

Behavioral Health Workforce Survey Data Report

**Behavior Analyst, Marriage and Family Therapist, Clinical
Mental Health Counselor, Social Worker, and Psychologist**

February, 2026

Table of Contents

Table of Contents	2
Executive Summary	4
Key Findings	4
Introduction	5
The scope of this report	5
Methodology	7
Health workforce survey	7
DOPL data preparation and analysis	7
Other data sources	7
Limitations	9
Survey Results	10
Survey response rate	10
Demographics	11
Age	11
Sex and gender	13
Race and ethnicity	15
Education	17
Highest education	20
Education debt	21
Geography	25
Employment Characteristics	27
Employment status	27
Employment arrangement	29
Employment roles	32
Patient characteristics	34
Payment Methods	37

Practice characteristics	40
Setting	40
FTE and direct patient care hours	43
Telehealth services	45
Future employment	47
Two-year employment intentions	47
Precepting	51
Care Coordination	57
Paraprofessionals	60
Comparative Insights	64
DOPL license counts trends	64
Gender, Race, and Ethnicity Distribution in Education and Debt	65
Sustainability	73
Workforce Supply and Demand	74
Demand	74
Supply	75
Conclusion	83
Appendix 1 - DOPL supply survey	84
Objectives	84
Target population	84
Response rates	84
References	88
Contact information	91

Executive Summary

The Utah behavioral health workforce is expanding, but faces critical challenges in geographic distribution, demographic representation, and financial sustainability. Since 2015, the number of active licenses has doubled, yet this growth is unevenly distributed across professions and regions. Although the Behavior Analyst workforce has grown substantially, the supply of Psychologists and Social Service Workers has grown more slowly.

Key Findings

- **Geographic Access Gaps:** Rural and frontier areas face severe shortages. Providers in these regions report higher working hours, increasing the risk of burnout. Psychologists have the lowest telehealth utilization in frontier areas at just 4.9%, significantly limiting access for remote residents.
- **Representation:** The workforce does not reflect Utah's demographic. Only 10% of the workforce identifies as non-white, compared to 24% of the state's population. Hispanic providers are underrepresented (10.9% of the workforce vs. 16.8% of the population) and face higher student debt.
- **Barriers to Care:** Private-sector settings represent most of the market and prioritize private insurance and self-pay. Limited Medicaid and Medicare acceptance, combined with low rural telehealth adoption, creates a "double barrier" for low-income and geographically isolated Utahns.
- **Sustainability Strains:** Utah is projected to face a deficit of 180 Mental Health Counselor FTEs and 920 Psychologist FTEs by 2028. Rising demand is overtaking supply, leading to increased workloads and a widening gap in workforce capacity.

Introduction

The Utah Health Workforce Information Center (HWIC, <https://hwic.utah.gov/>) was established in 2022 through HB176 (<https://le.utah.gov/~2022/bills/static/HB0176.html>) and is a key entity in efforts to collect and analyze healthcare workforce data in Utah. This legislation also created the Governor’s Health Workforce Advisory Council (HWAC), which provides strategic guidance and oversight on policies and initiatives to strengthen the state’s healthcare workforce across all sectors. The Department of Professional Licensing (DOPL), responsible for the licensing of healthcare professionals in Utah, is now required to integrate workforce survey questions into the licensing process. These surveys, previously developed and administered by the Utah Medical Education Council, help inform decisions regarding workforce trends and needs. By incorporating these surveys and capturing this data, the HWAC will now have data to inform health workforce initiatives and recommendations for Utah. This primary data will be integrated with state-level metrics, including education enrollment, paraprofessional records, unemployment insurance, and population statistics, alongside Help Wanted Online Job Posting and the Office of Professional Licensure Review’s findings. Furthermore, data from the Health Resources and Services Administration (HRSA), Bureau of Labor Statistics (BLS), Bureau of Economic Analysis (BAE), and National Provider Identifier (NPI) will provide the national context for a comprehensive evaluation of Utah’s behavioral health workforce landscape. Contact information is provided at the end of this report to assist with communicating additional details and answering questions.

The scope of this report

While “behavioral health” and “mental health” are often used interchangeably (CMS, 2025), behavioral health is increasingly recognized as a broader discipline. It encompasses mental health while also addressing the complex interplay between physical wellness and behavioral patterns, such as lifestyle choices and habits (Salt Lake Behavioral Health, 2025).

This report focuses on eight licenses regulated by the Utah Division of Professional Licensing (DOPL), as detailed in Table 1. The following sections outline the specific educational requirements, clinical hours, and key scope of practice for each credential. Although Behavior Analysts and Assistant Behavior Analysts do not provide traditional

mental health therapy, they are included in this report for two reasons: their focus on behavioral modification aligns with the broader definition of behavioral health, and both classifications are integrated into the state's behavioral health workforce data through their license renewal surveys. Because Substance Use Disorder Counselor (SUDC) license renewals followed a separate cycle, their survey findings will be provided in a standalone report. Additionally, the totals in the data below are separated into categories that include and exclude behavioral analysts. This distinction is made because behavioral analysts do not typically provide therapy and treatment services in the same way that CMHCs, MFTs, social workers, and psychologists do.

Table 1. Licenses' requirement and practice scope

License type	Education requirement	Clinical hours required	Key scope of practice
Behavior Analyst (LBA)	Master's or Doctorate in Applied Behavior Analysis (ABA)	1,500 experiential hours (within 5 years)	Specialized: Design/evaluate environmental modifications to improve behavior. Cannot perform mental health therapy.
Assistant Behavior Analyst	Bachelor's in Applied Behavior Analysis (ABA)	1,000 experiential hours (within 5 years)	Supervised practice: Must work under a qualified Behavior Analyst; cannot practice independently.
Clinical Mental Health Counselor (CMHC)	Master's or Doctorate in CMHC or equivalent (60 semester hours)	3,000 total hours (minimum 2 years); includes 1,200 direct client hours	Independent practice: Mental health therapy, evaluation, and treatment of emotional/behavioral disorders.
Marriage and Family Therapist (MFT)	Master's or Doctorate in Marriage and Family Therapy	3,000 total hours (minimum 2 years); includes 1,200 direct client hours	Independent practice: Focus on family systems, relationship dynamics, and individual mental health therapy.
Psychologist	Doctorate in Psychology (accredited)	4,000 total hours (1,000 must be in mental health therapy)	Independent practice: Psychological testing, neuropsychology, and mental health therapy.
Clinical Social Worker (LCSW)	Master's (CSWE accredited) or Doctorate in Social Work	3,000 total hours (minimum 2 years); includes 1,200 direct client hours	Independent practice: Mental health therapy, psychotherapeutic principles, and supervision of CSWs/SSWs.
Certified Social Worker (CSW)	Master's or Doctorate in Social Work	N/A (Must be supervised for therapy)	Hybrid: Independent in general social work; supervised when performing mental health therapy/psychotherapy.
Social Service Worker (SSW)	Bachelor's in social work OR Bachelor's in any field + 2,000 supervised hours	2,000 hours (if degree is not in Social Work)	Entry level: Case management, psychosocial assessment, and supportive counseling. Cannot diagnose or treat mental illness.

Utah State Legislature Act, 2025

Methodology

Health workforce survey

All practitioners who were eligible for online renewal were offered the survey during their license renewal process, and participation was voluntary. These types of sampling designs are often referred to as convenience or non-probability samples. The statistical analysis included in this report represents individuals who participated in the survey.

Comprehensive unit and item non-response rates are provided to support interpretation of the results (see Appendix 1).

Behavioral health providers whose licenses had expired the previous two years were eligible for online renewal and were invited to participate in the survey. DOPL reported there were 20,184 behavioral health workforces eligible for renewal, and 10,817 of them provided a valid DOPL license number and responded to at least one survey question; the survey response rate was approximately 53.6%. Comprehensive unit or item response rates are provided to guide the interpretation of the results. These are in the methodology section at the end of this report. Additional limitations that provide important context for subsequent report information will be included on an as-needed basis.

DOPL data preparation and analysis

Once the renewal period closes, quality checks are performed, including evaluation of duplicate respondent records, questions with multiple responses, and null-type values. Only respondents who replied to a question and provided a valid license number are included in the analysis. Invalid license numbers may introduce bias, as the invalid data might represent a distinct group that could potentially skew results.

Other data sources

While the focus of this analysis is on the behavioral health workforce survey, supplemental data is also used to help contextualize the survey results and provide deeper insights into the behavioral health workforce in Utah. Other data sources that are included in this report include: Unemployment Insurance (UI), National Provider Identifier (NPI) data provided by Health Resources and Services Administration (HRSA), DWS Help Wanted Online Job Posting data, Utah System of Higher Education (USHE) data, SUMH UCLAPP data, OPLR

data, Kem C. Gardner data, Bureau of Labor Statistics (BLS) data, and Bureau of Economic Analysis (BEA) data.

Unemployment Insurance (UI) analysis is based on data captured through the Utah Department of Workforce Services' Unemployment Insurance program. Employers pay unemployment taxes based on the wages earned by their employees. A data sharing agreement is in place that allows HWIC to request data for individuals found in healthcare workforce professional licenses.

UI data has limitations. Notably, the data contains an industry code and employer name but does not specify geographic area, job title, or scope of work performed by the individual. The data indicates a provider was employed in a healthcare-related industry based on the North American Industry Classification System (NAICS) code. In addition, self-employed healthcare workers like those in private practice do not report their wages since they do not pay into the Utah unemployment insurance program.

The NPPES serves as the national system designed to assign unique identifiers to health care providers and health plans who apply for the National Provider Identifier (NPI) through the Centers for Medicare & Medicaid Services. NPIs are being used across the health care industry and government health care programs. Some data limitations are listed in Table 2.

School graduation counts and the number of programs comes from USHE (Utah System of Higher Education). DWS Help Wanted Online Job Postings data is obtained from a data request. DWS provides monthly counts of jobs from Standard Occupational Classification (SOC) codes associated with behavioral health. Data on behavioral health paraprofessionals has been requested from SUMH UCLAPP. Population statistics for Utah are sourced from the Kem C. Gardner Institute. Wages information comes from UI data as well as BLS and BEA data. Utah's mental health status is derived from the Behavioral Risk Factor Surveillance System (BRFSS).

Note that all 2020 data should be interpreted with caution, as the COVID-19 pandemic caused significant disruptions in healthcare staffing, hiring patterns, and workforce demand that may not reflect typical trends.

Table 2. Data sources comparison

Data source	Primary gap	Who or what is missed
UI Data	Coverage is limited to eligible claimants	Gig workers, self-employed, underemployed individuals
DOPL Data	A license does not equal employment. A person can hold an active license but be retired, unemployed, working in a different field, or working in another state	Unlicensed professions, unemployed/retired licensees
NPPES NPI	Relies on provider self-reporting. It includes "Ghost" Providers. An NPI is active for life unless formally deactivated.	Retired providers, correct addresses, current specialties
HRSA NPI Data	Inherits source gaps & data aggregation	Street-level detail, providers in low-population areas, time lags

HWIC collect, 2025

Limitations

This report only represents those healthcare workers who responded to the behavioral health workforce survey. The behavioral health workforce survey was distributed to all licensees in this report during the license renewal period, and participation was voluntary. Sampling designs dependent on voluntary participation are often referred to as convenience samples or non-probability samples. Convenience or non-probability samples likely introduce biases that can significantly distort estimates of population characteristics (Bailey et al. 2024). While the response rate for the behavioral health survey was 53.6%, providers who chose to respond to the survey may not be representative of the entire behavioral health workforce. Therefore, the statistical analysis included in this report only represents individuals who participated in the survey and does not attempt to make inferences about the entire population. Because the survey is neither a complete census nor a statistically valid random sample, results generalized to the entire behavioral health workforce in Utah must be interpreted with caution.

Additionally, license counts from the DOPL include all individuals holding an active license but do not confirm whether the licensee is currently practicing, practicing in Utah, or working in a behavioral health role. All employment and demographic information is self-reported, which introduces the potential for misclassification, recall bias, and error. Finally, the data represents a single point in time and does not reflect changes in the workforce that may occur after data collection. Despite these limitations, the report offers a meaningful starting point for understanding Utah's behavioral health workforce.

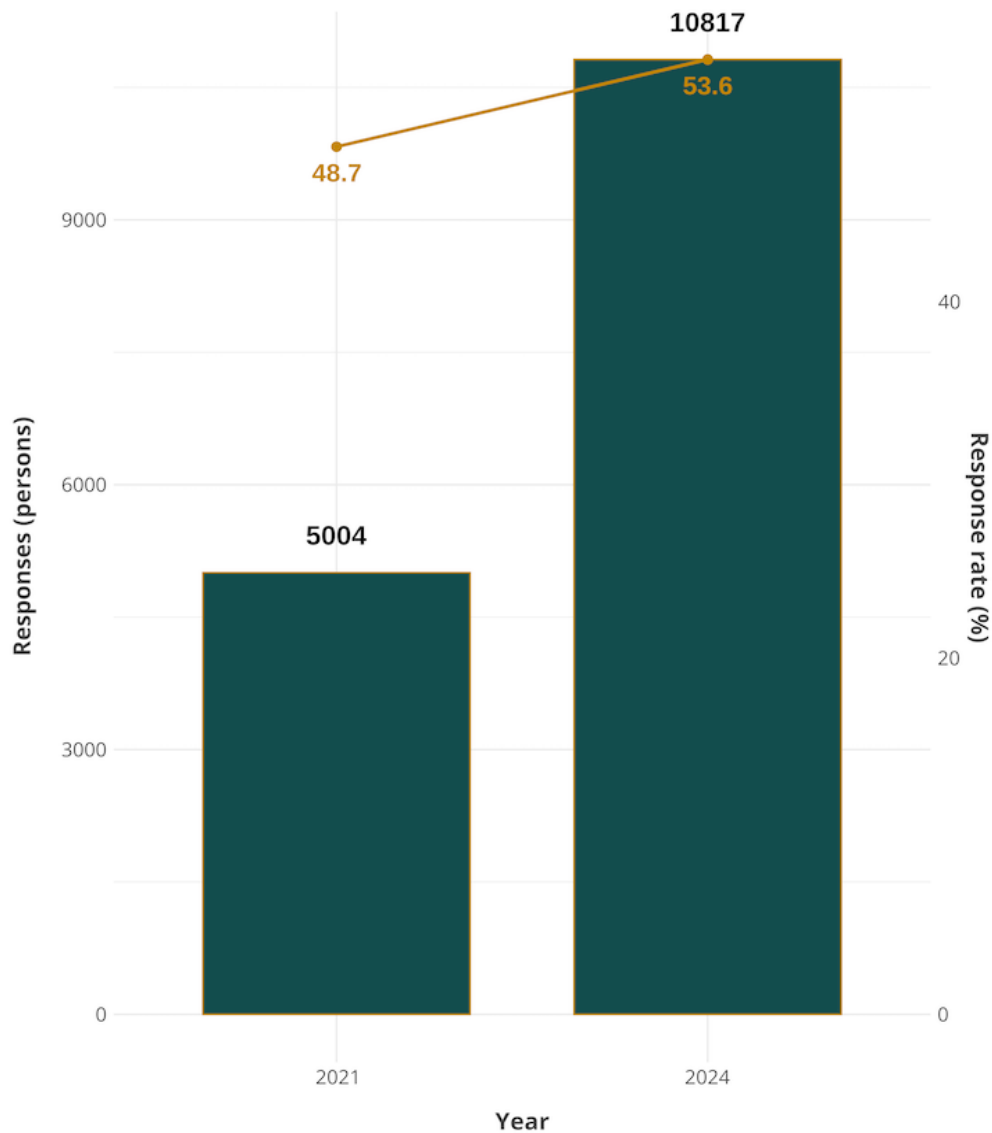
Survey Results

Survey response rate

Behavioral health providers who renewed their license during 2024 and those whose license expired in the previous two years were eligible for online renewal and were supposed to be invited to participate in the survey. Based on the population files supplied

Figure 1. Behavioral health survey respondents

Key takeaway: The respondents and response rate increase compared to past survey



Behavioral health workforce survey, Utah, 2024

by DOPL, approximately 53.6% responded to at least one survey question and provided a valid license number that matched the licenses from DOPL's database. This respondent rate is higher than the 2021 survey, which was administered by the Utah Medical Education Council (UMEC).

