

**CHILDREN'S MENTAL HEALTH PROMOTION IN UTAH:  
An Analysis of Children's Mental Health System Capacity and  
Workforce Development**

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## Acknowledgements

The Utah Department of Health has a long history of recognizing the importance of early childhood health and development; however this work may not have been possible without the financial support offered through the Assuring Better Child Health and Development (ABCD) project funded by The Commonwealth Fund and the technical assistance provided by the National Academy for State Health Policy. ABCD highlighted the importance of healthy social emotional development and the need to ensure that the professional workforce is offered every opportunity to enhance their capacity to provide care to children, adolescents and their families.

This report would not have been possible without the cooperation and support from the Community Mental Health Centers in providing yearly service information. The specific background of the Utah mental health providers and their training needs and gaps provided critical information that would not have been possible without the enthusiastic response from the professional mental health providers

## **Executive Summary**

Healthy mental development in children is a critical factor in their overall health and development. Children's mental health is a major area of unmet need for many families. Researchers have found that one in ten children in the United States has a mental health problem that affects their lives, and approximately six million children suffer from a serious emotional disturbance. (Jellineck, et. al., 1999 and VanLandeghem, et. al., 2005) Unfortunately, many do not receive needed mental health services and when services are received, they are often provided by professionals who lack specialized knowledge and skills to deal with the increasingly complex needs presented by children, adolescents and their families. (Jellineck, et.al., 1999 and VanLandeghem, et. al., 2005)

The number of children entering into mental health treatment continues to rise while at the same time financial resources are reduced. The ability of public programs to hire additional providers is limited, thus putting a strain on the system to respond to the increasing need. Often the responsibility to pick up unfunded, under funded and privately insured individuals falls upon the mental health provider in private practice. These clinicians may think that they lack the necessary background to respond to the unique needs presented by young children in particular. An unfortunate result is a mental health system inadequately prepared to address the complex issues that are now being recognized in young children, adolescents and their families. Clearly the best solution for addressing the need is to offer specialized training for mental health professionals enabling them to respond to the needs and to provide an appropriate level of care for all children and their families.

This report provides an overview of four years of study on the children's mental health system capacity in Utah and the findings of the Children's Professional Mental Health Provider Training Needs Assessment. The system capacity study was funded by The Commonwealth Fund as part of the Assuring Better Child Health and Development II (ABCD II) project, a three-year collaborative (2003-2007) focusing on increasing screening of infants and toddlers for social/emotional delay and postpartum mothers for maternal depression during well-child visits. A secondary focus in the Utah project was an assessment of the capacity of the mental health system to respond to anticipated increased referral for services.

The system capacity survey found that from 2003 through 2006 the number of children enrolled in Medicaid who accessed mental health services from the community mental health system increased by 138% while the numbers of professional staff employed and contracted by the mental health centers declined significantly. For example, staff in urban centers declined by 66% and staff in rural centers declined by 49% during the time frame. The most significant reduction came between 2004 and 2005 the number of contract staff in urban centers dropped by 59%.

These findings suggested that, with ongoing budget reductions, the most prudent strategy to addressing system capacity issues is to insure that clinicians are afforded the opportunity to participate in specialized training, thus improving the quality of care for children and adolescents. The underlying concept is providers using evidence-based practices build quality and accountability into the health and behavioral health care system. As a result the Utah Department of Health developed a professional mental health provider training needs assessment process through a survey of all licensed mental health providers.

The needs assessment found that the mental health workforce is comprised primarily of licensed clinical social workers who provide services through private practices (31%) to a largely adult population (44%) followed by adolescents (28%), young children (11%) and families (8%). The most common specific training needs identified were skills in diagnosis, and evidence based treatment techniques (cognitive behavioral therapy, dialectical behavior therapy, solution focused therapy, etc.). Other topics included: substance abuse treatment, early childhood, abuse, parenting, pharmacology, relationships, cultural competency, grief and loss, suicide prevention, adoption and foster care issues and treatment of trauma. Respondents felt that the greatest barriers to attending training are time away from the office, inability to pay for training and lack of interest in the topics offered. Conferences and workshops are the most requested forum for training however many respondents indicated a desire to receive credit for on-line courses, CD/DVD viewing, and literature review.

Based on this information, we are working closely with a variety of conference planners to sponsor specialized training opportunities for mental health, primary care, and early care and education providers to expand knowledge and skills in addressing children's mental health. In addition we are working with individuals, agencies and organizations on programmatic consultation to enhance their capacity through quality improvement activities.

## **Background on Children's Mental Health**

Over the past three decades the science of child development, including an understanding of the impact of early experiences on later social, emotional and cognitive development, has grown dramatically. In turn, there has been increasing interest and concern about the child's earliest experiences and how these experiences shape later development. (Zeanah, et. al., 2005) Healthy social emotional development of infants and toddlers provides the basis for the healthy development of young children and adolescents. Because some major mental health disorders are now recognized to have their onset in early childhood, early screening and intervention are critical to minimize the negative consequences for children, including school failure, co-occurring substance abuse disorder and involvement in the child welfare or criminal justice system. (Zeanah, et. al. 2005 and New Freedom Commission, 2003)

Research has shown that an estimated 21 percent of children and adolescents (11 million) in the United States has a diagnosable mental health or substance abuse disorder. (U.S. Department of Health and Human Services, 1999) Researchers have found that behavior problems identified during pre-school years often persist into adolescence and beyond and that teenagers described as emotionally disturbed had a history of problem behavior since pre-school. (Perry, et. al., 2007) Further, it is estimated that 1 in 5 children and adolescents has a mental health disorder and that 1 in 10 or about 6 million adults has a serious emotional disturbance. (Office of the Surgeon General, 2000) In 2003 the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that problems with alcohol or drug abuse exist in up to 80% of the families known to the child welfare system. (Substance Abuse and Mental Health Administration, 2003)

Data available in 1997 indicated that nearly 120,000 preschoolers in the United States under the age of six (1 out of 200) received mental health services. (Perry, et. al., 2007) In 2005, Gilliam found that nearly seven out of every 1000 children enrolled in preschool were expelled due to behavioral concerns. Boys were 4.5 times more likely to be expelled than girls. The report indicated that children were much less likely to be expelled from preschool if the teacher had access to mental health clinicians to provide intervention when problems arose. (Perry, et. al., 2007)

Students identified as having behavior or emotional problems under the 2004 Individuals with Disabilities Education Improvement Act (IDEA) have a 50% risk of dropping out of school and are at a higher risk for developing social problems, including school bullying, gang activity, substance abuse, and violent activity. (Perry, et. al., 2007) The American Psychological Association (1993) found that these behaviors act as “accelerators” and predictors for adult violence and criminal behavior which provide a direct connection between pre-school disruptive behavior and adolescent and adult anti-social acts. (Perry, et. al., 2007)

