning

- Share finalized guidance with LMHAs, LSAs, and other relevant community partners through the Behavioral Health Commission and offer technical assistance or peer learning opportunities

Timeline

0-6 months | Scoping and partnership

- The Behavioral Health Commission initiates engagement with LMHAs, LSAs, and HWAC to define the scope and approach for guidance development.
- Identify rural and frontier communities and other priority partners for early engagement.

6-12 months | Guidance development

- Facilitate structured dialogue with local authorities to inform guidance content.
- Draft and refine enhanced needs assessment guidance with ongoing local authority input and HWAC analytical support.

1-2 years | Dissemination and application

- Disseminate finalized guidance and provide technical assistance support as needed.
- Assess voluntary adoption and gather feedback for refinement.
- Translate emerging findings into workforce planning implications for HWAC and partner agencies.
- Determine whether additional guidance development or targeted follow-up is warranted.

Recommendation 6: encourage or require commercial insurers to reimburse peer support services

This recommendation proposes that Utah explore policies or mechanisms to encourage or potentially require commercial insurers to reimburse peer support services, a behavioral health workforce role shown to improve engagement, continuity, and recovery outcomes. Peer support is already reimbursable under Utah Medicaid, and the Utah Behavioral Health Commission has identified strengthening peer roles as a system priority. Expanding reimbursement to commercial insurance plans would promote parity across coverage types, reduce uncompensated care for community mental health providers, and create a more stable and sustainable compensation structure for peer support workers. Because peer support workers currently rely primarily on Medicaid reimbursement for income, expanding coverage to commercially insured populations would meaningfully broaden the compensation base available to this workforce and support the financial viability of peer support as a long-term career.

Lead entities:

Utah Department of Insurance; Utah Behavioral Health Commission

Consulted entities:

Utah Health Workforce Advisory Council (HWAC); commercial insurers and managed care organizations; self-funded employer plan administrators; peer support workforce organizations and certification bodies; behavioral health provider associations

Background

Peer support specialists serve essential functions within Utah's behavioral health system, providing engagement, navigation, recovery support, crisis stabilization assistance, and trust-building rooted in lived experience. Peer support services are reimbursed by Medicaid in 48 states, reflecting widespread national recognition of peer support as a legitimate, evidence-based component of behavioral health care. Despite these advancements, peer support workers in Utah serving commercially insured or uninsured populations frequently operate without established reimbursement mechanisms, resulting in financial instability for providers and restricting peer service delivery primarily to Medicaid recipients. The absence of commercial reimbursement directly constrains the compensation available to peer support workers, limiting the workforce's ability to attract and retain individuals in these roles and undermining the sustainability of peer support as a viable career pathway. Expanding reimbursement to commercial payers would not only broaden access to peer services but would represent a meaningful step toward stabilizing compensation for this segment of the behavioral health workforce.

Key considerations

Expanding peer support reimbursement across commercial and self-funded plans involves navigating distinct regulatory environments. Fully insured commercial plans are subject to state regulation and could potentially be reached through state insurance mandates or benefit requirements. Self-funded employer plans operate under federal ERISA rules and are generally not subject to state insurance mandates, meaning voluntary approaches may be the more feasible pathway for that segment. Any expansion will require clarity on peer certification standards, documentation expectations, supervision structures, and billing practices.

Potential metrics

- Number of commercial or self-funded plans adopting peer support coverage
- Increases in the number of certified peer and youth peer specialists employed in settings serving commercially insured populations
- Increased access to peer services across payer types
- Number of policy options or pathways formally assessed by the Department of Insurance and Behavioral Health Commission

Recommended actions

- Engage the Utah Department of Insurance to assess the scope of state regulatory authority over commercial insurers with respect to peer support reimbursement

- Examine existing Utah insurance statutes and behavioral health parity requirements to identify where amendments or clarifications could support expanded peer support reimbursement
- Evaluate the feasibility, reach, and trade-offs of a state mandate applying to fully insured commercial plans
- Assess voluntary approaches such as guidance documents, technical assistance, or incentive structures that could encourage self-funded employer plans to adopt peer support coverage
- Convene behavioral health providers, peer workforce organizations, commercial insurers, and employer plan representatives to gather input on implementation readiness and administrative considerations
- Compile research, statutory review findings, and stakeholder input into a formal set of policy options for consideration by the Department of Insurance, Behavioral Health Commission, and relevant legislative stakeholders

Timeline

0-6 months | Scoping and initial engagement

- Initiate conversations with the Utah Department of Insurance to assess regulatory authority and appetite.
- Begin review of Utah code for relevant statutory provisions.
- Identify key stakeholders for engagement across payer types and the peer workforce.