Figure 1 shows the count of respondents for the behavioral health workforce surveys. The 2024 survey results dramatically improved over the previous survey. The 2024 survey increases the number of responses by 116% from the 2021 survey. The item average response rates based on the number of respondents is 78%. Over 56% of the questions' response rate was over 95%, and lots of questions with low response rate were follow-up questions. All item response rates were detailed in the response rates portion of Appendix 1.

Demographics

The following section includes practitioner survey response information on demographic information such as age, race/ethnicity, and sex/gender.

Age

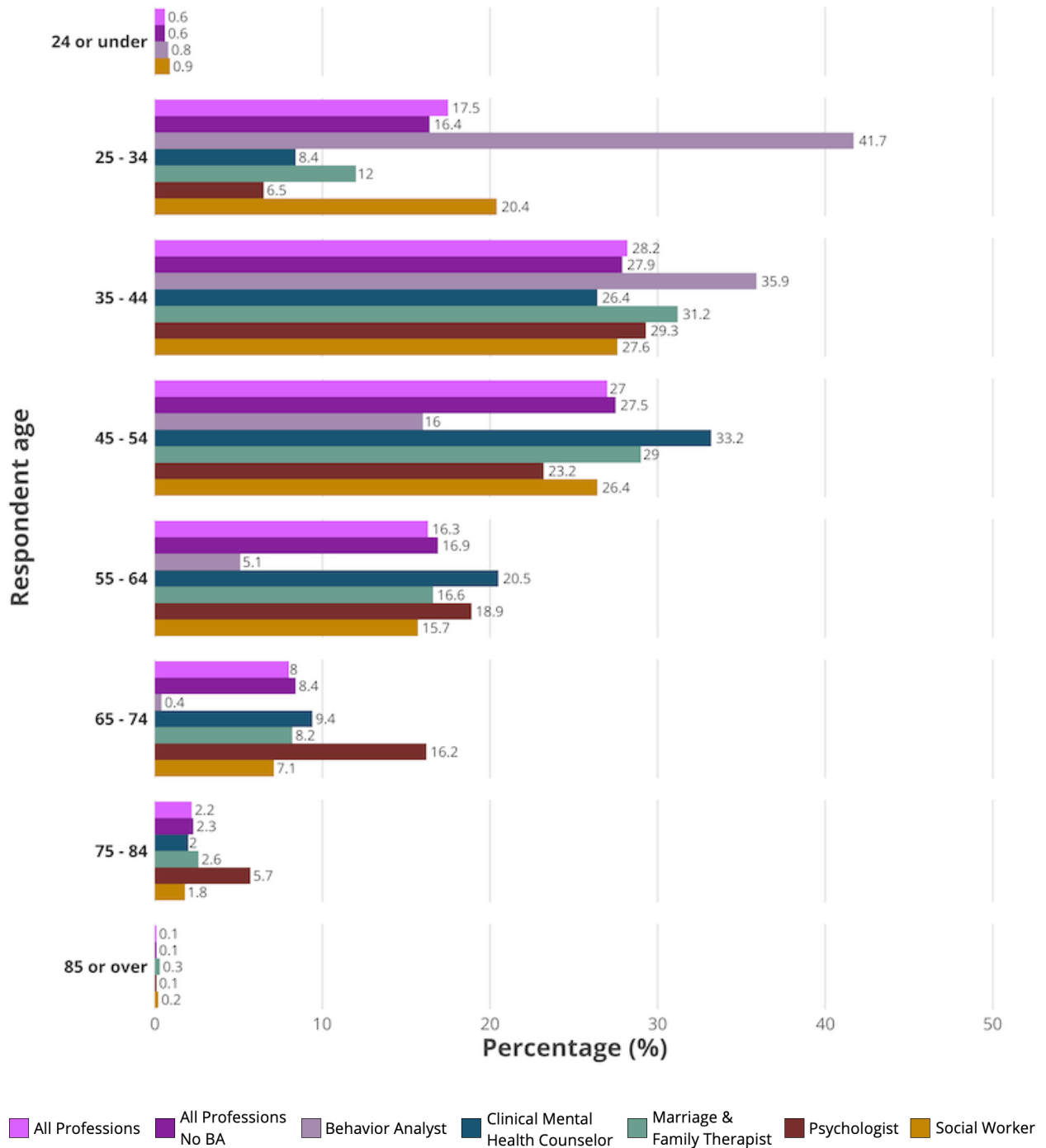
The age of the provider workforce is important to consider in anticipating supply levels.

Figure 2 shows the proportion of respondents within various age groups. The respondents' age data came from a DOPL database and not from the survey. Age was calculated by subtracting the day of the birth date from the date the survey was made available.

Approximately 55.2% of respondents in this survey were between the ages of 35 - 54. Compared to other professions, Behavior Analysts were younger than other professions. 41.7% of Behavior Analyst respondents were 25 to 34 years old, and 78.4% Behavior Analyst respondents were under 44. This concentration of younger professionals reflects that Behavior Analyst licenses were first established in Utah in 2015.

Figure 2. Behavioral health providers' age

Key takeaway: Most are between 35 to 54, but Behavior Analysts are in younger ages



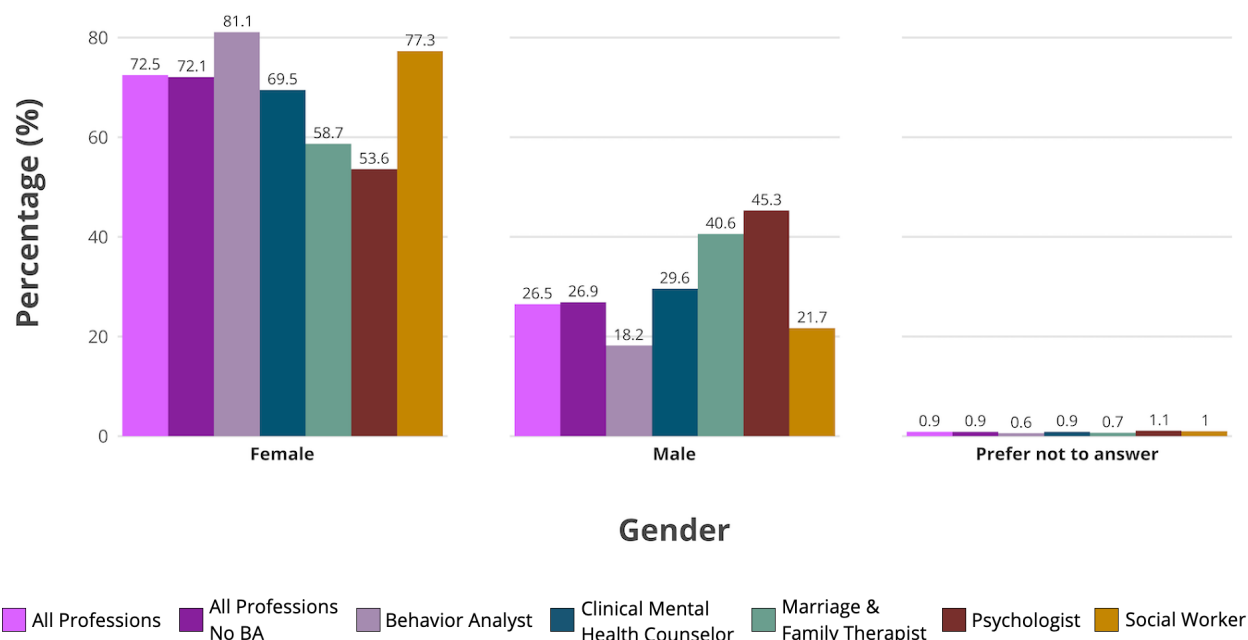
Behavioral health workforce survey, Utah, 2024

Sex and gender

Sex is an influential characteristic in patient-provider relationships, as it can affect communication, comfort levels, and overall patient experiences.

Figure 3. Behavior health providers' gender

Key takeaway: Most respondents are female; Behavior Analysts and Social Workers are dominant by female



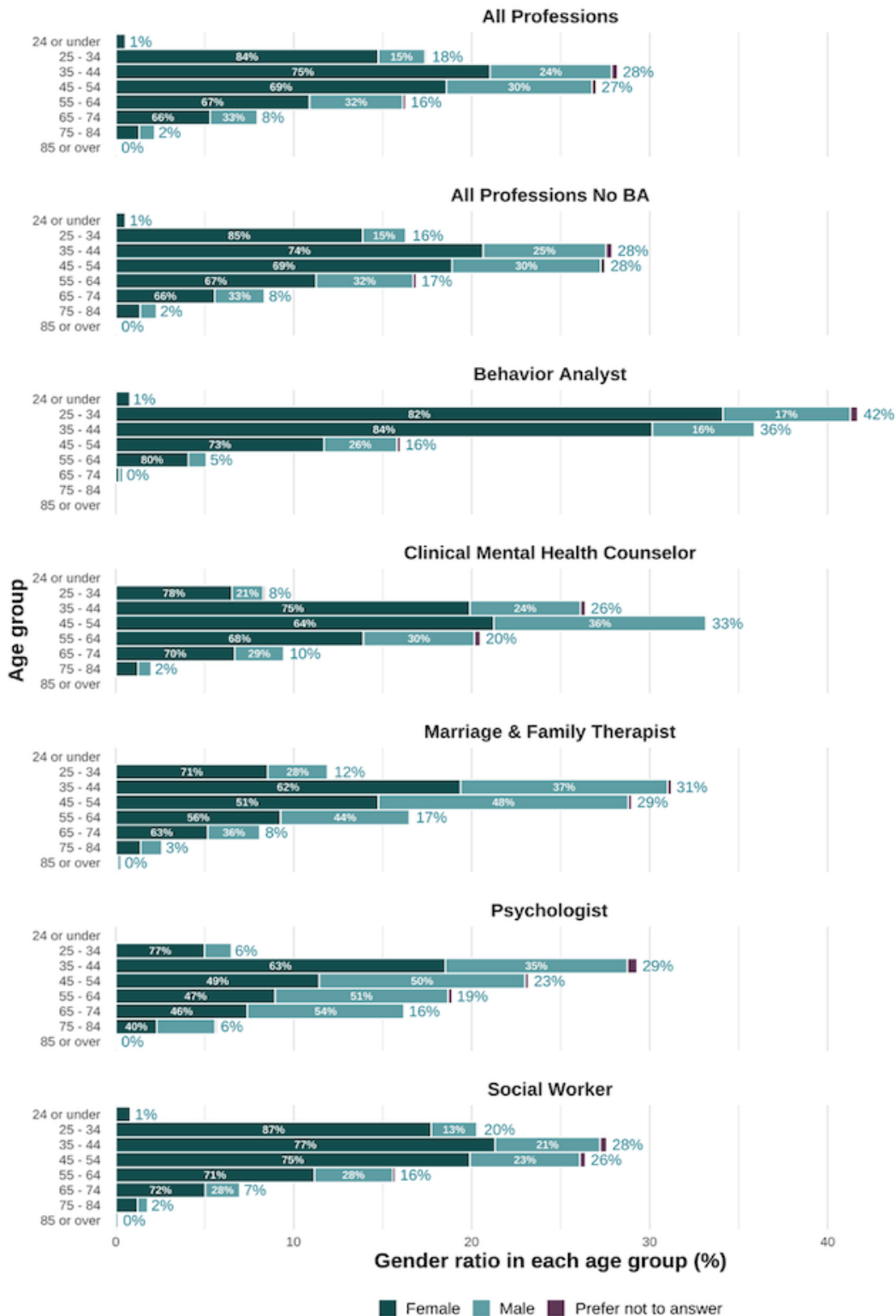
Behavioral health workforce survey, Utah, 2024

Figure 3 shows that the Utah behavioral health workforce was predominantly female, with approximately 72.5% of respondents identifying as female and only 26.5% identifying as male; the ratio of female to male was 2.7:1. Female providers were at least half in each profession. Over 77% of behavior analysts and social workers were female. Behavior analysts had the highest female-to-male ratio up to 4.5:1, and the social workers ratio was 3.6:1, highlighting a lack of male representation.

Figure 4 shows that female providers were the majority in every age group in most professions, except for psychologist. Male psychologists were more than female after age 45.