Utah’s Indicator-Based Information System for Public Health (IBIS-PH) includes Utah’s Youth Risk Behavior Survey (YRBS) data. In YRBS, students are asked a series of questions on many topics, including mental health and suicidal ideation. YRBS data indicate that from 1999 to 2005 the percentage of students reporting feeling sad or hopeless has risen from 25.9% to 28.2%. The percent of youth attempting suicide has risen during the same time from 6.88% to 7.98% while the rate of suicide deaths declined from 12.8 to 9.3 per 100,000 populations. (Utah IBIS-PH, 2007) While the suicide completion rates have declined, Utah continues to rank among the highest in the nation for suicide rates. A recently published report by Mental Health America ranked Utah as the seventh highest state for the number of suicide deaths and number as the most depressed state. The report further indicated that among adolescents in Utah, 10.14 percent experienced a major depressive episode in the past year (Mental Health America, 2007).

In Utah the use of alcohol and other drugs of abuse are typically low. However, adolescent use of alcohol and other drugs and the relationship to antisocial behavior are concerning. The Utah Prevention Needs Assessment (PNA) Survey conducted by the Student Health and Risk Prevention Project (SHARP) under the direction of the Utah State Office of Education, surveyed students in grades six, eight, ten and twelve in all Utah public schools about their use of alcohol and other drugs of abuse. The 2005 survey found that, while there was little increase in the use of substances over a two-year period, there was a significant increase in the use of tobacco and stimulants. The study also found a high correlation between substance use and antisocial behavior and a strong link between students who report depression and the use of alcohol and other drugs of abuse. For example, students who report being depressed are five times more likely to have used drugs within the past 30 days than students who did not report being depressed. (Utah SHARP Report, 2005)

Unfortunately, almost 70% of children and adolescents in the United States with mental health problems do not receive behavioral health services and only 21% of children needing a mental health evaluation received services. (Kataoka, et. al., 2002) Less than one in five children and adolescents receives needed treatment. (Office of the Surgeon General, 2000)

Untreated children's mental health disorders often lead to mental health disorders in adulthood. The increasing number of mental health issues is a contributing factor to rising health and economical costs, decreased productivity, and premature death. For example, in 1997 the United States spent more than \$1 trillion on health care including almost \$71 billion on mental illnesses. In addition, the annual economic cost of mental illness is estimated to be \$79 billion and most of that amount (almost \$63 billion) reflects the loss of productivity as a result of mental illness. Sadly, almost \$12 billion are lost in productivity costs as a result of premature death either from untreated co-occurring medical/mental health problems or suicide. (The President's New Freedom Commission on Mental Health, 2003)

In 2005, the Children's Defense Fund reported that, "Child poverty has increased by over 1.4 million children since 2000, accounting for more than a quarter of the 5.4 million people overall who report living in poverty. More than one out of every six American children was poor in 2004." (Children's Defense Fund, 2005) Child poverty contributes to the overall increase in health costs because poor children are more likely to develop chronic health problems. (Currie, 2005)

Mental health promotion came into focus in 1999 with Surgeon General David Satcher's report on mental health, *Mental Health: A Report of the Surgeon General*, which provides a framework of research into the importance of understanding mental health an important ingredient to successful physical health and wellbeing. Dr. Satcher in his preface to the report states, "Promoting mental health for all Americans will require scientific know-how, but even more importantly a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fear, and misunderstanding that remain as barriers before us."(U.S. Department of Health and Human Services, 1999)

The concept of children's mental health promotion began as national experts recognized gaps in addressing children's mental health needs through a continuum of services beginning with promotion and prevention, early identification, intervention and treatment. Promotion and prevention activities focus on optimal social and emotional development, wellness and resilience. (VanLandegham, et. al., 2005)

The 1999 Surgeon General's report opened the door for increased research and focus on all areas of mental health including children's mental health. The most notable attention came in 2001 when President George W. Bush announced his New Freedom Initiative and subsequently convened the President's New Freedom Commission on Mental Health. (New Freedom Commission on Mental Health, 2003)

The primary outcome of the New Freedom Commission was a blueprint for transforming the mental health services delivery system. The Commission found that unmet needs and barriers interfere with the ability to access mental health treatment. The system currently does not focus on recovery, promotion of healthy mental development or developing a workforce that is better equipped to address the ever increasing complexities of mental health problems that are now being presented in the treatment setting. (New Freedom Commission on Mental Health, 2003) The Commission outlined the importance of evidence-based practices in a system of care approach.

The system of care philosophy focusing on improving the delivery of mental health services to children and adolescents has evolved over the past 20 years. First articulated by Beth Stroul and Bob Friedman in their 1986 monograph, *A System of Care for Children and Youth with Severe Emotional Disturbances*, a system of care is defined as, "A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families." (Pires, 2002) The original concept has evolved to include core competencies focusing on integrating care planning and management, insuring cultural and linguistic competency, and building meaningful partnerships with families and youth at service delivery and policy levels. (ibid, 2002) In a system of care, families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals and that address each person's cultural and linguistic needs. This helps children, youth and families function better at home, in school, in the community and throughout life. Systems of care is an

approach to services that recognizes the importance of family, school and community and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural, and social needs.

One of the key components of system of care is providing supports that are effective and evidence based. The evidence-based movement has grown substantially over the past 20 years as many different entities including medicine, education, public health, government and non-government entities have embraced evidence based practices and have learned of the importance of providing evidence-based care. The evolution of evidence-based practice reflects the nationwide effort to build quality and accountability in service delivery (Huang, et. al., 2003)

The basic tenet of evidence-based care is a desire to determine what works and what does not work, to understand why programs work and to increase accountability for funding. (Rogers, et. al., 2007) Evidence-based treatment is determined by a rigorous process in which experts using agreed upon criteria come to a consensus that the research findings are credible and can be substantiated. (Rogers, et. al., 2007) In terms of mental health care, evidence-based treatments have been shown to provide the best outcomes for those receiving care.

The use of evidence-based practices in children's mental health has been slow to evolve. Barriers in implementation range from financial constraints in restructuring programs at a time of budget reductions, reluctance to change practice behaviors (Huang, et. al., 2003) to lack of evidence-based practices for severe, co-occurring mental health problems and uncoordinated and fragmented services. (Hoagwood, 2003) In addition, evidence-based practices have not been developed for some disorders and do not work for all individuals. Finally, researchers have faced difficulties in determining what constitutes "evidence".