6-12 months | Research, stakeholder engagement, and feasibility assessment

- Conduct stakeholder listening sessions with insurers, providers, and peer workforce representatives.
- Complete assessment of mandate and voluntary policy pathways, including ERISA implications.
- Compile findings into a formal policy options summary.

12-18 months | Recommendations and strategic alignment

- Present policy options to the Department of Insurance, Behavioral Health Commission, and HWAC.
- Determine whether legislative action, regulatory guidance, or a voluntary engagement strategy is the recommended path forward.
- Identify next steps, including whether additional legislative or rulemaking action should be pursued.

Recommendation 7: advise and monitor DOPL working group on statewide behavioral health provider database

This recommendation elevates HWAC's role in advising and supporting the Division of Professional Licensing (DOPL) working group established under HB0071 (2026 General Session), which requires DOPL to study the feasibility and cost of creating and maintaining a statewide behavioral health provider directory. HWAC's engagement would ensure that this directory reflects the state's behavioral health workforce needs, incorporates workforce-relevant data elements, and aligns with broader statewide initiatives, including the Utah Rural Health Transformation Program's health infrastructure work.

Lead entities:

Utah Department of Commerce, Division of Professional Licensing (DOPL) - mandated lead under HB0071; Utah Health Workforce Advisory Council (HWAC); Utah Department of Health and Human Services

Background

Utah's behavioral health workforce data is fragmented across multiple systems, including licensing records, Medicaid enrollment data, LMHA/LSA provider rosters, association lists, and employer-level records. This fragmentation makes it difficult to develop a comprehensive understanding of behavioral health workforce supply, maldistribution, or practice characteristics needed for policy and planning purposes. HB0071 now requires DOPL to convene a working group to study the feasibility and cost of building a statewide behavioral health provider directory and to report recommendations to the legislative interim committee. At the same time, the Utah Rural Health Transformation Program calls for developing a resource directory detailing physical and behavioral health service availability, capacity, and access in rural communities.

Key considerations

To be meaningful for workforce planning, the directory must capture fields that licensing systems alone do not traditionally collect, such as capacity, specialty, practice setting, telehealth availability, and whether providers are accepting new patients. This requires strong collaboration with data experts and sector stakeholders to balance usefulness, feasibility, and provider burden.

Potential metrics

- Inclusion of HWAC-advised behavioral-health-specific data fields in the directory design
- Alignment between DOPL directory fields and RHTP Initiative 3C resource directory elements
- Number of agencies using directory data for workforce planning or access monitoring (longer-term)

Recommended actions

- Determine the preferred mechanism for HWAC to advise the DOPL working group under HB0071

- Identify priority fields for the directory such as practice locations, settings, specialties, patient populations, telehealth offerings, languages spoken, and whether providers are accepting new clients
- Ensure fields reflect needs specific to rural and frontier service delivery
- Monitor outcomes of the recommendations as presented to the interim legislative committee and revisit future next steps

Timeline

0-6 months

- HWAC representative(s) to join and/or monitor the DOPL working group.
- Coordinate with the broader HWAC to identify and recommend core behavioral health workforce data elements.

6-12 months

- Monitor feedback from the Health and Human Services Interim Committee.

1-3 years

- Dependent on outcome of interim committee recommendations.

Recommendation 8: enhance behavioral health workforce data collection during DOPL licensure processes

This recommendation calls for enhancing the minimum set of workforce data elements for behavioral health professionals collected through DOPL licensure and renewal processes. Building on Utah's existing voluntary workforce survey administered during license renewal, this enhancement would embed a narrowly defined set of required questions directly within licensure workflows to improve data completeness, reliability, and usability for statewide workforce planning, while minimizing administrative burden and avoiding duplication. Implementation should be timed to align with the rollout of DOPL's new licensing system planned for 2027.