Figure 4. Age and gender distribution by professions

Key takeaway: Females are the main gender in behavioral health respondents



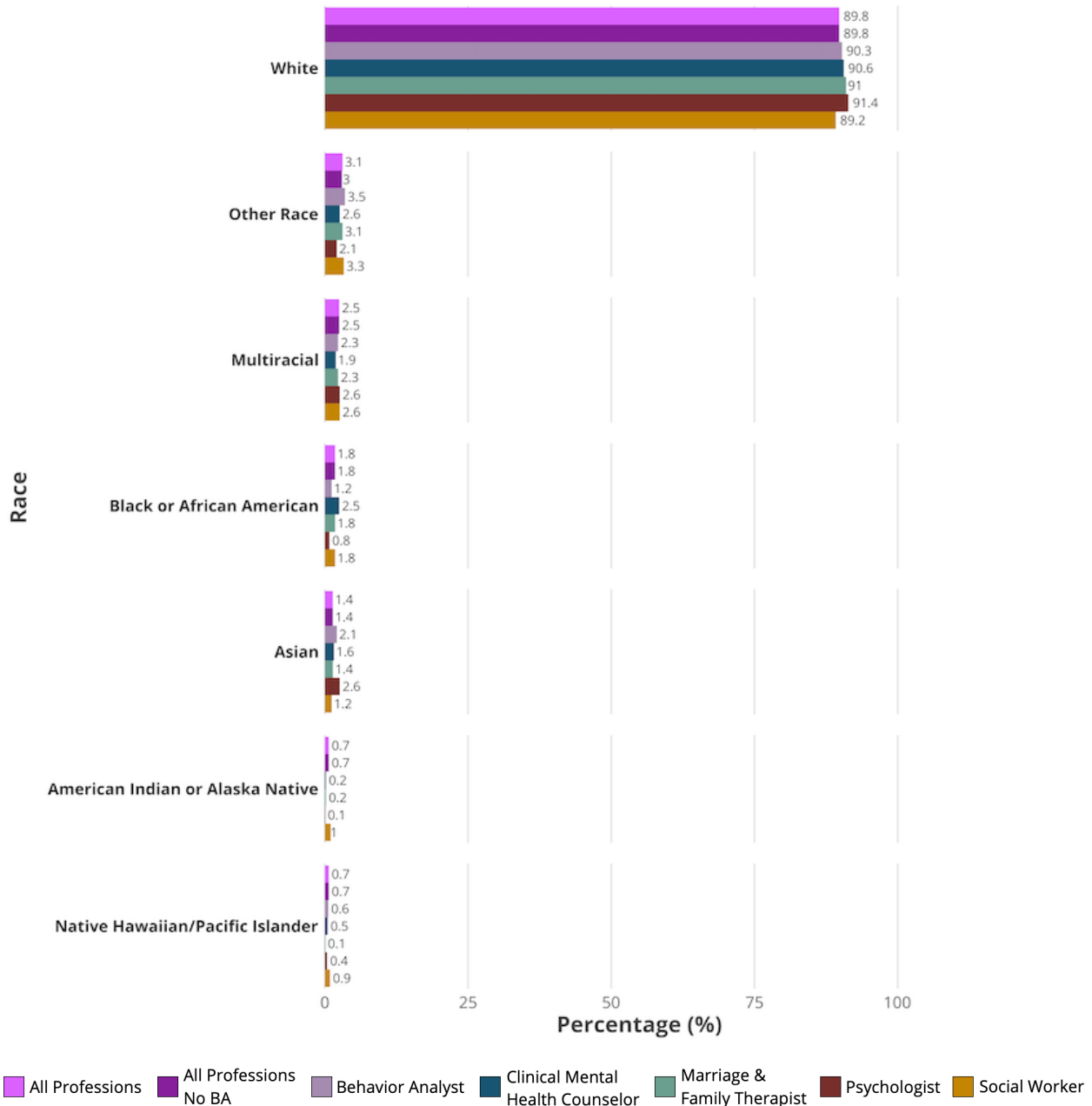
Behavioral health workforce survey, Utah, 2024

Race and ethnicity

Like issues of sex and gender, race and ethnicity were important to consider when analyzing provider workforce demographics (Togioka, et al., 2024).

Figure 5. Behavioral health respondents' races

Key takeaway: Most respondents are white



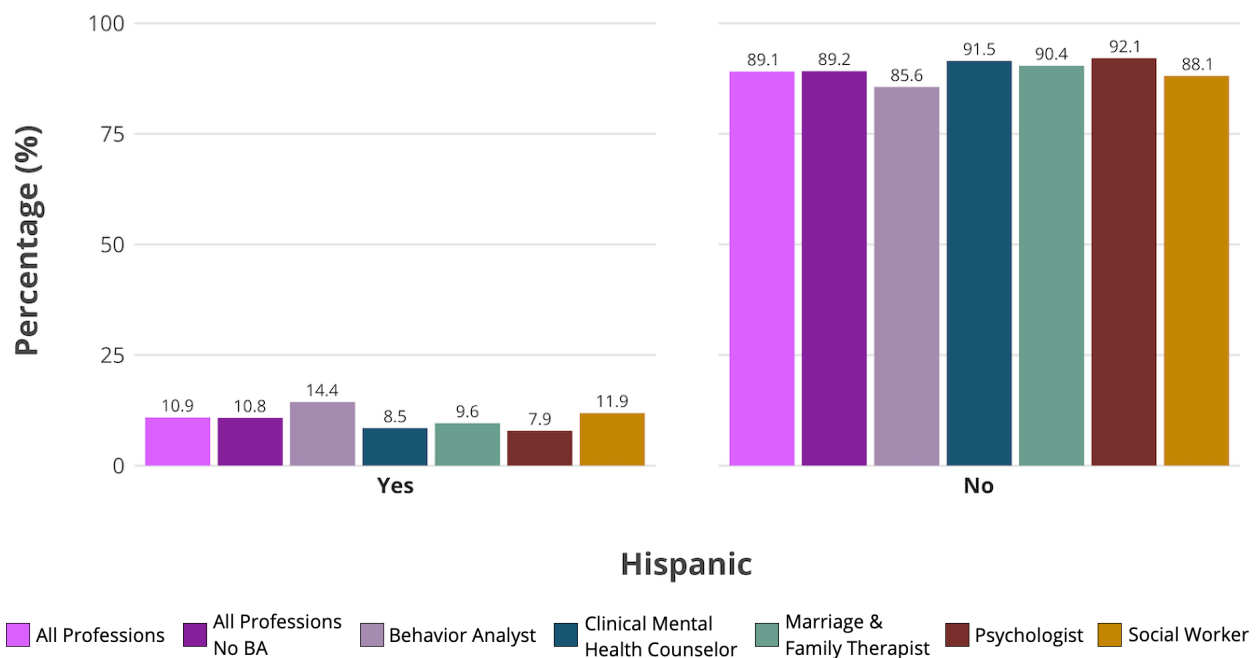
Behavioral health workforce survey, Utah, 2024

Figure 5 shows the race of respondents. Multiracial did not appear as a response option, but was created for this report by counting respondents who selected multiple racial options.

About 90% of behavioral health survey respondents were identified as white compared with roughly 76.5% of Utah's overall population in 2025 (reference for Healthy Salt Lake). This is also reflected in every profession. While findings are not displayed here, supplementary analyses showed that females were more than males in each profession by race, too.

Figure 6. Behavioral health respondents' ethnicity

Key takeaway: Most of respondents are not Hispanic



Behavioral health workforce survey, Utah, 2024

Additionally, 1,177 respondents were identified as Hispanic, shown in Figure 6, representing approximately 10.9% of respondents. Among the Hispanic respondents, 77.7% were female. Female Hispanic providers were mainly working as social workers and clinic mental health counselors, which counts of 644 and 109, respectively. Hispanic residents made up about 16.8% of the state's population in 2025. Increasing representation in the workforce could broaden perspectives and improve patient care.

Education

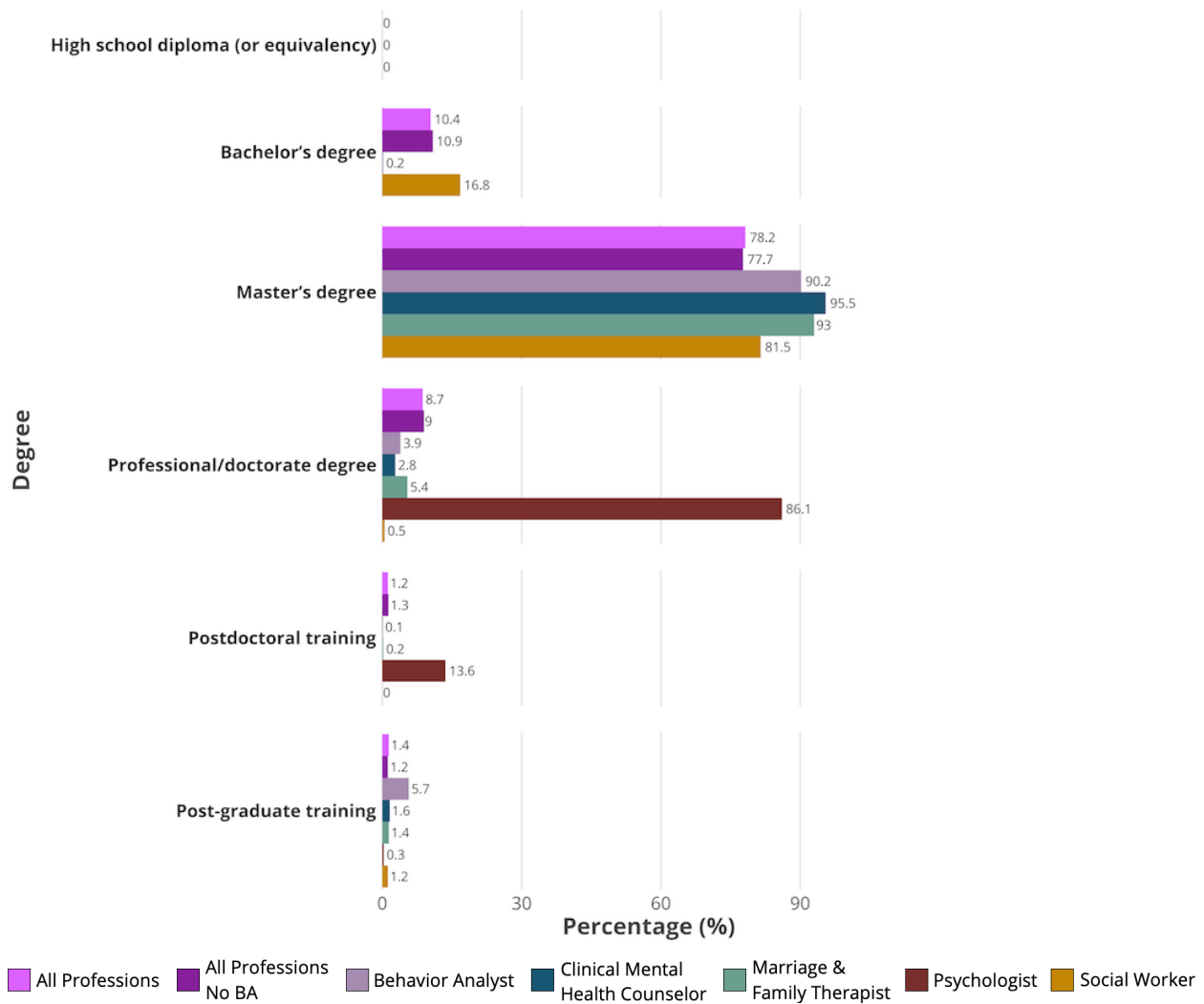
This section included practitioner survey response information on education, including qualifying education and highest education data, which are helpful for identifying common points of entry into the field and assessing the prevalence of advanced degrees. Understanding the distribution of advanced degrees also provides insight into career ladder trajectories and potential areas for growth.

Qualifying education

Aspects of providers' qualifying education, such as degree and degree location, were reviewed below.

Figure 7. Respondents' first qualifying education

Key takeaway: Most respondents' first qualifying degree are at least master's degree

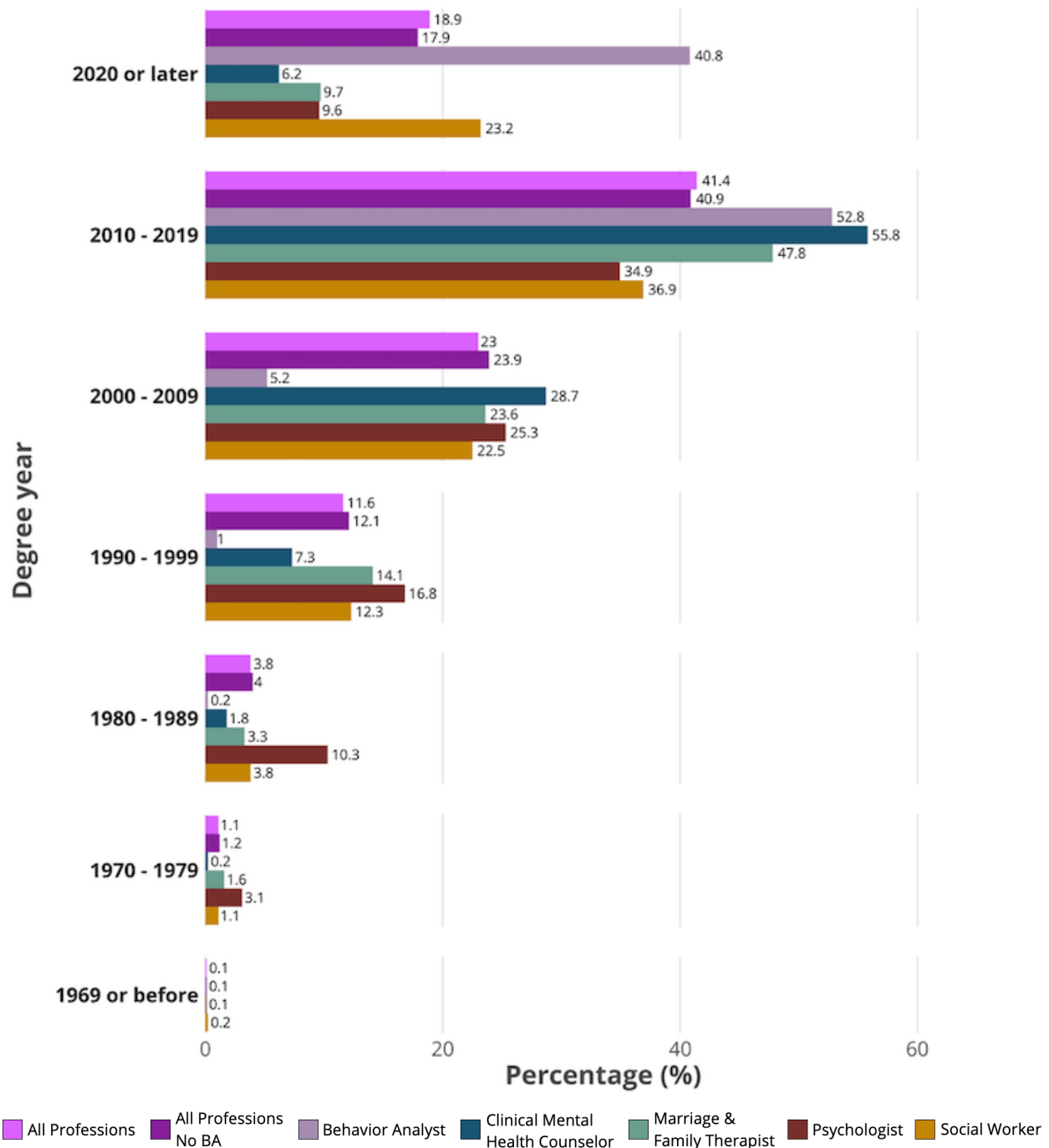


Behavioral health workforce survey, Utah, 2024

Figure 7 shows that most of the behavioral health providers' first qualifying degrees were master's degrees. Most Psychologists started with a doctorate degree, which was required for this license.