The criteria for what constitutes evidence-based practice vary among groups serving children. These range from "evidence-based" practices grounded in systematic randomized clinical trials, to "evidence-informed" practices based on meta-analyses of existing studies, to "evidence-suggested" practice based on consensus groups and expert opinion. (Huang, et. al.,, 2003) What is critical in this conversation is that groups are beginning to recognize the importance of the development of system improvement in order to ensure the effective treatment of children and adolescents and are finding that a key component to the ongoing system of care is capacity growth related to provider workforce development.

In 2006, the National Technical Assistance Center for Children's Mental Health at Georgetown University found that most states perceived workforce development as critically important in their work of providing support for children and families. Nearly two-thirds of the respondents to the study believed that workforce development is very important in developing, implementing and sustaining a system of care for children. In a follow-up study Georgetown researchers surmised that "Success in children's mental health depends on the ability of systems to support the development of their competencies." (National Technical Assistance Center for Children's Mental Health, 2006) Georgetown University researchers have recommended that providers of children's mental health care need to develop competencies in a full range of areas including: child development, family and youth partnerships, cultural competency, and developing collaborative relationships with community partners. Institutions of higher education can address the needs by offering educational opportunities focused on evidence-based practices across disciplines, including social work, psychology, and psychiatry. In-service trainings are needed to insure that advanced level clinicians are kept abreast of new developments in evidence-based practices, available community resources and opportunities to collaborate on initiatives related to children's mental health. (National Technical Assistance Center, 2005)

In addition, many mental health and primary care providers lack training in providing care in a culturally sensitive manner. As the United States has become more heterogeneous, cross-cultural effectiveness has emerged as an essential skill for any service provider working with children, adolescents and their families. Providers need to be sensitive to differences across families and within cultural groups; knowledge, understanding, sensitivity and respect for cultural differences can significantly enhance the effectiveness of service providers and increase consumer satisfaction. (Lynch, et. al., 2004)

Training opportunities are often expensive, and clinicians have difficulty finding time away from busy practices to attend. Much of the training of professional mental health providers focuses on the psychotherapies directed towards promoting adult mental health and on preventing serious mental illness. Many training programs lack curricula geared at evidence-based practices, working with parents, consumers and other informal support networks, interdisciplinary collaborations, strength-based and wrap-around services, and developing cultural competence. (Promising Practices in Children's Mental Health-System of Care- 1998 Series, p.24)

## **Chapter 1: Enhancing Utah's Capacity to Support Children's Healthy Mental Development**

The practice of mental health therapy in Utah is governed by laws passed by the Utah State Legislature. The law governing the practice of mental health therapy is found in Utah Code 58-60-102, Utah Mental Health Professional Practice Act, which provides definitions and outlines who is authorized to practice mental health therapy in the state.

The State of Utah requires that all individuals providing mental health specific therapeutic services be properly trained and licensed. Individual, family, group therapy, and mental health assessment require licensing at the Master's level or higher. Case management, education and support may be provided by an individual trained at the Bachelor's level but these individuals must also be licensed as a Social Service Worker. The licensing body is the Utah Department of Commerce, Division of Occupational and Professional Licensing (DOPL), which requires that all professional licenses be renewed every two years. Licensed professionals are listed for public review on the licensing website which is updated daily.

(<http://www.dopl.utah.gov/>)

Six disciplines are licensed to practice mental health therapy in Utah. However, for the purposes of this report the following professions that were studied:

- Licensed Clinical Social Work/Certified Social Work
- Psychologists
- Licensed Professional Counselors
- Marriage and Family Therapy

Psychiatrists and Advanced Practice Registered Nurses (APRN) were excluded from the survey because the list of physicians and APRN does not specify specialty of practice.

In October 2006, 4858 mental health professionals (excluding APRNs and psychiatrists) were licensed to practice in the State of Utah. Of the 4858, 67.3% were social workers, 15% were psychologists, 9% were marriage and family therapists and 8% were professional counselors. While most providers work independently in private practice, many work in other settings including: community mental health centers, schools, health and psychiatric hospitals, for profit agencies, and governmental entities (state, city, county and federal). The majority of clinicians provide direct clinical intervention; others work in academics, research or administration.

Mental health services may be provided through contract with private medical insurance, private pay, fee for services, or Medicaid/SCHIP. In accordance with the Social Security Act Utah law restricts services for Medicaid enrollees living in most counties of the state to a community mental health center under contract with Utah Medicaid.

Nine community mental health centers contract with Medicaid through a Pre-paid Mental Health Plan (PMHP) and two centers provide services to Utah Medicaid enrollees on a fee-for-service basis. Of the nine pre-paid plans, four are in the large urban areas along the Wasatch Front and the remaining five are located in the rural or frontier areas in Eastern, Central and Southern Utah. The two fee-for-service centers provide care to children in a small northern county and the southeastern counties surrounded by the Navajo and Ute Indian Reservations.

In January 2004 the Utah Department of Health embarked on a three year project, *Enhancing Utah's Capacity to Support Children's Healthy Mental Development*. The project was part of the Assuring Better Child Health and Development II (ABCD II) initiative funded by The Commonwealth Fund. The primary focus of ABCD II was on screening infants and toddlers for social/emotional delay and postpartum mothers for maternal depression. Five states were chosen to participate in the project which was targeted at Medicaid enrolled children who received well-child services from primary care providers.

Utah's ABCD II project identified two primary goals: 1) to increase screening of infants and toddlers for social emotional delay and postpartum mothers for maternal depression during well-child visits using standardized screening tools and to provide referral when needed, and 2) to assess the capacity of the mental health system to provide mental health care to children identified with a social emotional delay.

Primary care providers (pediatricians, family practice physicians, physician assistants, and APRNs) involved with the ABCD II project participated in three quality improvement projects focused on increasing screening during well-child visits. The quality improvement projects have proven to be successful with project data reflecting a 70-80% increase in the participating primary care providers who now screen for a full range of developmental (including social/emotional) delays and postpartum depression on a regular basis.

#### Public Mental Health System Capacity

Utah's ABCD II project completed a three year study of the capacity of the public mental health system to provide care to children birth to 21 years of age. Surveys were conducted in

2004, 2005, and 2006 to determine the number of medical and licensed mental health professionals available to provide services to children enrolled in Medicaid. The survey focus was on infants and toddlers, since there is no mechanism in place to determine age breakdown of children seen by providers, the survey practice results reflect information for children birth to 18 years of age.