Lead entities:

Utah Health Workforce Advisory Council (HWAC); HWAC Data Subcommittee; Division of Professional Licensing (DOPL); Health Workforce Information Center (HWIC)

Consulting partners:

Utah Behavioral Health Commission; Behavioral Health Provider Associations

Background

Accurate, timely workforce data are essential for effective behavioral health workforce planning. While Utah has made progress through voluntary surveys and periodic data collection efforts, optional completion frequently results in incomplete response rates, limiting their usefulness for statewide planning and forecasting. Licensure and renewal processes represent the most consistent statewide touchpoint with the behavioral health workforce, and Utah's planned rollout of a new DOPL licensing system in 2027 presents a timely opportunity to embed enhanced data collection processes thoughtfully and efficiently.

Key considerations

Data collection should focus exclusively on information necessary for legitimate workforce planning purposes and should be embedded seamlessly within existing licensure and renewal workflows. Close collaboration with DOPL's licensing system integration team is critical to ensure that required data elements are technically feasible, logically sequenced, and minimally disruptive to licensees and administrative staff. Questions should be standardized, clearly defined, and designed for long-term stability.

Potential metrics

- Completion rate for required workforce data elements
- Reduction in missing or inconsistent workforce data fields
- Improved accuracy of behavioral health workforce supply and distribution analyses

Recommended actions

- Through the HWAC Data Subcommittee, evaluate and recommend the most effective path forward for enhancing behavioral health workforce data collection through licensure processes, considering options such as required data elements, priority questions on regulatory confirmation pages, or other approaches
- Convene the HWAC Data Subcommittee, including behavioral health stakeholders and HWIC staff, to define minimum necessary workforce data elements
- Engage DOPL licensing system integration and modernization staff early to assess feasibility of required versus optional fields, workflow placement, and impacts on system performance
- Align implementation of data collection enhancements with the 2027 DOPL system rollout
- Develop clear, plain-language explanations for licensees describing why the information is required, how data will be used for workforce planning, and how privacy and confidentiality will be protected

Timeline

0-6 months | Planning and governance

- Convene HWAC Data Subcommittee and confirm HWIC, DOPL staff, and behavioral health stakeholder participation.

- Initiate early consultations with DOPL system integration staff for feasibility considerations.

6-18 months | Design and alignment

- Finalize approach based on stakeholder feedback and DOPL/HWIC feasibility review.
- Align data collection enhancement implementation efforts with DOPL licensing system build and testing timelines.
- Pursue legislative change if necessary to enable implementation.

18-30 months | Implementation and launch (aligned with 2027 system rollout)

- Deploy enhanced workforce data collection initiatives as part of the new DOPL licensing system.
- Conduct monitoring and quality checks during initial renewal cycles.
- Refine processes as needed based on early findings.

Recommendation 9: enhance data on behavioral health paraprofessionals available for workforce planning

This recommendation calls for enhancing statewide data on behavioral health paraprofessionals through targeted, role-appropriate data collection strategies. Utah certifies a range of paraprofessional behavioral health roles through DHHS and DOPL, including case managers, peer support professionals, crisis workers, community health workers, behavioral health technicians, and behavioral health coaches. Each of these groups plays a critical but distinct role in Utah's behavioral health system, yet all are currently missing from existing workforce datasets beyond basic regulatory data. This recommendation prioritizes expanding data collection to include case managers and peer support professionals, where need and feasibility are well established, while also exploring the inclusion of crisis workers and community health workers as data collection planning matures.

Lead entities:

Utah Department of Health and Human Services (DHHS); Division of Professional Licensing (DOPL); Health Workforce Information Center (HWIC)

Consulting partners:

Utah Health Workforce Advisory Council (HWAC); Behavioral Health Employers and Community Mental Health Authorities; Medicaid and Managed Care Partners; Workforce Development and Training Programs

Background

Behavioral health paraprofessionals are essential to effective service delivery, particularly for individuals with complex needs who require coordination across clinical, social, and

community-based services. Because these roles are credentialed outside of DOPL's licensure-based system (in the case of DHHS-certified roles), they are not currently captured in HWIC's workforce datasets and are largely absent from statewide workforce analyses. Limited data across these workforce segments constrains the state's ability to assess capacity, identify geographic or programmatic gaps, and understand workload dynamics that affect access and quality.