Figure 8. Behavioral health respondents' qualifying degree year

Key takeaway: Most respondents completed their qualifying degree at 2010-2019

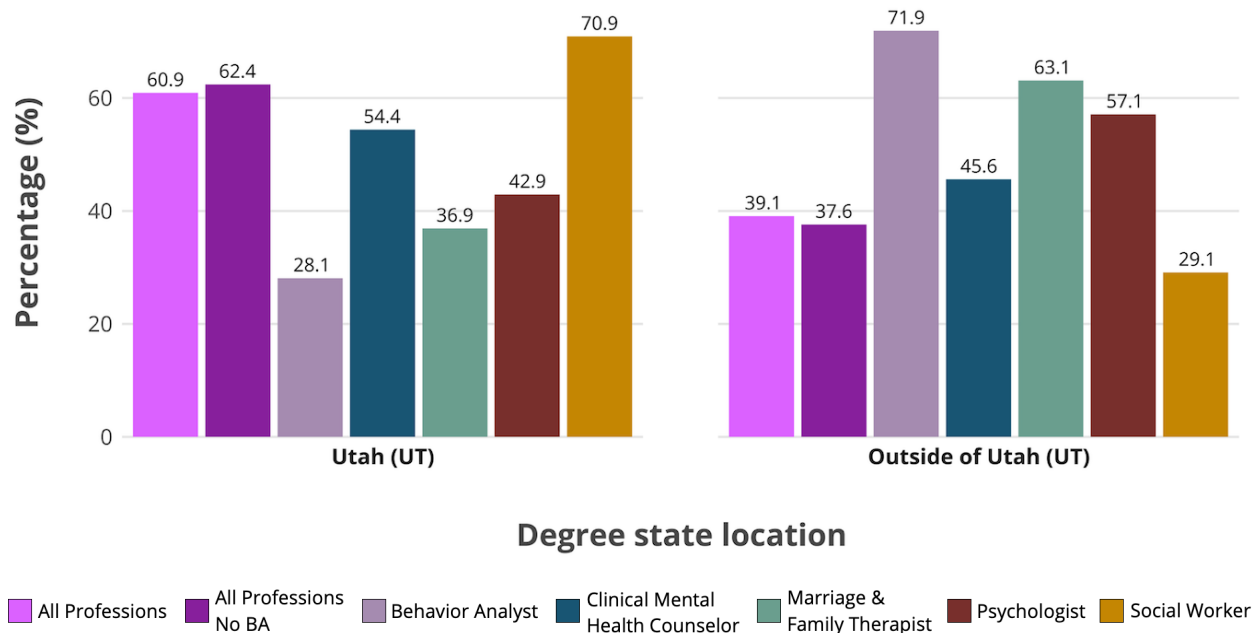


Behavioral health workforce survey, Utah, 2024

Figure 8 shows that most providers completed their qualifying degree between 2010 and 2019, meaning that most of the respondents worked in the area for at least 5 years after they got their degree. 93.6% of Business Analysts and 62% of Clinical Mental Health Counselors completed their degrees after 2010.

Figure 9. Behavioral health respondents' first qualifying degree locations

Key takeaway: Most of respondents' degree are completed in Utah, but varies by professions



Behavioral health workforce survey, Utah, 2024

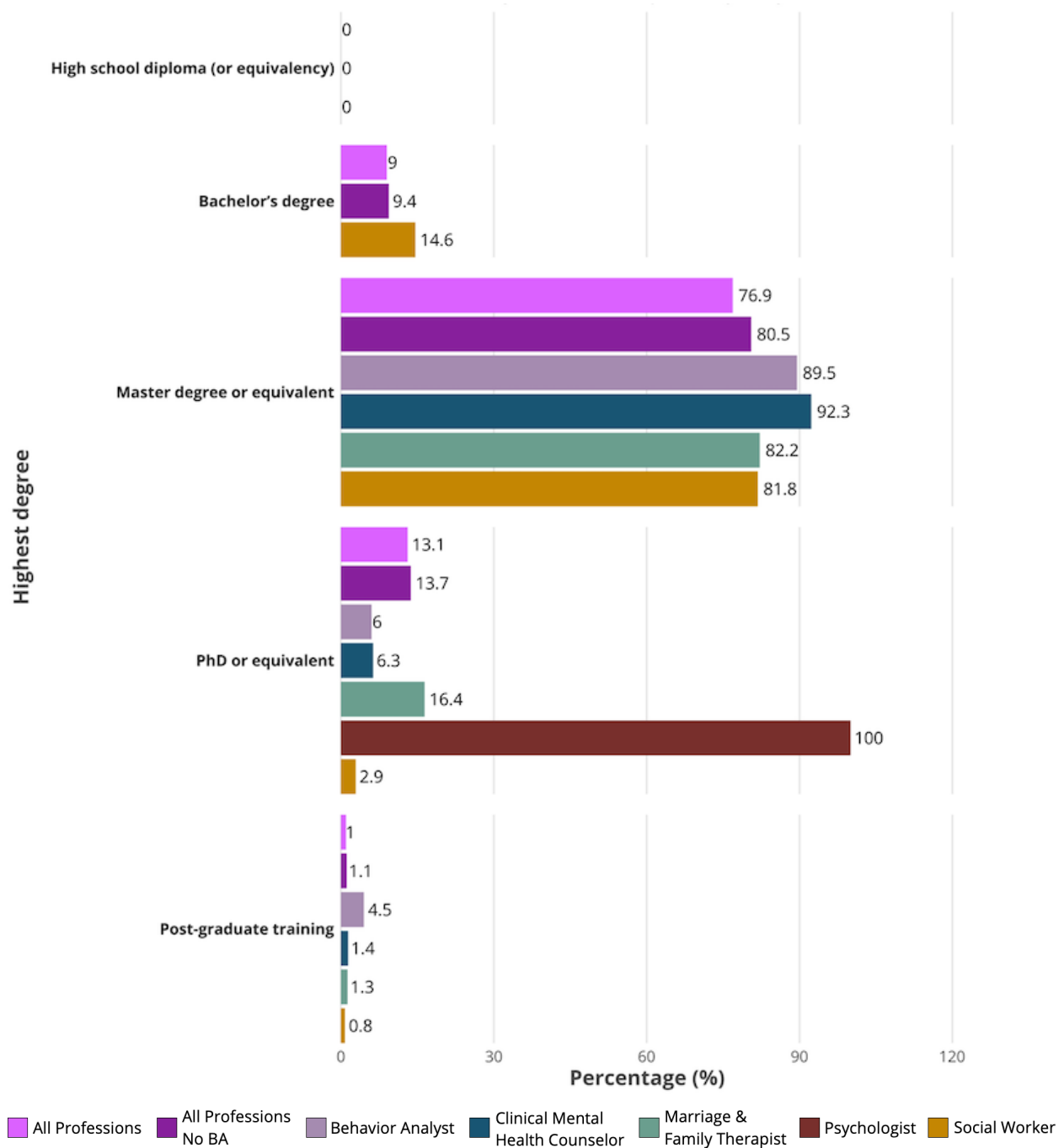
Even though 60.9% of respondents in this survey completed their qualifying degree in Utah, as shown in Figure 9, 39.1% of respondents completed their degrees outside Utah. 70.9% of Social Workers and more than half Clinical Mental Health Counselors completed their degrees in Utah, but most other professions' respondents completed their degree outside Utah, especially 71.9% Business Analysts and around 60% of marriage & family therapists and psychologists completed their degree out of state. A total of 18 respondents received their degrees outside the United States. No respondents in Psychologists and Marriage & Family Therapists got their degrees outside of the United States.

Highest education

Most of the respondents had master's degrees related to their licenses (Figure 10). Behavior analysts' highest degree was the other master's degree.

Figure 10. Behavioral health respondents' highest degree

Key takeaway: Most respondents have masters' degree related to their licenses



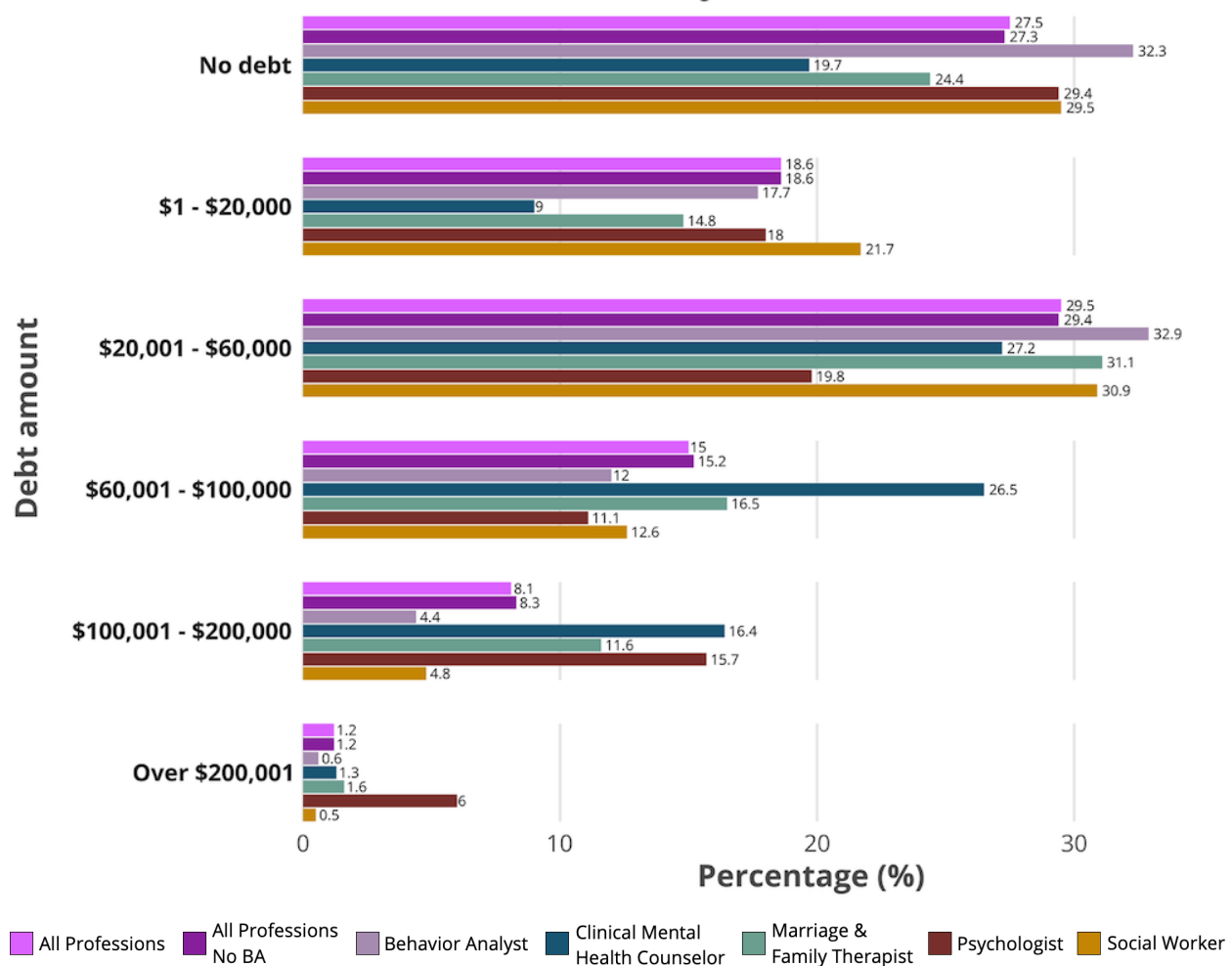
Behavioral health workforce survey, Utah, 2024

When comparing the first qualifying degree with the highest degree, approximately 6.7% of behavioral health survey respondents pursued a higher degree or post-graduate training following their qualifying degree. Among various professions, Marriage and Family Therapists (MFTs) demonstrated the highest propensity for advanced education at 13.3%. Notably, respondents who entered the field with only a high school diploma or those already in post-graduate tracks were significantly more inclined to pursue further education, with over 77% seeking advanced credentials.

Education debt

Responding providers' educational debt was depicted below. It was important to note this data showed total educational debt at the time of graduation and not their current educational debt.

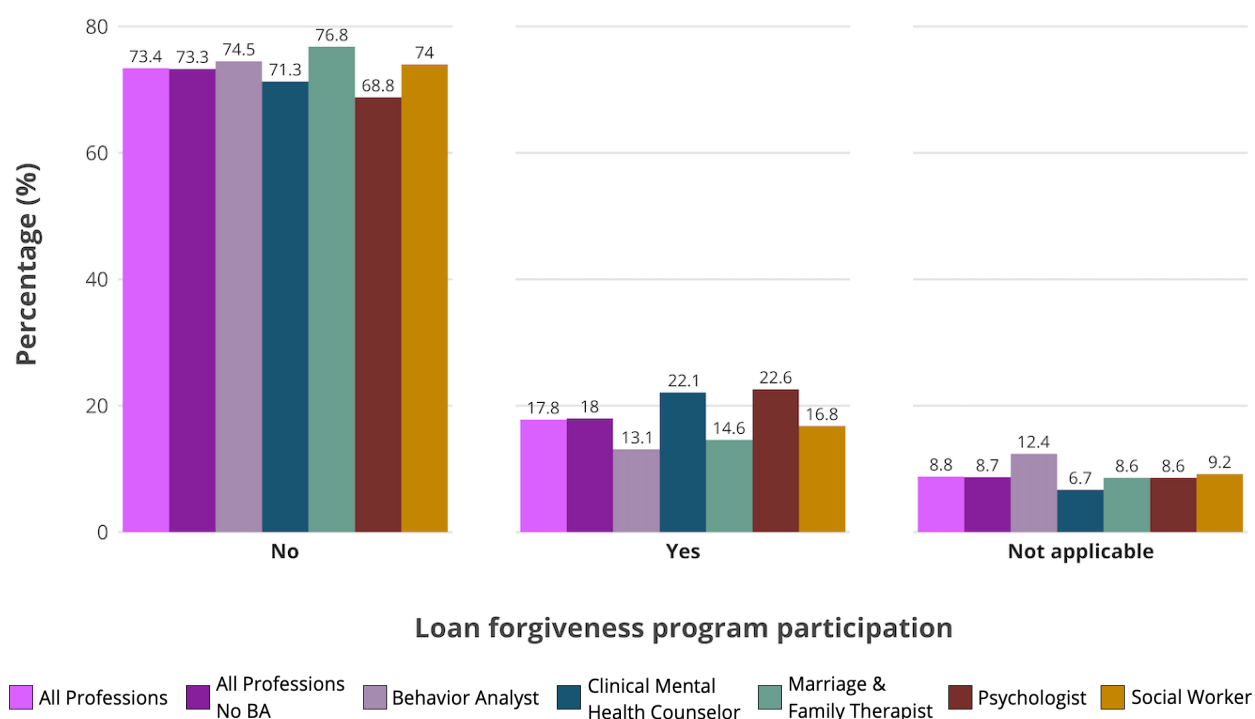
Figure 11. Education debt at the time of graduation from behavioral health program



Behavioral health workforce survey, Utah, 2024

Most behavioral health providers had debt, about 27% were debt-free, which gives them greater flexibility in career choices, including pursuing advanced roles or working in underserved areas, and may support higher retention and continued professional growth. In short, a largely debt-free workforce could be more stable, adaptable, and capable of pursuing professional growth. Most respondents' debt was under \$60,000. CMHC had the lowest percent of those reporting no debt and debt higher than \$60,000 was about 44.4%. Notice that 6% of psychologists had more than \$200,000 (Figure 11).