### Study Outcome

Results of the study indicate that community mental health centers employ staff on a full or part-time basis. Some centers contract with private mental health providers to further enhance their capacity. Information collected during the three years of the study indicates that the number of professional staff employed and contracted by the mental health centers have declined significantly over the study period. Staff in urban centers declined by 66% and staff in rural centers have declined 49% during the three year time frame. The most significant reduction came between 2004 and 2005 when urban centers reduced the number of contract staff by 59%. The specific reason for the reduction is not clear, however most likely Medicaid billing changes resulted in less revenue for centers that then led to reduction in staff. In some cases vacancies were not filled or contracts were not renewed.

### Number of Children Served

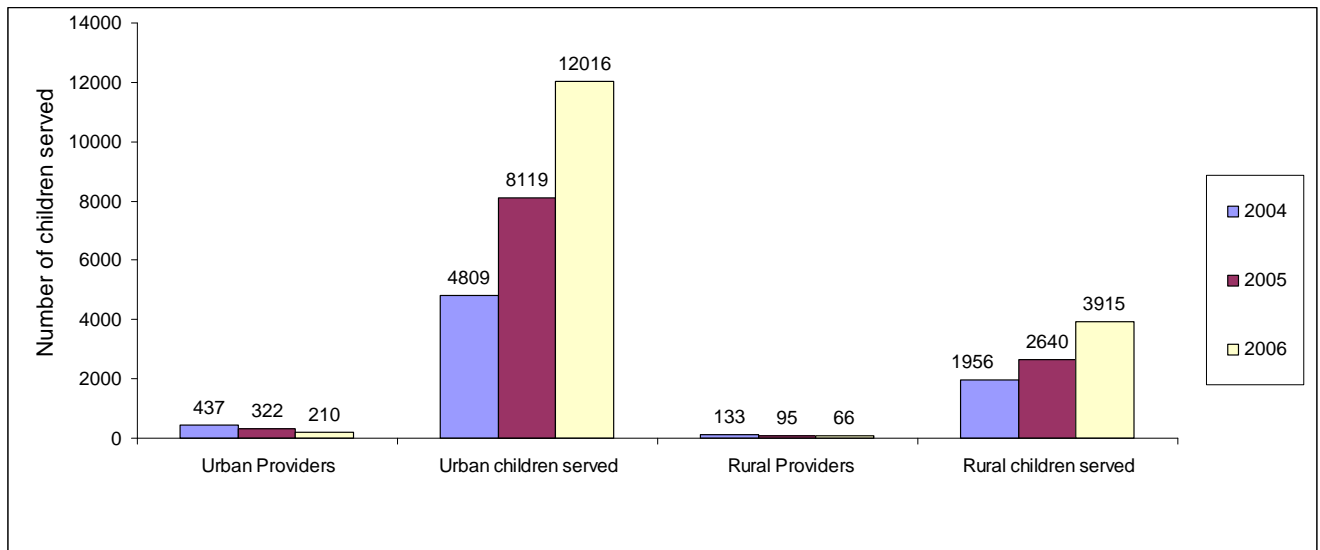
A review of children enrolled in Medicaid who have received services from a community mental health center provides a limited understanding of the load placed upon the public mental health system. Population estimates indicate that as of July 1, 2006, there were approximately 804,569 children (age birth to eighteen) in Utah, of which 116,746 (14.5%) were enrolled in Medicaid and another 35,051 (4.4%) in CHIP. (IBIS-PH and Utah Department of Health Data Medicaid Warehouse, 2006)

Review of mental health center service data reveals that the number of children served from 2004 through 2006 increased 138%. The increase was largely in the number of urban children served, with an increase of over 7200 children being served over the three year period.

The increase in the number of children served has been a concern particularly when compared to the overall reduction in the number of staff available to provide care to the most vulnerable children. For example, in 2006, urban centers employed and contracted with 210 licensed mental health providers who in turn provided services to 12,016 children (57 children

per provider). Even more disturbing is the disparity between the urban and rural numbers with 66 staff serving 3,915 children (59 children per provider). Figure One further highlights the changes.

**Figure One: Urban and Rural Providers and the Number of Children Enrolled in Medicaid Who Received Services 2004, 2005 and 2006**



The study found that the public mental health system is over-taxed and under-funded. Anecdotal stories indicate that public mental health centers are under staffed, and many children wait for long periods of time to receive care. In addition, changes in the funding structure have resulted in public mental health centers restricting their care to only children enrolled in Medicaid. This leaves the remainder of the children in need to seek care from other sources or not at all.

The challenges are further emphasized when looking at the population distribution in the urban versus rural/frontier areas in the state. The majority of Utah’s population, about 78%, resides along an area in Northern Utah known locally as “The Wasatch Front”. The remainder of the residents lives in rural and frontier areas in northern, central, eastern and southern areas of the state an area comprising 75% of the land. The geographic expanse and population distribution present many challenges for residents in obtaining mental health services in their communities, such as finding qualified providers, and lack of anonymity in small communities where everyone knows why a person would be walking into a mental health center.

## Summary and recommendation of community mental health system capacity findings

The system capacity report found that the community mental health system is suffering from financial cutbacks as a result of changes in Medicaid billing and has in turn reduced the number of staff employed and contracted by the centers. While the number of mental health professionals licensed by DOPL has grown (20% over three years), the number employed and contracted by the centers has fallen. At the same time the number of children enrolled in Medicaid who have received treatment from a mental health center continues to grow. Budget reductions have made it difficult to increase the number of staff available to provide care.

The conclusions from the system capacity study are that under current fiscal constraints, capacity will best be built by providing training focusing on issues affecting children, youth and families. This is consistent with the findings of several national studies which reported that workforce development is critically important for mental health professionals to provide support and mental health intervention for the young population and their families. The development of a highly skilled workforce will provide the most stable source to improve systems of care.

The report on system capacity recommended a professional mental health provider training needs assessment. A study of this nature would more adequately identify the training needs, determine gaps in training opportunities and provide quantitative information about what is available or not.

The information contained in the second chapter of this report will provide an overview of the findings of the Children's Professional Provider Mental Health Training Needs Assessment.

## **Chapter 2- Utah Department of Health Professional Mental Health Provider Training Needs Assessment**

### Introduction

The Utah Department of Health report on System Capacity in Children's Mental Health (Utah Department of Health, 2007) called for a comprehensive review of training interest and need within the professional mental health community. As a result, the department's Bureau of Maternal and Child Health completed a Professional Mental Health Provider Training Needs Assessment. The needs assessment surveyed licensed providers currently practicing in the following mental health professions:

- Psychologist (PSY)
- Social Worker (LCSW and CSW)
- Licensed Professional Counselor (LPC)
- Marriage and Family Therapist (MFT)

Psychiatrists and Advanced Practice Registered Nurses (APRN) were excluded from the survey because the list of physicians and APRNs doesn't identify speciality practice.