Key considerations

Data collection efforts should remain role-specific, minimally burdensome, and clearly purpose-driven. Surveys for DHHS-certified case managers and peer support professionals should reflect the diversity of non-licensed behavioral health roles and be designed with input from those closest to each certification program. Coordination across DHHS, DOPL, HWIC, and HWAC is essential to ensure data elements are complementary and enable integrated, system-wide workforce analyses without duplication.

Potential metrics

- Improved estimates of the number and distribution of DHHS-certified case managers and peer support professionals
- Determination of whether crisis workers and community health workers can be incorporated into expanded data collection efforts
- Improved information on how behavioral health technicians and coaches are deployed across practice settings
- Identification of geographic, programmatic, or population-specific capacity gaps
- Ability to incorporate case managers, peer support professionals, and extenders into broader behavioral health workforce planning

Recommended actions

- Through coordination among DHHS, HWIC, and HWAC, identify key data elements needed to understand case manager and peer support capacity, including role type, setting, caseload, and population served
- Develop surveys specifically for DHHS-certified case managers and peer support professionals, aligned with certification or renewal touchpoints where feasible
- Initiate conversations with crisis worker and community health worker certification program leads to assess the feasibility of incorporating those roles into data collection planning
- Align data collection for behavioral health technicians and coaches with DOPL-based licensure processes and workforce surveys supported by HWIC and HWAC
- Analyze data collected through these surveys and incorporate findings into broader behavioral health workforce analyses

Timeline

0-6 months | Planning and design

- Identify priority workforce questions across role categories.
- Design DHHS-administered surveys for case managers and peer support professionals.
- Coordinate alignment with HWIC/HWAC and DOPL data collection for technicians and coaches.

6-12 months | Initial data collection

- Launch DHHS-administered surveys.
- Monitor response rates and implementation challenges.
- Begin preliminary data integration with licensure-based datasets.

12-24 months | Integration and refinement

- Incorporate findings into statewide behavioral health workforce planning.
- Refine data collection approaches based on findings and stakeholder feedback.
- Determine whether periodic administration is warranted.

Recommendation 10: enhance data collection and reporting on behavioral health field instructor and supervisor workforce needs

This recommendation calls for enhancing data collection and analytic outputs to better understand current and future capacity of behavioral health field instructors and clinical supervisors across Utah. Field instruction and clinical supervision are essential components of the behavioral health workforce pipeline, yet Utah currently lacks a complete and reliable picture of how many professionals provide these services, under what conditions, and where capacity constraints exist. Improving the clarity, consistency, and usability of available data while minimizing administrative burden will support workforce planning, training expansion, and inform targeted investment in supervision capacity if and where data demonstrate a true infrastructure gap.

Lead entities:

Utah Health Workforce Advisory Council (HWAC); Health Workforce Information Center (HWIC)

Consulting partners:

Division of Professional Licensing (DOPL); DHHS; behavioral health licensing boards; Utah System of Higher Education (USHE) and academic programs; behavioral health employers and professional associations

Background

Field instruction and clinical supervision are foundational to the preparation and licensure of behavioral health professionals, including social workers, counselors, marriage and family therapists, psychologists, and substance use disorder counselors. Despite their central role in workforce supply, supervision capacity has historically been difficult to quantify, particularly in behavioral health, where supervision occurs across diverse settings and is not always formally tracked.

Utah has made progress through inclusion of supervision-related questions in the behavioral health workforce survey. However, the current survey uses the term 'preceptor,' which is more commonly associated with medical training and does not accurately reflect supervision structures in behavioral health. Updating survey language to use 'field instructor' or 'clinical supervisor' would better align with behavioral health practice and improve data quality. Additionally, clinical supervision form templates provided by DOPL indicate that supervisors must be approved by DOPL before serving as clinical supervisors, which creates the potential for a comprehensive clinical supervisor registry that could supplement survey-based data with administrative records.