Figure 12. Loan forgiveness program participation

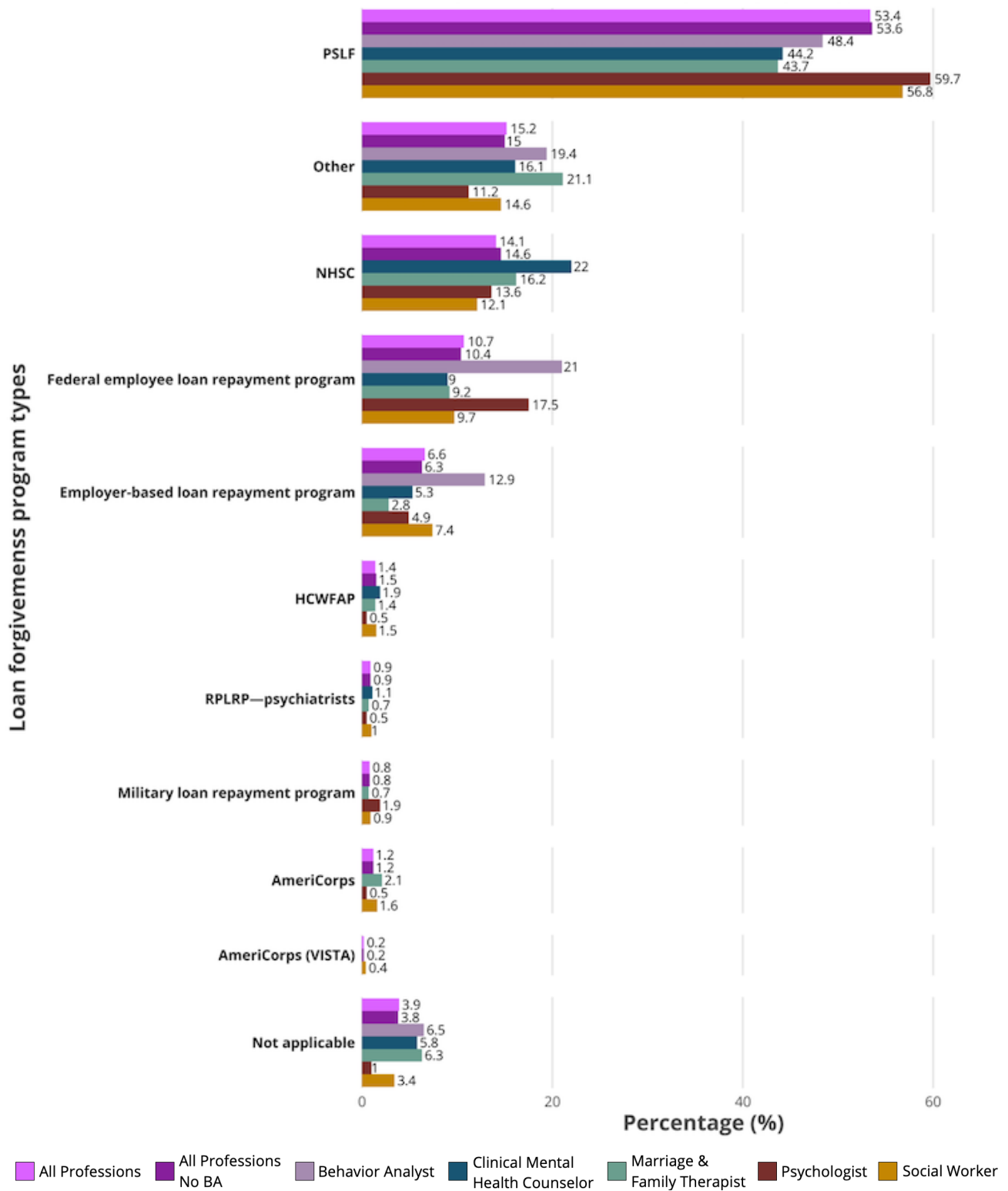


Behavioral health workforce survey, Utah, 2024

Only 17.8% of respondents participated in a loan forgiveness program, as illustrated in Figure 12. Clinical mental health counselors and psychologists had a higher participation rate, although it was still only around 22%.

The most common loan forgiveness program was the Public Service Loan Forgiveness Program (PSLF), as indicated in Figure 13. It was followed by the National Health Services Corps and the Federal Employee Loan Repayment Program.

Figure 13. Educational loan forgiveness program type

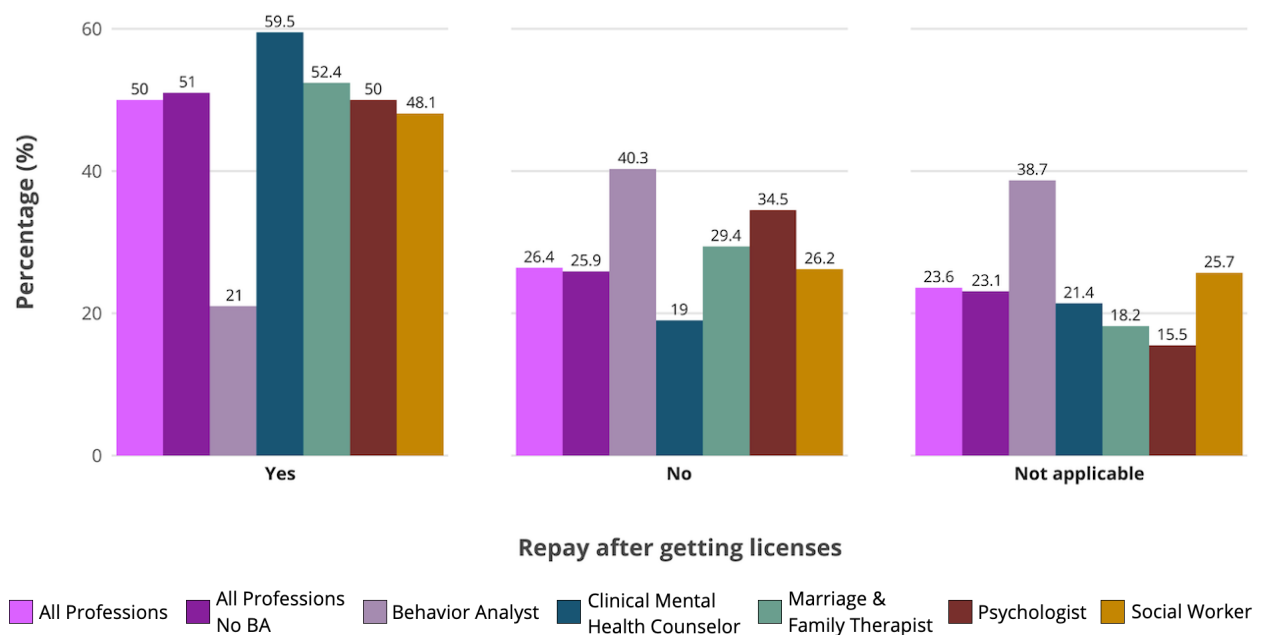


Behavioral health workforce survey, Utah, 2024

Some Federal Loan Repayment Programs require a full license to be eligible. Half of the respondents repaid their education loans after licensing, and clinical mental health counselors were as high as near 60%, on the contrary, 40.3% of Behavior Analysts could repay earlier (Figure 14). That indicated financial stress and barriers to entry while prospective students couldn't repay loans for several years before they got a full license, especially for clinical mental health counselors.

Figure 14. Repay education loan after licensing

Key takeaway: Half of respondents repay federal loans after graduating to get licenses

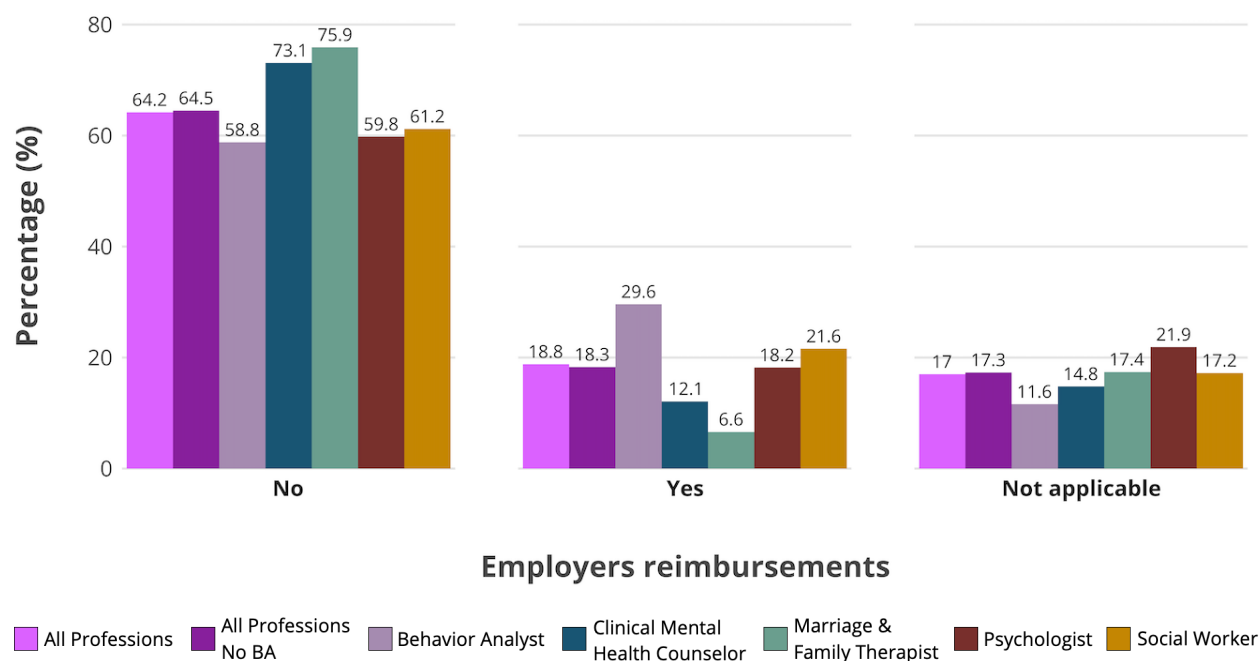


Behavioral health workforce survey, Utah, 2024

Unfortunately, except for the loan forgiveness programs, the respondents were hard to get support from the employers. Most of the employers won't provide discounts or reimbursement for respondents' education debts (Figure 15). Behavior Analysts were the most likely to get support from employers among the respondents, but still less than 30%.

Figure 15. Employers provide reimbursement education debts

Key takeaway: Most employers won't provide discounts or reimbursement for education debts

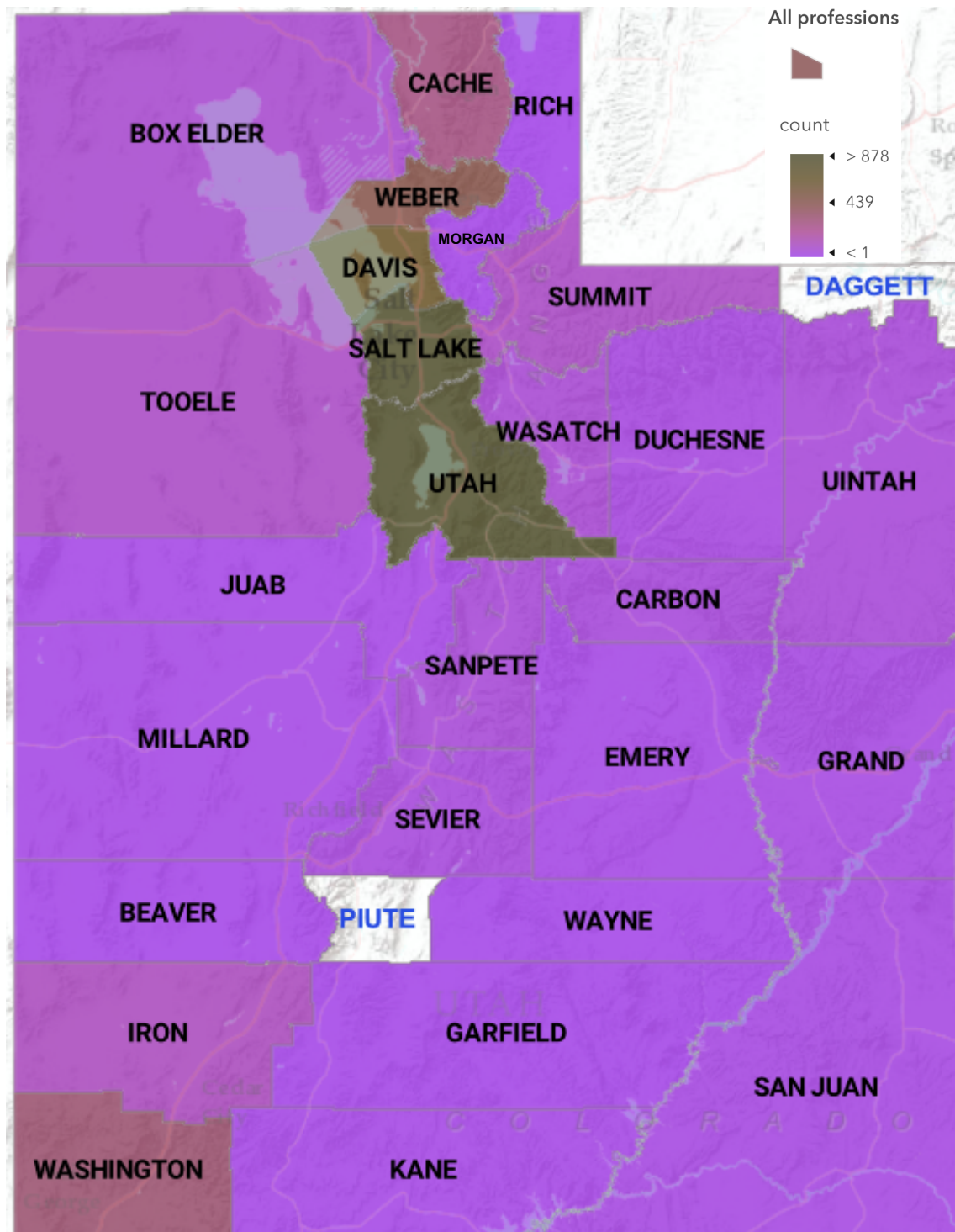


Behavioral health workforce survey, Utah, 2024

Geography

As Map 1 shows, 42.4% respondents practice location were in Salt Lake County and 21.2% were in Utah County. The percent varied by profession, but these two counties were the major counties of respondents' practice location.