### Methods

Lists of professionals licensed to provide mental health care and treatment were obtained from the Utah Department of Commerce, Division of Occupational and Professional Licensing (DOPL). DOPL is the state professional oversight agency and updates the licensing list on a daily basis.

A questionnaire consisting of twelve items was created (see Appendix A). The questionnaire was divided into four general sections, background information, issues related to training, specific training topics and demographic information.

### Results

#### Professional Background Data

The questionnaire was mailed in October, 2006 to 4765 licensed mental health professionals. A total of 1395 questionnaires were returned completed, a response rate of 30.9%. Of the 1395 respondents, 89% are currently practicing in a clinical setting. The remaining

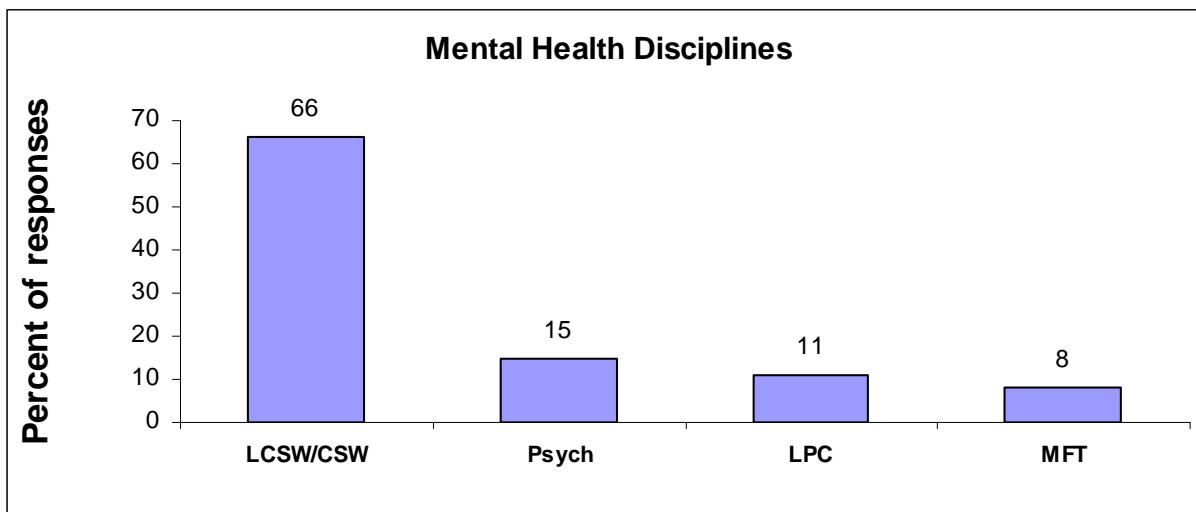
works as administrators, retired, or have relocated out of state/country, or are not currently working as mental health providers.

The following figures are provided as background information on the licensed professionals related to the number and percent of licensed professionals, where they practice, with whom they practice and the types of payment accepted. The numbers are not mutually exclusive because many professionals are dually licensed, practice in multiple settings with many different types of clients and accept reimbursement from multiple sources.

Information in this report reflects respondent’s answers to the survey questions. It should not be interpreted as definitive information about the number of providers working in a given area nor can individual data be compared to determine differences. As previously noted, this information is offered as background into the respondents and their practice.

Figure Two indicates the percentage of respondents by discipline. The highest percentage was social workers (66%), followed by psychologists (15%), professional counselors (11%) and marriage and family therapists (8%).

**Figure Two: Percent of Respondents by Profession**

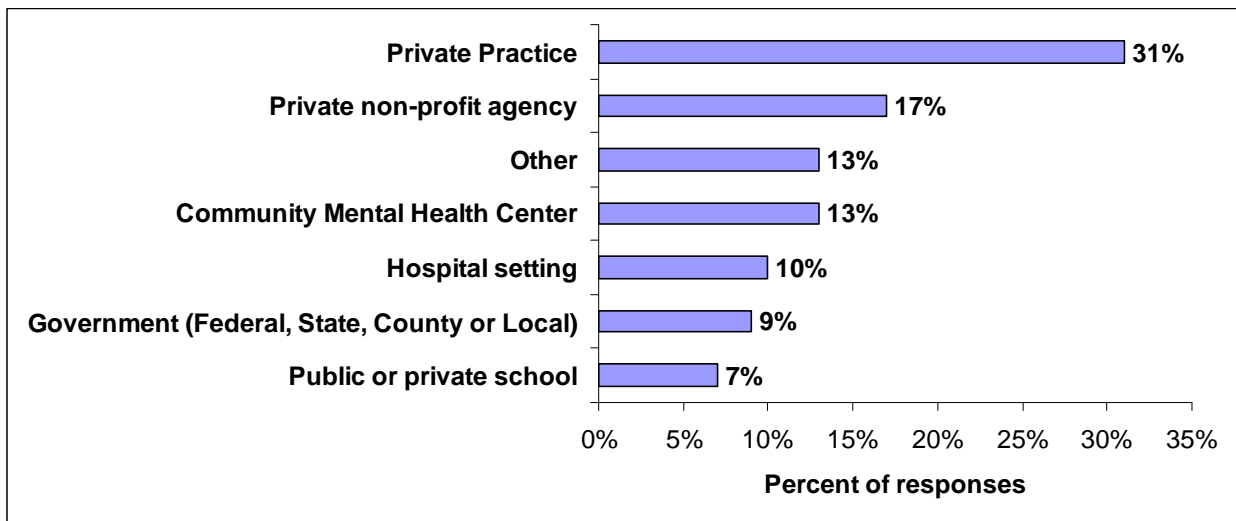


The majority of respondents (31%) work in private practice settings, followed by private non-profit agencies, community mental health centers, hospital and government agencies, as noted in Figure Three. Respondents indicating “other” report that they work in corrections, adolescent residential treatment facilities, substance abuse, geriatric settings (i.e. long term care