Key considerations

Enhancing behavioral health workforce training capacity data should prioritize clarity, consistency, and minimum necessary burden. No single data source is likely sufficient on its own; instead, a combination of survey data, administrative records, and targeted follow-up analyses may be needed. Data improvements should focus on understanding capacity and constraints, not evaluating or regulating individual supervisors.

Potential metrics

- Ability to confidently estimate the number of active behavioral health field instructors and supervisors
- Geographic and discipline-specific distribution of supervision capacity
- Identification of supervision bottlenecks affecting workforce pipeline growth
- Expanded analytic reports incorporating behavioral health supervision data

Recommended actions

- Revise supervision-related workforce survey questions to replace the term 'preceptor' with 'field instructor' and/or 'clinical supervisor' and clarify definitions to ensure consistent interpretation across behavioral health professions
- Through HWAC and HWIC, identify which data elements are most critical for understanding supervision capacity, such as number of supervisees, settings, licensure level, and geographic location
- Consider secondary analyses such as follow-up surveys of behavioral health professionals who report providing supervision, and targeted surveys or input from academic programs to assess demand for field instruction and supervision placements

- Coordinate with DOPL to assess how required supervision documentation submissions could be used to quantify the clinical supervisor workforce
- Once sufficient data are available, develop periodic reports or dashboards on behavioral health field instruction and supervision capacity
- Use enhanced data and analytic outputs to determine whether shortages in field instruction or clinical supervision capacity exist statewide or in specific disciplines or regions

Timeline

0-6 months | Survey and data foundations

- Update workforce survey terminology and definitions.
- Identify priority supervision capacity indicators.
- Initiate coordination with DOPL on additional data elements that could be used to quantify clinical supervisors.

6-12 months | Data enhancement and analysis

- Implement updated survey questions.
- Assess feasibility of secondary analyses and administrative data integration.
- Begin exploratory analysis of supervision capacity trends.

12-24 months | Reporting and refinement

- Develop enhanced analytic outputs incorporating behavioral health supervision data.
- Evaluate data quality and usefulness for workforce planning.
- Refine approaches based on stakeholder feedback.

Recommendation 11: regular reporting of data on existing workforce incentive programs

This recommendation calls for the regular publication and synthesis of data already collected through existing workforce incentive programs, including the Health Care Workforce Financial Assistance Program and Rural Physicians Loan Repayment Program administered by the Office of Primary Care and Rural Health (PCRH). PCRH currently collects programmatic data through required provider applications, site applications, and semi-annual progress reports. Making this information more visible through strengthened dashboards or other reporting would improve transparency, support data-informed policy decisions, and inform future investment in health workforce strategies.

Lead entities:

Utah Department of Health and Human Services (DHHS), Primary Care and Rural Health (PCRH); Health Workforce Information Center (HWIC)

Consulting partners:

Utah Health Workforce Advisory Council (HWAC)

Background

Utah administers several healthcare workforce incentive programs intended to recruit and retain providers in rural and underserved areas, including behavioral health professionals. These programs require detailed provider-level, site-level, and longitudinal reporting, generating valuable information about workforce placement, retention, and service delivery. PCRH already collects rich data elements through provider application forms, site application forms, and six-month progress reports. Despite the breadth of information collected, these data are primarily used for program administration and compliance. There is an opportunity to aggregate and publish select, de-identified key details to better demonstrate program participation and inform workforce planning without creating additional reporting requirements.

Key considerations

Wherever possible, efforts should build entirely on existing data collection processes, with no additional burden placed on providers or sites. Reporting should focus on data most relevant to workforce planning and program accountability, such as license types and service delivery in underserved areas.