Map 1. Location of survey respondents

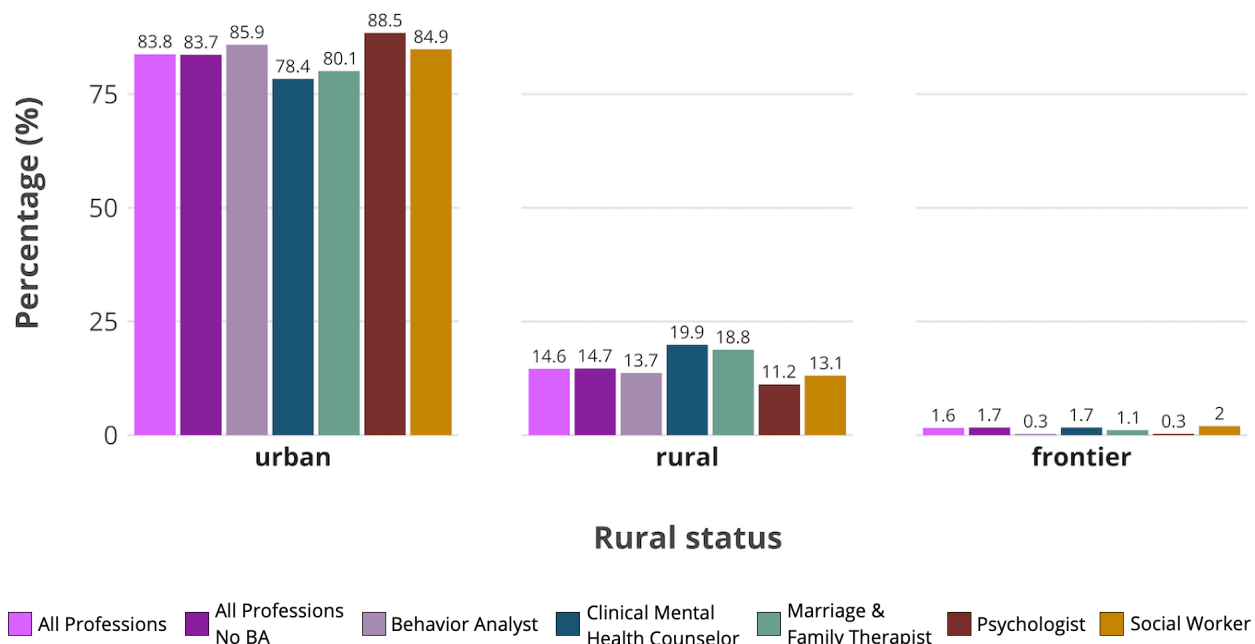


Behavioral health workforce survey, Utah, 2024

According to Kem C. Gardner Policy Institute's data, there were 18.3% Utahns living in rural areas and 2.6% living in frontier areas. Figure 16 shows only 16.2% behavioral health practice locations located in these areas, especially psychologists' location was much less, only 11.5% in frontier and rural areas.

Figure 16. Respondents' location in urban and rural areas

Key takeaway: Most of respondents' practice location are in urban areas



Behavioral health workforce survey, Utah, 2024

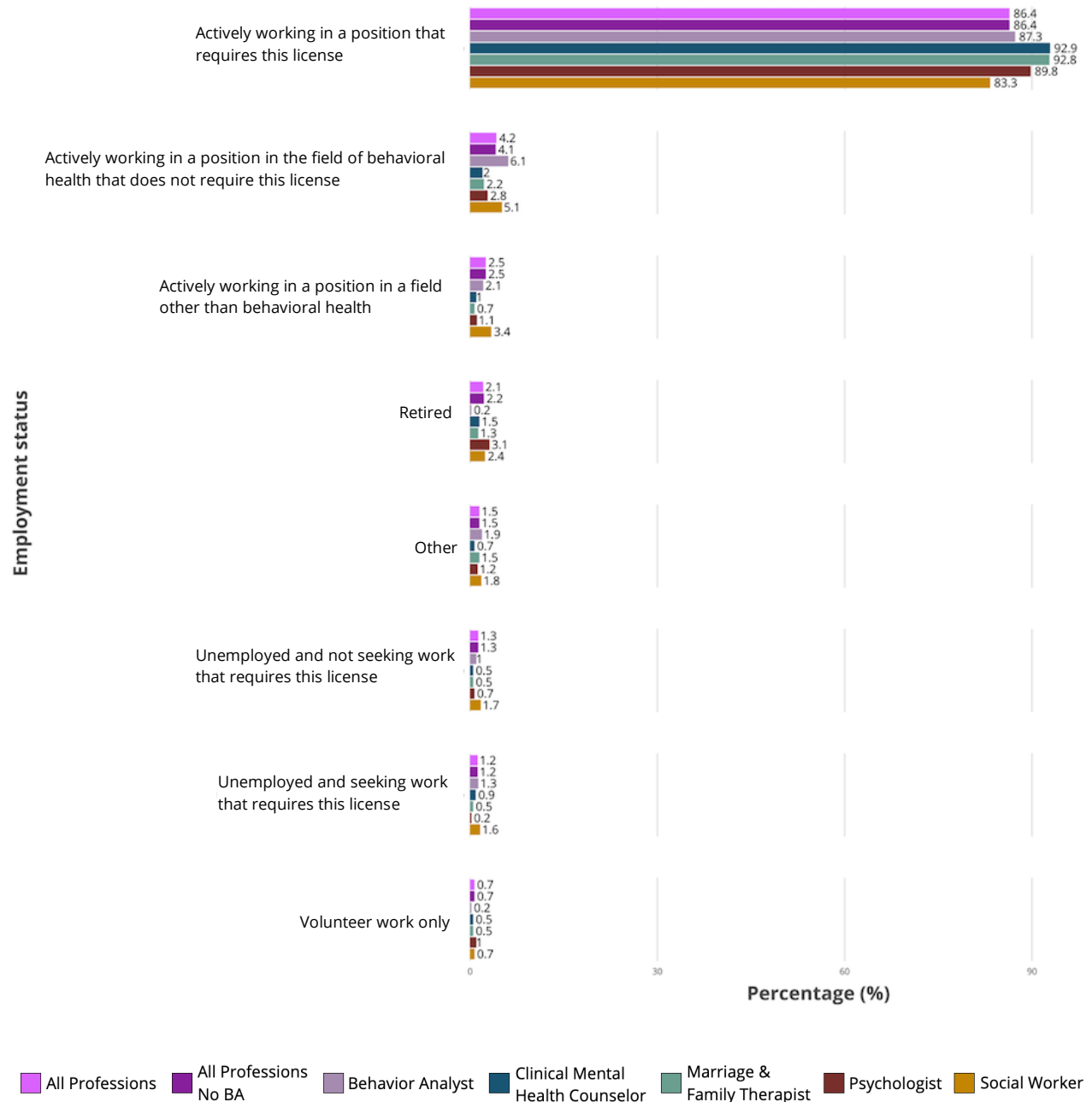
Employment Characteristics

Employment status

About 86.4% respondents reported actively working in a position that required their license as shown in Figure 17. While approximately 93.1% of respondents indicated they were actively working. Over 92.8% of CMHC and MFT respondents were actively working in a position that required their licenses. About 8.2% to 8.5% Behavior Analyst and Social Workers respondents actively worked in a position that did not require this license or was not related to behavioral health.

Figure 17. Employment status distribution

Key takeaway: Most respondents are actively working



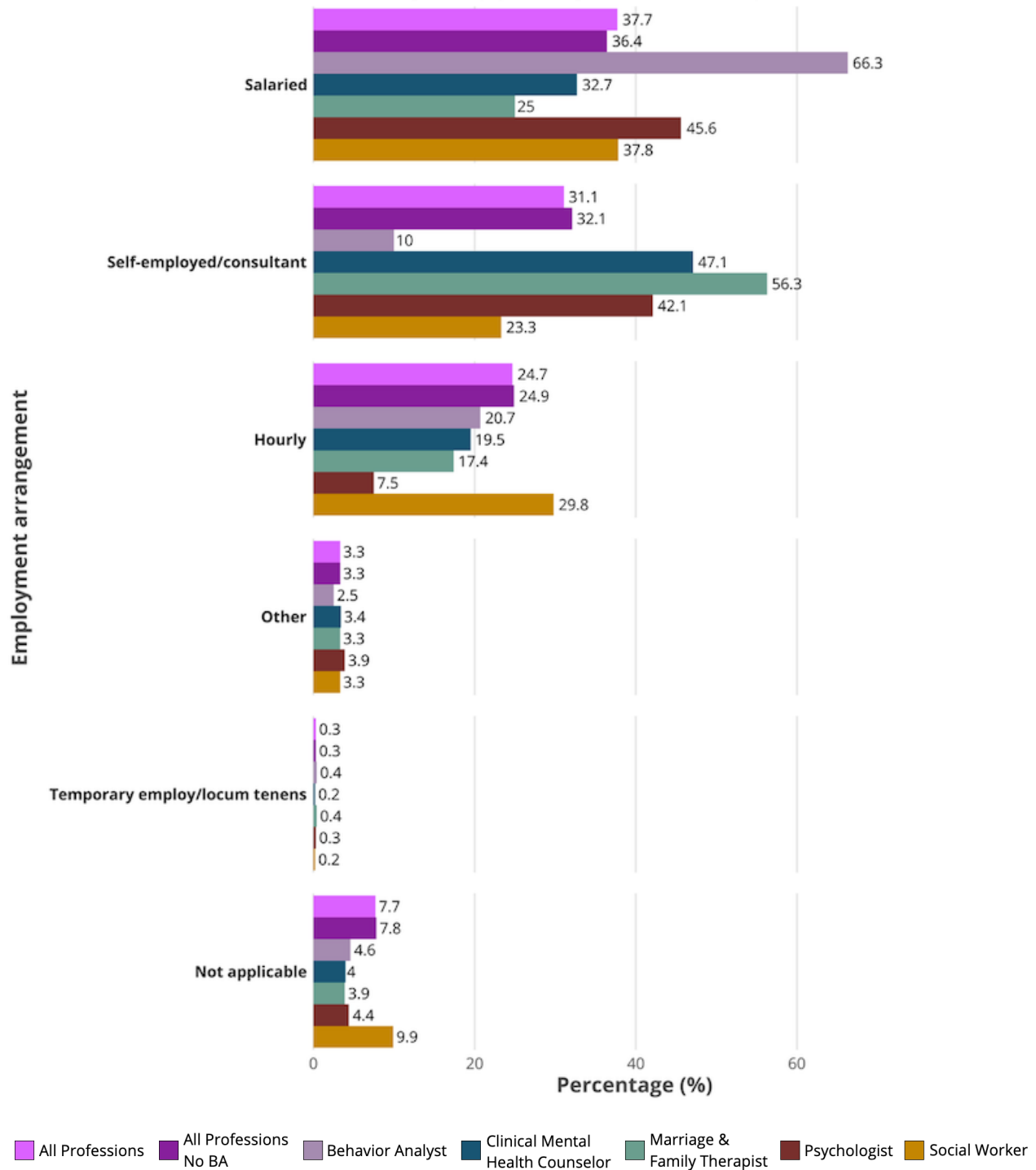
Behavioral health workforce survey, Utah, 2024

Employment arrangement

According to the survey respondents (Figure 18), the employment arrangements varied by profession and location. 73.7% of respondents worked in secondary practice locations. In primary settings, 4.6% of respondents had multiple arrangement settings. 37.7% of respondents were salaried, while 31.1% were self-employed or consultants. MFTs lead in independent work, with over half reporting as self-employed or consultants. CMHCs and psychologists followed at around 40%. However, the secondary practice location told a different story (Figure 19). Except for those answers of “Not Applicable”, self-employed or consultants were far more common than salaried. Notably, behavior analysts remained an outlier, primarily maintaining salaried positions regardless of their practice location.

Figure 18. Employment arrangement distribution in primary practice location

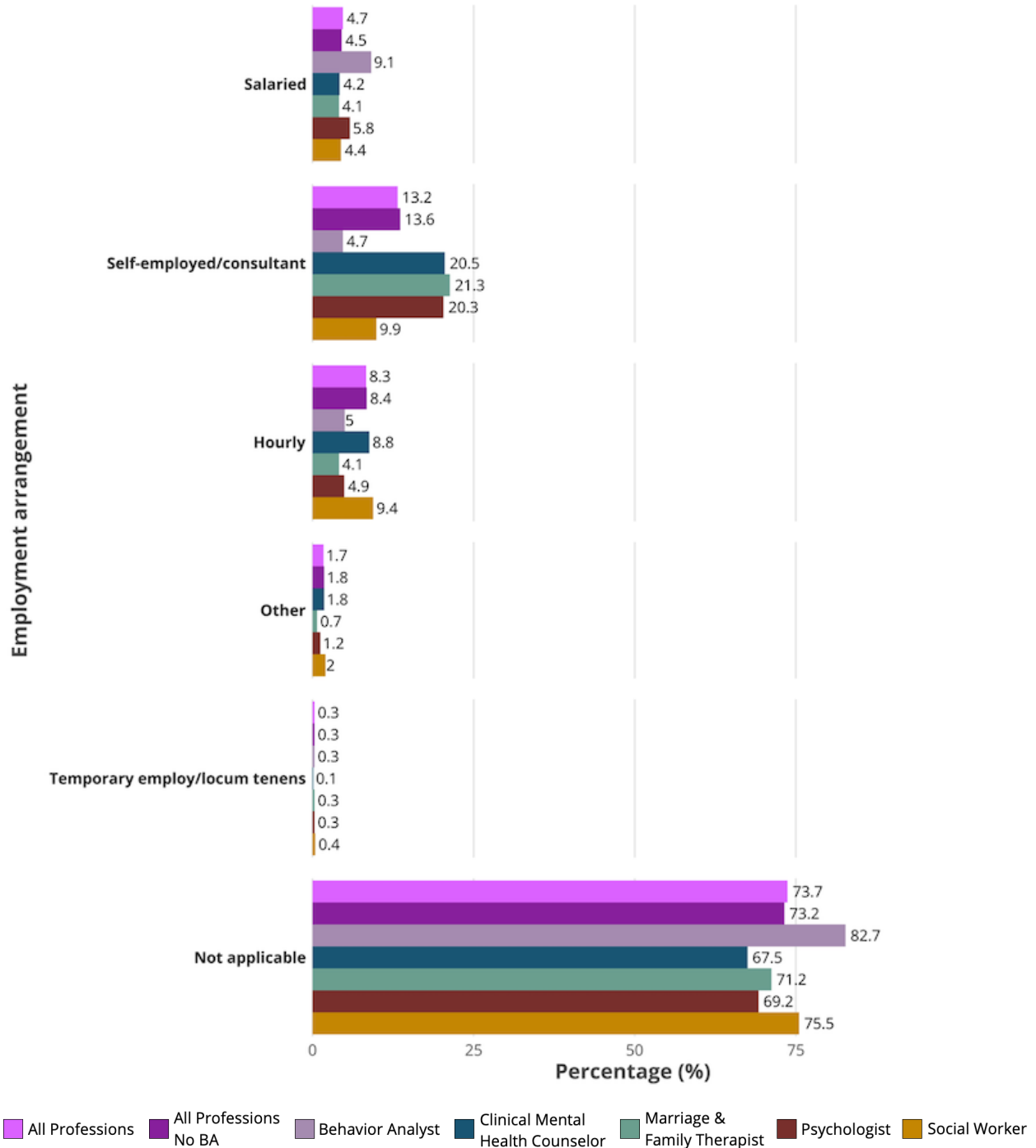
Key takeaway: Most respondents are salaried but varied by professions