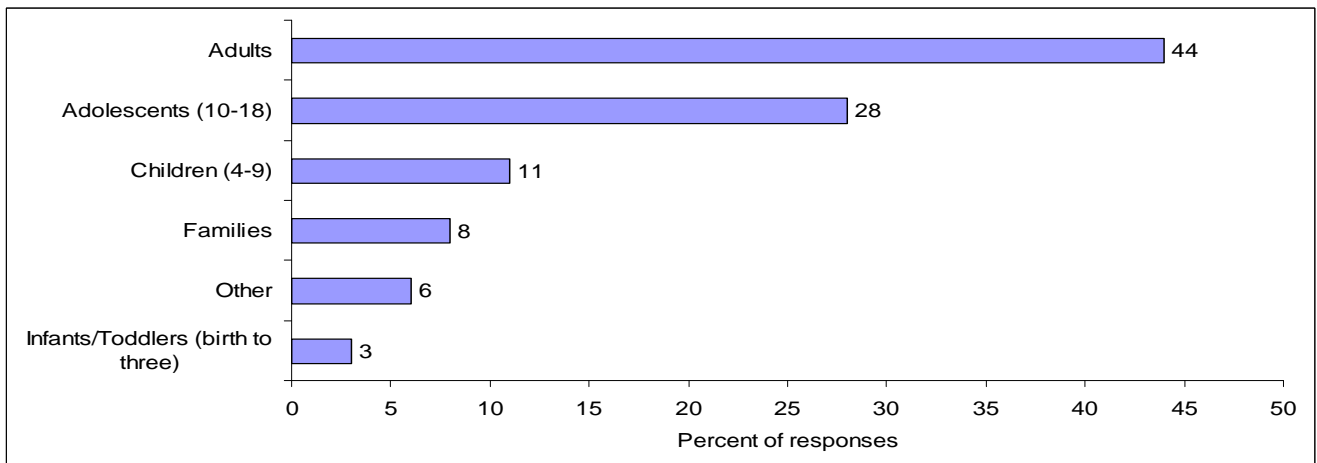
facilities), or as administrators of mental health agencies. Of the administrators the most common were social workers teaching at colleges and universities.

Figure Four provides information on the population served as reported by respondents. The majority of respondents work with adults (44%) followed by adolescents, young children, families, “*other*” (which includes, geriatrics, corrections, managed healthcare, etc) and infant/toddlers. This figure reflects the anecdotal concerns often expressed in the questionnaire comment section and discussed in professional circles throughout the state that there appears to be a very small percentage of mental health professionals serving children under nine. Specific concern is raised in the low percentage of respondents indicating that they work with infants/toddlers birth to three.

**Figure Three: Type of Practice Setting**



**Figure Four: Population Served as Indicated by Respondents**



The most common payment source is private insurance consistent with the large number of providers in private practice. Over one-third of the respondents indicate they accept either Medicaid or Children’s Health Insurance Program (CHIP). CHIP is Utah’s SCHIP plan and provides health insurance for children who are under age 19, not currently covered by health insurance, are legal residents or U.S. citizens and meet the income guidelines (at or below 200% of federal poverty level). A large number of respondents indicated payment from less common sources. “*Other*” payment sources include:

- Religious organizations
- Medicare
- Other government programs
- Private resources or self pay
- Cash, check or credit
- Free of charge

The data show that most clinicians practice in multiple counties which are generally in close proximity to one another. The majority (69%) work in the urban counties located along the Wasatch Front.

#### Training Data

The professional mental health provider training needs assessment surveyed respondents specific to attendance at training, preferred training format, and barriers to obtaining training. The majority of respondents (91%) indicated that they had received training in children’s mental health within the last two years. Additionally 83% of the respondents indicated that they feel they have adequate opportunity to attend training.

The most common barriers to training as reported by respondents are time and cost, with the majority of the respondents (40% in private practice and 15% working in public agencies) indicating that their workload and expensive conferences result in challenges in attending training. Other barriers are limited training in rural areas and lack of interest in topics offered. Figure Five on page 21 further outlines the information on common barriers to participating in training.

**Figure Five: Barriers to Training**

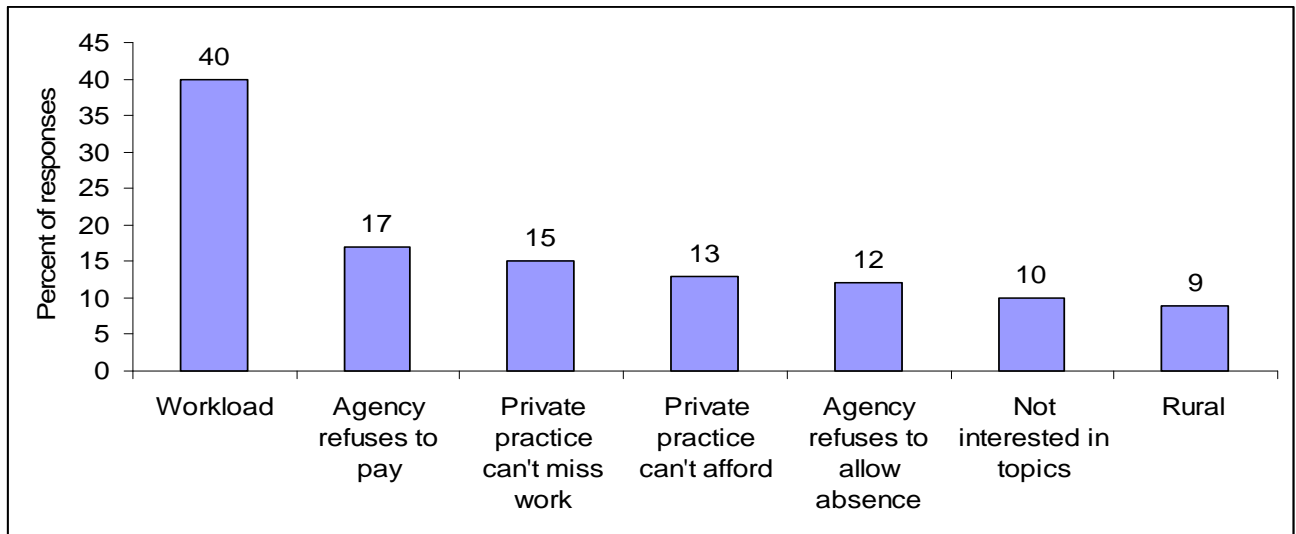
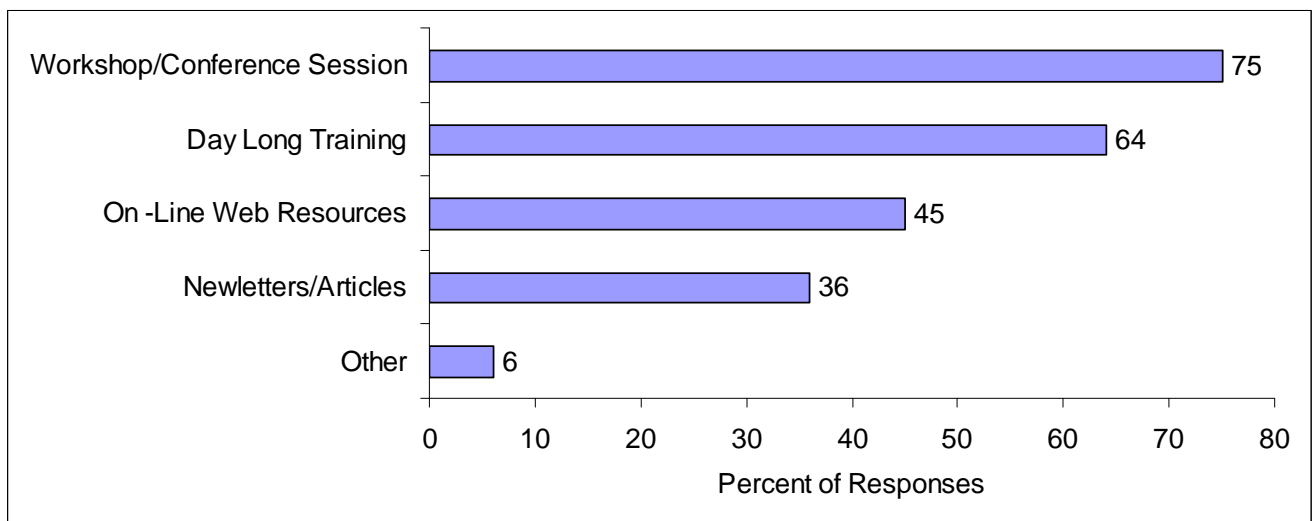