Potential metrics

- Distribution of providers by profession and geography
- Retention through and beyond service commitments
- Service delivery trends in rural and underserved areas
- Provider-level indicators including profession, license type, employment setting, geographic service location, and length of participation
- Site-level indicators including site type, populations served, and HPSA designation

Recommended actions

- Review provider, site, and progress report data fields currently collected by PCRH and identify which data elements are suitable for aggregation and reporting
- Select a limited set of high-value indicators that reflect program impact on workforce recruitment, retention, and access, ensuring inclusion of behavioral health-specific measures
- Create periodic summary reports (annual or biennial) or dashboards highlighting distribution of providers by profession and geography, retention through and beyond service commitments, and service delivery trends in rural and underserved areas
- Share aggregated findings with HWAC and other entities to inform broader workforce analyses or policy decisions
- Align reporting timelines with existing data collection cycles and update outputs periodically to reflect new cohorts and longitudinal trends

Timeline

0-6 months | Data inventory and planning

- Inventory existing PCRH data fields and reporting formats.
- Identify candidate outcome measures for publication.

6-12 months | Initial reporting development

- Develop draft summary tables or dashboard concepts.
- Pilot internal review of aggregate outcomes.

12-24 months | Publication and refinement

- Publish initial outcome report or dashboard.
- Refine indicators and presentation based on stakeholder feedback.
- Establish ongoing reporting cadence.

Conclusion

Utah's behavioral health workforce challenges are real, significant, and growing. The data and stakeholder perspectives documented in this Strategic Plan confirm that the state faces persistent shortages in critical professions, troubling trends in the training pipeline, geographic gaps that leave rural and frontier communities underserved, and systemic pressures on compensation and provider capacity that, left unaddressed, will deepen over time. At the same time, Utah has meaningful workforce strengths to build on, a robust marriage and family therapy workforce, strong advanced practice provider capacity, a growing paraprofessional infrastructure, and a body of licensed professionals who, by and large, intend to stay in the field and serve their communities.

The eleven recommendations presented in this plan reflect a deliberate, evidence-informed response to these conditions. They are designed to be actionable within existing authorities and resources, collaborative across agencies and sectors, and responsive to what providers, employers, educators, and communities have said they need. Taken together, they represent a coordinated effort to strengthen the behavioral health workforce pipeline, improve data and planning infrastructure, support emerging workforce roles, and reduce the systemic barriers that limit access to care for Utahns who need it most.

This Strategic Plan is a beginning, not an endpoint. The Utah Health Workforce Advisory Council and its partners are committed to monitoring progress, updating recommendations as conditions evolve, and continuing to engage with the providers, educators, and communities whose work and wellbeing are at the center of this effort. Improving Utah's behavioral health workforce will require sustained commitment across agencies, sectors, and legislative sessions. HWAC looks forward to working alongside the Utah Behavioral Health Commission, DHHS, DOPL, higher education partners, and the broader behavioral health community to advance the work reflected in these pages and to ensure that every Utahn has access to the behavioral health care they need.

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Behavioral Health Workforce Subcommittee

The following individuals served on the HWAC Behavioral Health Workforce Subcommittee and contributed directly to the development of the recommendations in this plan.

- *Mia Nafziger, Administrator , Utah Behavioral Health Commission*
- *Carrie Merino, Program Director, CHMC Masters Program, Utah Valley University*
- *Derek Larsen, Director, Community Mental Health Clinic, Utah Valley University*
- *Stephanie Bank, Director, BSW Program, College of Social Work, University of Utah*
- *Jessica Black, Advocacy & Clinical Development Director, Grandview Family Counseling*
- *Jamie Brass, Director of Professional Affairs, Utah Psychological Association*
- *Chris Wilkins, President, Association of Utah Substance Abuse Professionals*
- *Stacy Eddings, Research Consultant III, Utah Department of Health and Human Services, Office of Substance Use and Mental Health*
- *Holly Uphold, Manager, Utah Department of Health and Human Services, Utah Health Workforce Information Center*
- *Lisa Hancock, Peer Support & Customer Service Supervisor, Optum*
- *Chris Williams, Division Director, Workforce Research & Analysis, Utah Department of Workforce Services*
- *Tyler Goddard, Behavioral Health Manager, FourPoints Health*

Contributing organizations and partners

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- Utah Local Mental Health Authorities (LMHAs) and Local Substance Use Authorities (LSAs)
- Behavioral health provider associations, employers, and professional organizations across Utah
- Utah Valley University (UVU)

Stakeholder participants

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