Behavioral health workforce survey, Utah, 2024

Figure 19. Employment arrangement distribution in secondary practice location

Key takeaway: More respondents are self-employed/consultant except those not applicable



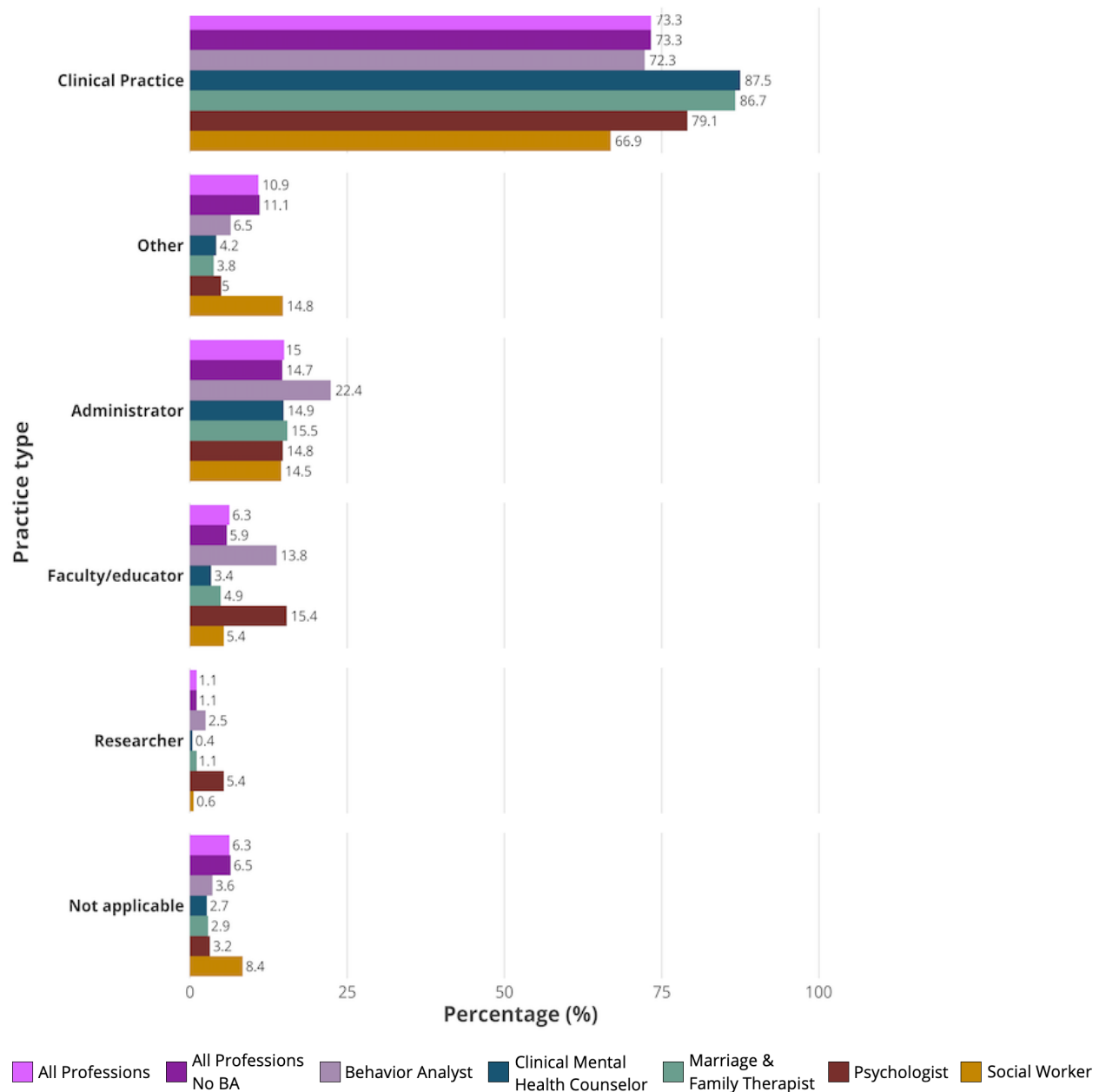
Behavioral health workforce survey, Utah, 2024

Employment roles

Figure 20 shows respondents' primary role, whereas Figure 21 depicted respondents' secondary role. Except for those answers of "Not Applicable", "Clinical practice" was the most reported in both primary and secondary locations. Notice that 15% respondent claimed as administrator, and the behavior analysts' rate was highest at 22.4%.

Figure 20. Practice type in primary practice

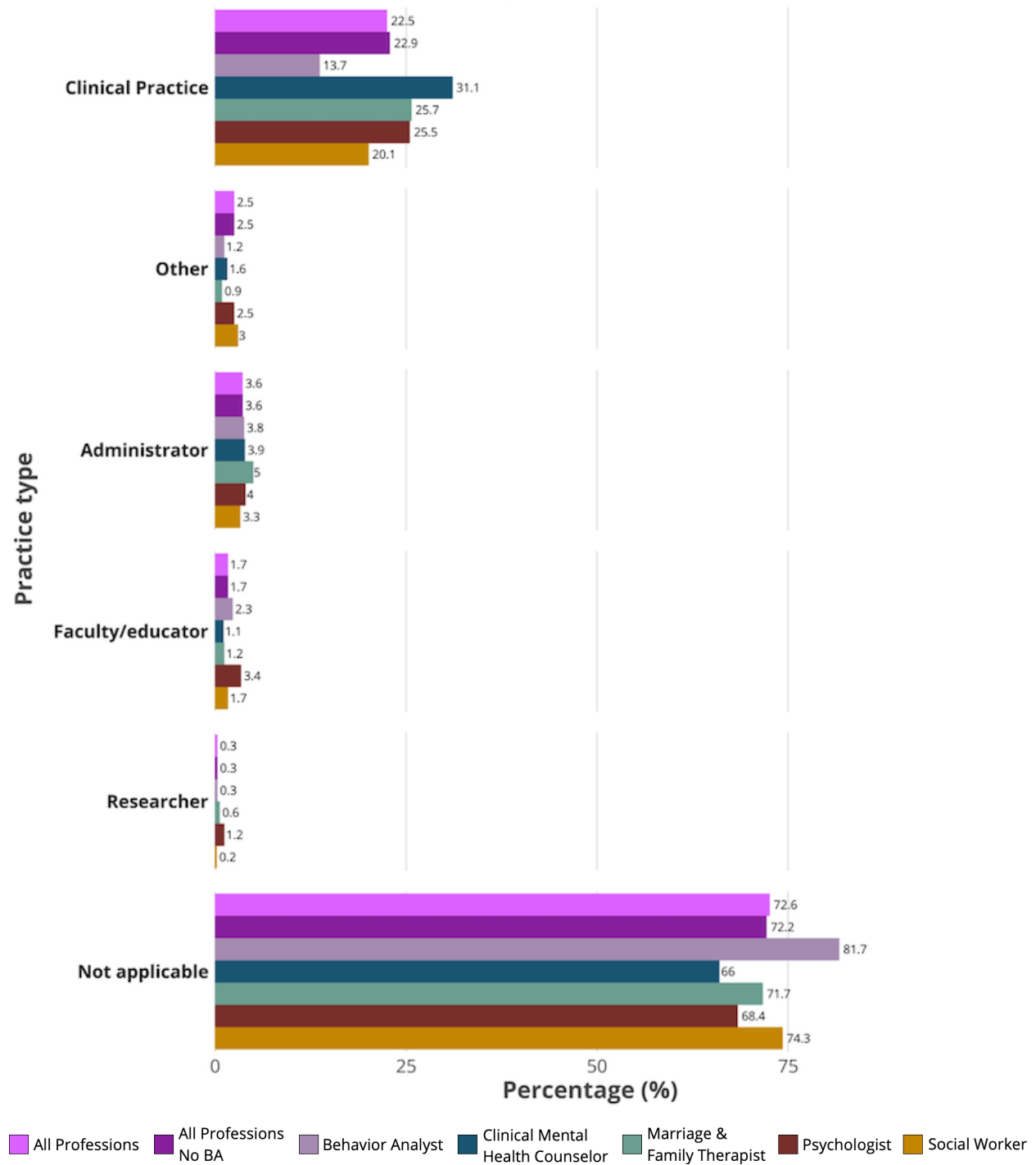
Key takeaway: Most respondents work in clinical practice



Behavioral health workforce survey, Utah, 2024

Figure 21. Practice type in secondary practice

Key takeaway: Most respondents work in clinical practice



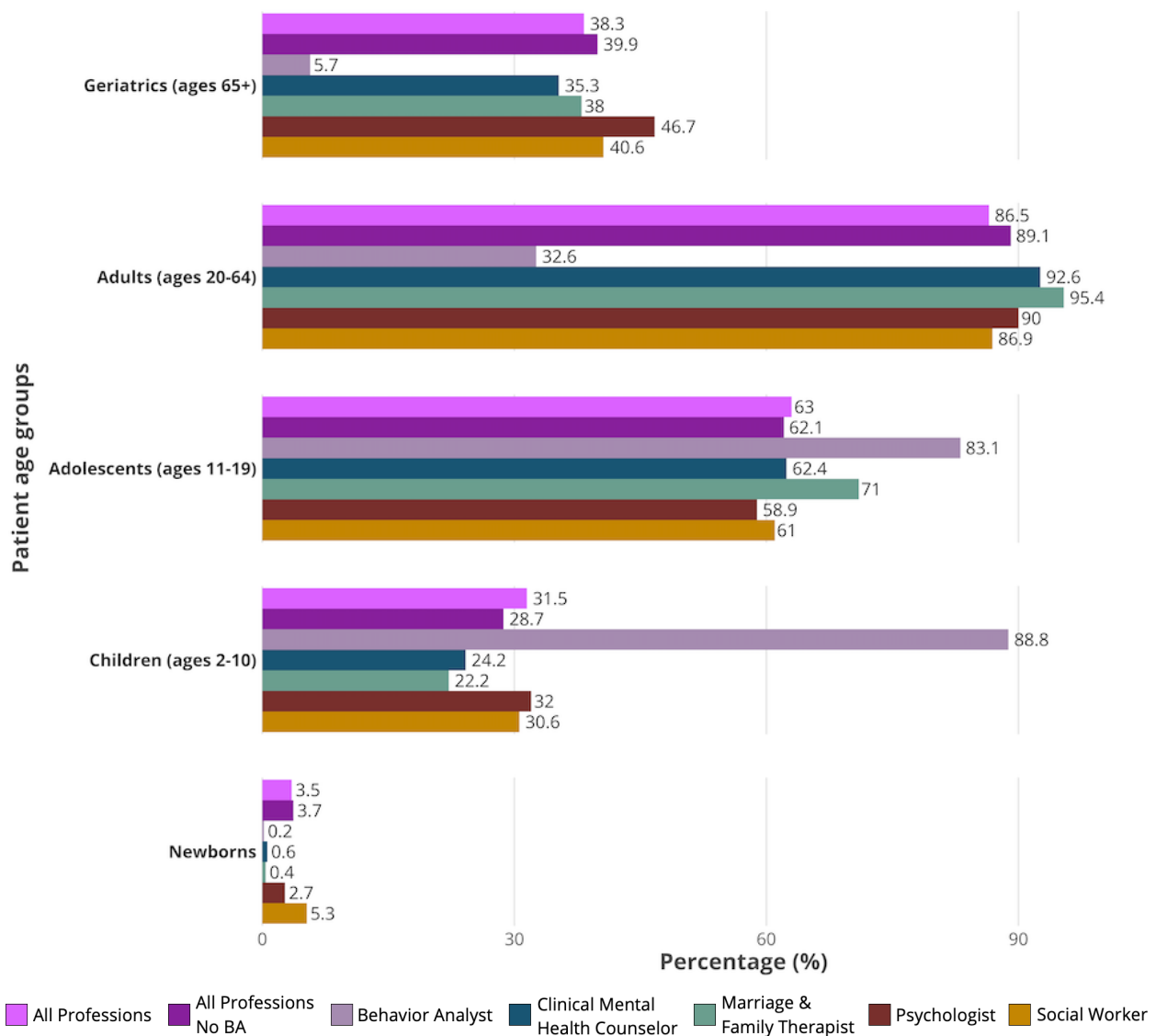
Behavioral health workforce survey, Utah, 2024

Patient characteristics

The next section includes patients' age, payment methods, and demographic characteristics. Each percentage was calculated according to the number of respondents who answered the question with multiple choices. The percentage will not equal 100% because respondents could have multiple selections.

Figure 22 shows that over 86.5% respondents would work with adults, except business analysts who would work with children more than others.