Figure Six lists the format preferences. Respondents indicated a strong preference in attending either workshops or day long training programs (75% and 64% respectively). A large number of respondents recommended allowing more non-traditional types of training including: review of newsletter articles or on-line resources, with continuing education hours (45% and 36%). Other format areas included audio recordings, video/DVD trainings, or sitting in on actual therapy sessions with discussion afterward.

**Figure Six: Preferred Training Formats**



Specialized Training

Respondents were asked to rank order a list of topics specific to children’s mental health and system of care. Children’s mental health topics were infant/toddler mental health, children’s

mental health, adolescent substance abuse treatment, youth suicide prevention, mental health in schools and maternal depression.

The data reveal that the majority of respondents were mostly interested in training on children's mental health and adolescent substance abuse treatment. These were followed by youth suicide prevention, maternal depression, mental health in schools, and infant/toddler mental health. An option for "other" was provided. Respondents marking "other" generally listed topics that were either additional to the six choices or topics on adult mental health, adult substance abuse, sexual and physical abuse (including sex offender treatment, domestic violence, geriatrics, parenting skills, or self harm).

Responses to the system of care question indicate that the topic of most interest is clinical diagnosis and treatment (74%) which includes the use of evidence-based practice with nearly half of the respondents indicating an interest in engaging families in service delivery or planning (49%). These were followed by legal, ethical and confidentiality (42%), collaboration between primary and subspecialty care providers (41%) and promoting cultural diversity and cultural competency (35%).

The final question in this section was about their top three training interests. This question provided the most specific insight into the types of training mental health professionals are interested in. The top topics include:

- Specific treatment techniques (including evidence based practices)
- Clinical diagnosis
- Substance abuse (adult and adolescent)
- Early childhood developmental and social emotional delay
- Physical, sexual and domestic abuse
- Parenting
- Pharmacology
- Marriage, divorce and custody issues
- Cultural competency (including gay, lesbian, bi-sexual and transgender)
- Grief and loss
- Suicide prevention
- Adoption and foster care
- Trauma

Data indicated that clinicians are most interested in topics related to clinical diagnosis and treatment techniques. The review of specific diagnosis and treatment categories reveals that the areas of most interest are:

Clinical diagnosis specific to children and adolescents:

- Attachment
- Mood Disorders
- Autism
- Attention Deficit Hyperactivity Disorder (ADHD)
- Anxiety Disorders

Clinical diagnosis specific to adults:

- Anxiety Disorders
- Mood Disorders
- Maternal Depression
- Eating Disorders
- Personality Disorders

Treatment modalities:

- Family Therapy (all)
- Play Therapy
- Relationship Therapy (couples and marriage)
- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)

### Early Childhood Mental Health

Early childhood mental health or healthy social emotional development has gained increased attention in recent years. The science of early childhood development has shown that the first three years of life represent a period of intense growth and development providing a foundation for a child's ability to interact with others, move through their early developmental milestones and make sense of the world. (Shonkoff, et. al., 2000)

Given the importance of early childhood development it is critical that the mental health workforce be provided with every opportunity possible to develop the skills necessary to address the many challenges of serving this population. As the importance of early childhood development has risen to the surface so has the realization that the workforce is unprepared to address infant/toddler needs. Shonkoff and Phillips in their seminal work *From Neurons to Neighborhoods* reported that there is a critical need to expand the number of individuals available to work in environments with young children in order to successfully promote healthy

social emotional development and to provide early detection and intervention through screening, referral and treatment of serious early childhood mental health issues. (Shonkoff et. al., 2000)

Data from the Professional Mental Health Provider Needs Assessment indicate that very few clinicians regard themselves as working exclusively with infant/toddlers and that most prefer to focus their children's work on those from age nine to eighteen. However, those who indicated that they focus on the early childhood population indicate a strong desire for specialized training in early childhood mental health and maternal depression. These were followed by children's mental health (ages nine to eighteen), adolescent substance abuse, youth suicide prevention and mental health in schools.

Data analysis specific to desired training in early childhood developmental or social emotional delay found that the top three topics listed by respondents are attachment (including reactive attachment), autism and attention deficit hyperactivity disorder (ADHD). Maternal depression follows very closely, a significant finding as early childhood professionals have long recognized the role that maternal depression plays in attachment, development and mental health disorders in developing infants, toddlers and young children. The remaining topics included other early childhood development (including developmental and learning disabilities), infant/toddler mental health, fetal alcohol syndrome, Aspergers, and training in use of diagnostic tools and specific intervention techniques.

#### Utah's Mental Health Workforce

Utah's mental health community is primarily Caucasian (96%), female (61%) and has a mean age of 47.6 years. The Professional Mental Health Provider Training Needs Assessment was designed to survey only clinically licensed mental health providers with at least a Master's education. Of the respondents who indicated information on educational background 78% indicated a Master's, and 22% a Doctorate. The category "other" would include any additional degree or certificate to a master's or doctorate.

#### Summary

The background data from the Professional Mental Health Provider Training Needs Assessment indicate that the mental health profession in Utah consists largely of social workers in private practice, primarily serving adults with private insurance. The data further indicate that very few professionals specialize in working with infants/toddlers, but are working with older

children or adolescents. Many clinicians indicate they provide care in multiple settings to multiple populations.

Information on access to and attendance at training indicates that mental health workers in Utah are committed to furthering their professional skills and abilities. The majority of respondents (83%) reported they have adequate opportunities to attend trainings, however 10% indicated that they are not interested in the topics offered. Most indicated they have received training focusing on children's mental health within the past two-years. Forty percent of the respondents indicated that workload interferes with their ability to attend training followed by cost and geographic location.

The most common formats preferred were workshops, conference, or day long training sessions. Of interest was the large number of respondents who indicated that they would appreciate the opportunity to obtain training and receive continuing education credits through more non-traditional formats including web resources, print newsletters/articles, DVD/videos/CDs, or observation and discussion.

Review of the data related to topics of interest reflects the level of interest and desire by respondents to "voice their opinions". Many respondents listed additional topics in the "other" training topic section and most listed more than three choices. A number of respondents provided additional comments on the back side of the questionnaire. It is clear from the information that mental health professionals are deeply committed to enhancing knowledge and skills. They have clear opinions of the topics of interest and desire training specific to children's (and adult) mental health.

### Conclusion and Next Steps

This needs assessment is the first of its kind in Utah and provides a baseline for future studies of this nature. It will provide a critical link as Utah providers and agencies begin addressing the goals of the New Freedom Commission Report and the National Technical Assistance Center for Children's Mental Health at Georgetown University.

The Needs Assessment will be of further use when addressing anticipated increases in demand for new mental health providers. The 2006-2007 Bureau of Labor Statistics Occupational Outlook Handbook projects that the demand for new mental health providers will increase between 18% and 26% nationwide by the year 2014 (United States Bureau of Labor Statistics) Much of the need is attributed to the aging population and number of baby boomers

entering into retirement; however since Utah has the highest birth rate in the nation, it is clear that the increase in need will also affect work with children, adolescents and their families in our own state. An increased demand for mental health providers will lead to increased training needs or specialized to advanced level practice. This study will provide the vehicle to address the anticipated needs.

The study provides information indicating interest in children's mental health promotion, training needs and training gaps in context with providing children's mental health services in Utah. The assessment information provides a background to develop a workforce development plan that assures cogent training for mental health providers. A more developed mental health workforce leads to higher quality care and services to children, adolescents and their families.

The assessment reflects the level of professional training desired and highlights the common barriers of time, expense and lack of interest in offered topics that interfere with participation. Furthermore, the needs assessment points out that providers are interested in pursuing more "non-traditional" forms of training, including, review of CD/DVDs, self-study of print newsletter or articles, and clinical observation and discussion.

The needs assessment provides a view of the variety of training topics of interest which varies from clinical diagnosis and specific treatment techniques to cultural competency, suicide prevention, and physical and emotional abuse. It provides a clear picture that providers are very interested in having input into the types and quality of training offered throughout the state. Further, it makes a critical statement encouraging conference sponsors to be responsive to identified training needs in conference planning and conference integrity. Simply put conference sponsors are in a position to support workforce development on a local level by collaborating with the professional disciplines they are trying to reach.

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Appendix A-

Mental Health System Professional Needs Assessment Questionnaire

**Children's Mental Health Training Needs Assessment 2006**

This study is being conducted by the Utah Department of Health, Maternal and Child Health Bureau to determine gaps in specialized training of mental health professionals working with families, young children, youth and postpartum mothers in Utah. We need your input. Please fill out the following questionnaire.

1. Do you currently provide any clinical mental health services in Utah?

Yes

No (If no, please indicate why, e.g.; retired, administrative, etc.)

\_\_\_\_\_  
\_\_\_\_\_

2. Please describe your primary practice. (Please check one)

Psychologist

Social Worker (LCSW, CSW)

Licensed Professional Counselor

Marriage and Family Therapist

Other \_\_\_\_\_

3. Please indicate your current primary practice setting. (Please check one)

Private Practice

Community Mental Health Center

Private non-profit agency

Public or private school

Hospital setting

Government (Federal, State, County or Local)

Other (Please specify) \_\_\_\_\_

4. What is your PRIMARY client population? (Please check one)

Infants & Toddlers (Birth-3 years)

Children (4 years -9 years)

Adolescents (10 years -21 years)

Adults

Families

Other (Please specify) \_\_\_\_\_

5. In which county(ies) do you provide services? (List all that apply)

\_\_\_\_\_

6. What type of payment(s) do you or your facility (agency) generally accept? (Please check all that apply)

- Private Insurance
- Medicaid
- No insurance accepted
- Sliding Fee Scale
- CHIP
- Other (Please specify) \_\_\_\_\_

7. Please rank the following mental health topics in order of importance for you in your practice by indicating 1-6, with 1 being the most important:

- Infant/toddler Mental Health/healthy mental development (birth to five)
- Children's mental health (includes depression, anxiety, ADHD, bi-polar, etc)
- Youth Suicide Prevention
- Mental health in the school setting
- Adolescent substance abuse
- Maternal depression
- Other (Please list) \_\_\_\_\_

8. Please select from the following list the continuing education areas you would be interested in receiving information. (Please check all that apply)

- Promoting cultural diversity and cultural competency
- Legal, ethical and confidentiality issues
- Engaging families in service delivery or health care planning
- Collaboration between primary and subspecialty care providers
- Clinical diagnosis and treatment

9. Have you received any training within the last two years specifically related to any of the topics listed in question 7 or 8?

- Yes
- No

10. What is your continuing education requirement for licensure?

\_\_\_\_\_

11. Do you feel that you have adequate opportunities to participate in continuing education programs?

- Yes
- No (Please explain) \_\_\_\_\_

\_\_\_\_\_

12. Please list the reasons that may limit your participation in continuing education. (Please check all that apply)

My agency makes it difficult for me to miss time at work to attend training.

My agency refuses to pay for training.

My workload makes it difficult to attend.

I am in private practice and cannot afford time away from paying clients.

I am in private practice and cannot afford to pay for training.

I am in a rural area and there is no training available near me.

I am not interested in the topics offered.

Other (Please list) \_\_\_\_\_

13. What additional training topics would you be interested in receiving? Please use this section to list your top three topics related to children and family mental health issues.

---

14. What type of training format would be beneficial to you?

(Please check all that apply)

Workshop/conference session

Day long training

Newsletter/articles

On-line web resources

Other (Please specify) \_\_\_\_\_

#### Demographic Information

This section is to obtain basic demographic information about you.

Age: \_\_\_\_\_

Gender:  Male

Female

Education:  Masters

Doctorate

Other (Please specify) \_\_\_\_\_

Ethnicity:  Hispanic/Latino

Non Hispanic/Latino

Race:  White  
 Black/African American  
 Hawaiian/Pacific Islander  
 Asian  
 American Indian/Alaskan Native  
 Other (Please specify) \_\_\_\_\_

**THANK YOU VERY MUCH FOR YOUR TIME**

*Utah Department of Health*