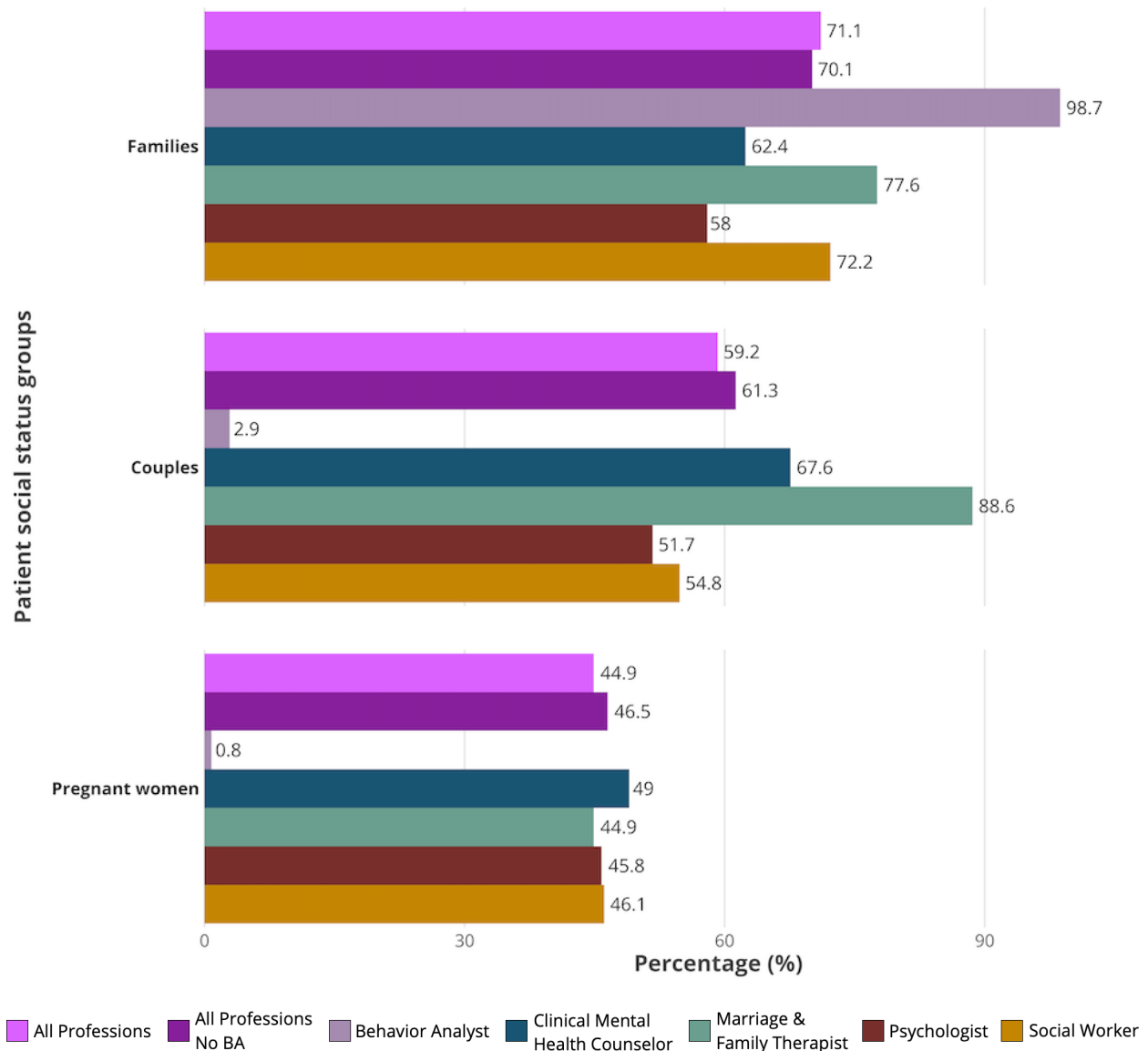
Figure 22. Patient age groups by professions



Behavioral health workforce survey, Utah, 2024

Almost all behavior analyst respondents (98.7%) worked with families (Figure 23). Marriage & Family Therapists worked with the couples the most. This was not surprising given the nature of their training.

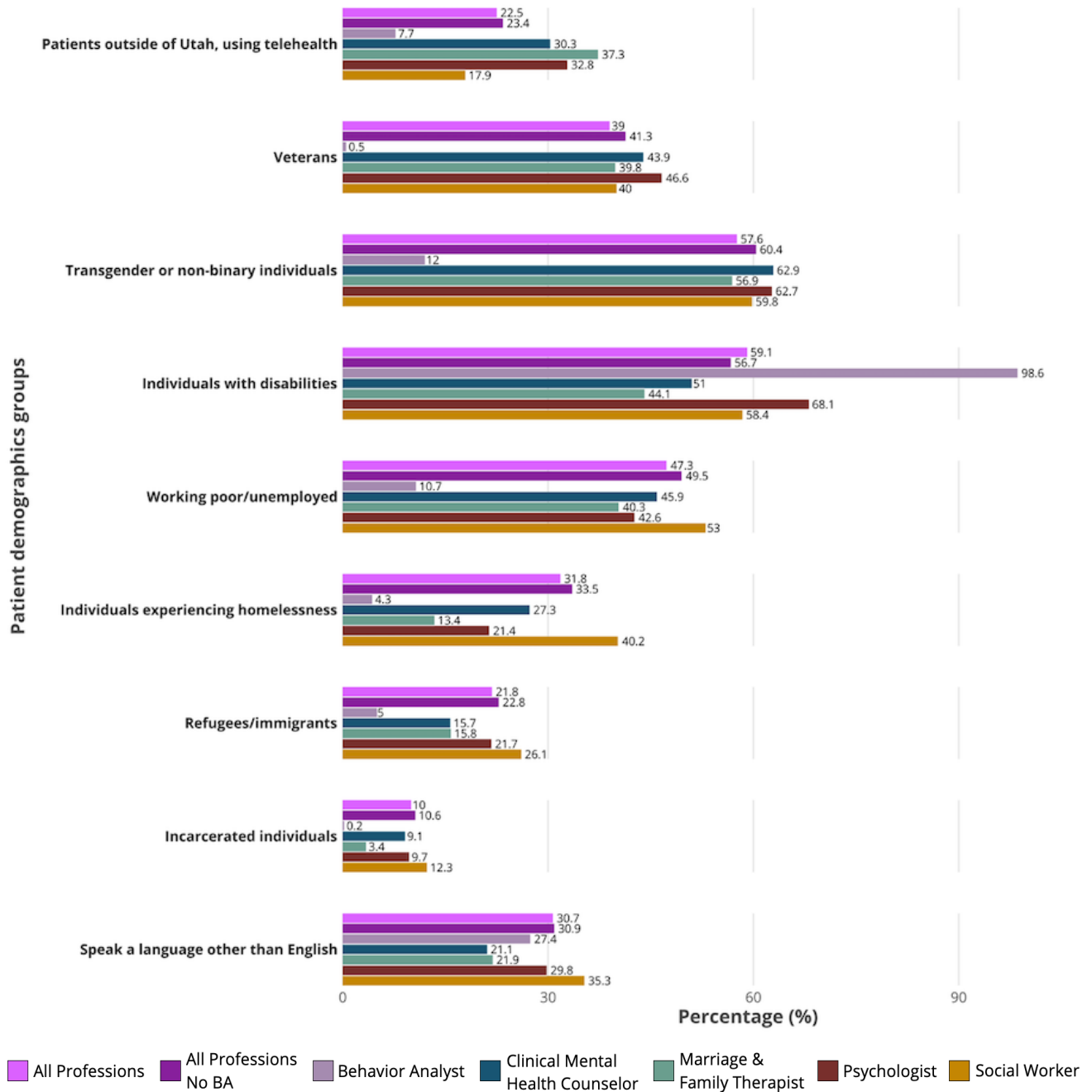
Figure 23. Patient social status groups by professions



Behavioral health workforce survey, Utah, 2024

Figure 24 shows that most respondents worked with patients who could speak English. Less than 31% respondents reported that they worked with patients who spoke a language other than English. Over 30% of MFTs, CMHCs, and psychologists had patients outside Utah and used telehealth; in comparison, behavior analysts were less likely to have patients outside of Utah and offer telehealth (7.7%).

Figure 24. Patient demographics groups by professions

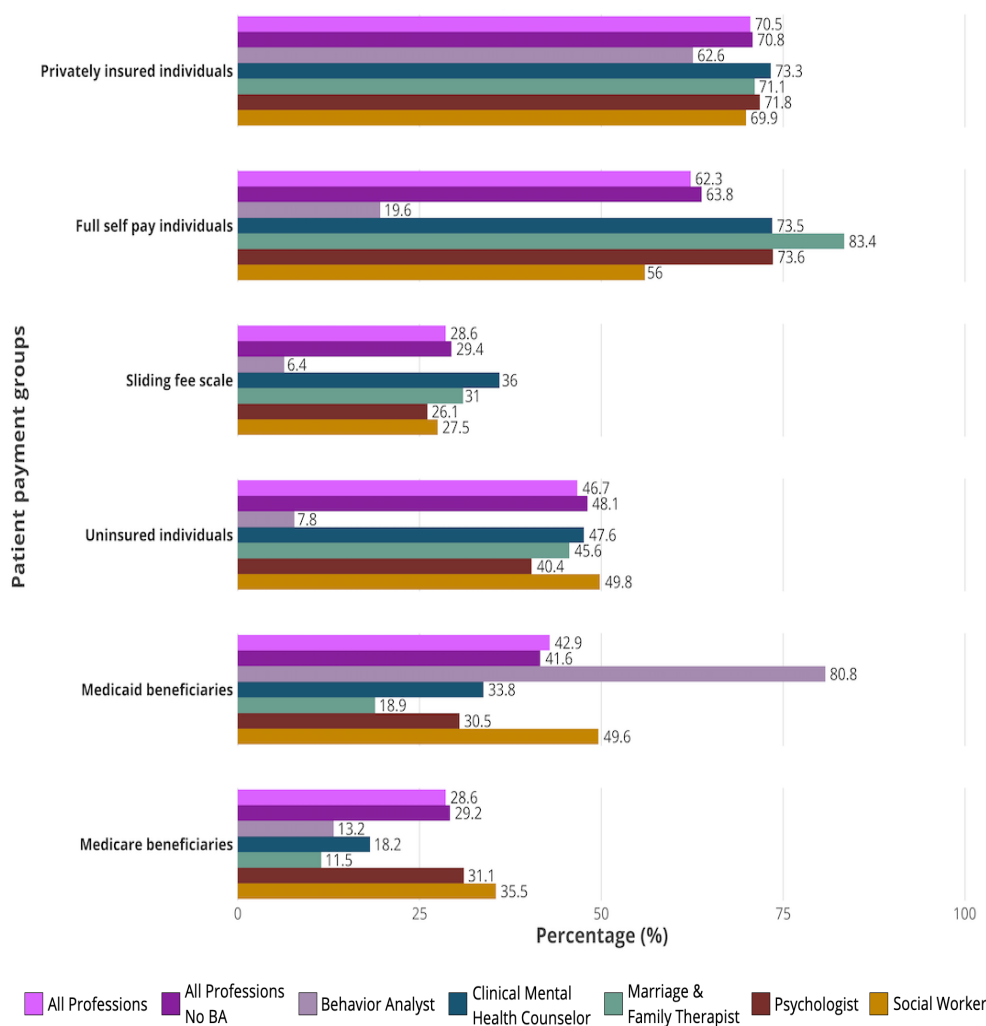


Behavioral health workforce survey, Utah, 2024

Payment Methods

According to payment methods in Figure 25, about 70% of respondents accepted private insurance, except for behavior analysts (62.6%). About 60% of respondents accepted full self-pay. Social workers (56%) were a little lower than average, but the other professions' acceptance was about 73%. CMHCs, MFTs, and psychologists were less likely to report accepting Medicaid or Medicare patients, with rates ranging from 11.5% of MFTs accepting Medicare to 49.5% of social workers accepting Medicaid. About 40% or fewer of respondents reported working with uninsured individuals. Less than 30% of respondents reported accepting sliding fee scale payment. About 7% of respondents reported accepting only self-pay (Figure 26). Marriage and family therapists and psychologists were the highest in reporting that they only accept self-pay at 10%.

Figure 25. Patient payment groups by professions



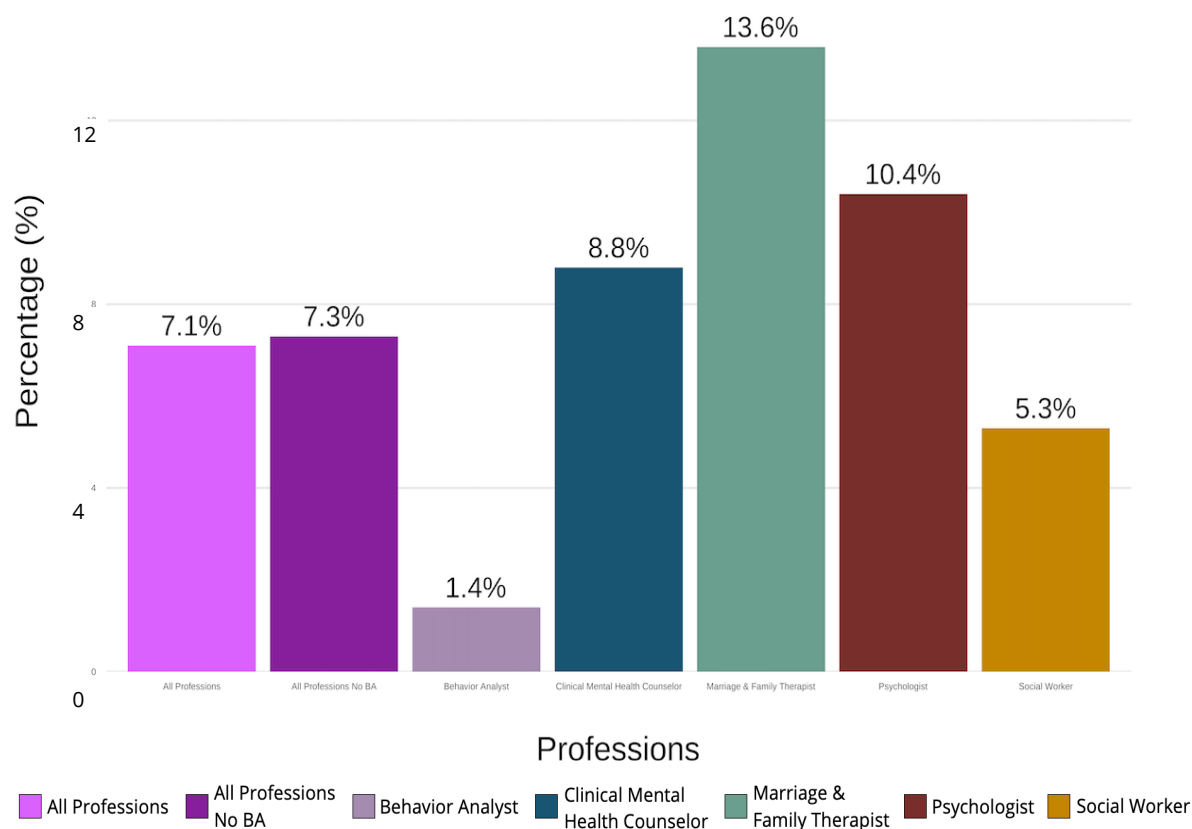
Behavioral health workforce survey, Utah, 2024

Using patient characteristics, as seen in Figures 22, 23, 24, and 25, we can outline typical patient profiles for each profession.

- Behavior analysts reported mainly working with individuals with disabilities (98.6%), children and adolescents ages 2-19 (88.8%), families (98.7%), and accepted Medicaid beneficiaries (80.8%).
- Clinical Mental Health Counselors' patient groups reported working primarily with adults and Adolescents (ages 11-19) and accepted privately insured and full self-pay individuals.
- Marriage & Family Therapists' patients reported working primarily with adults, couples, and families, and a lot of respondents accepted some full self-pay individuals.
- Psychologists' patients were largely adults and adolescents (ages 11-19) and accepted full self-pay and privately insured individuals.

Figure 26. Respondents accepting self-payment only

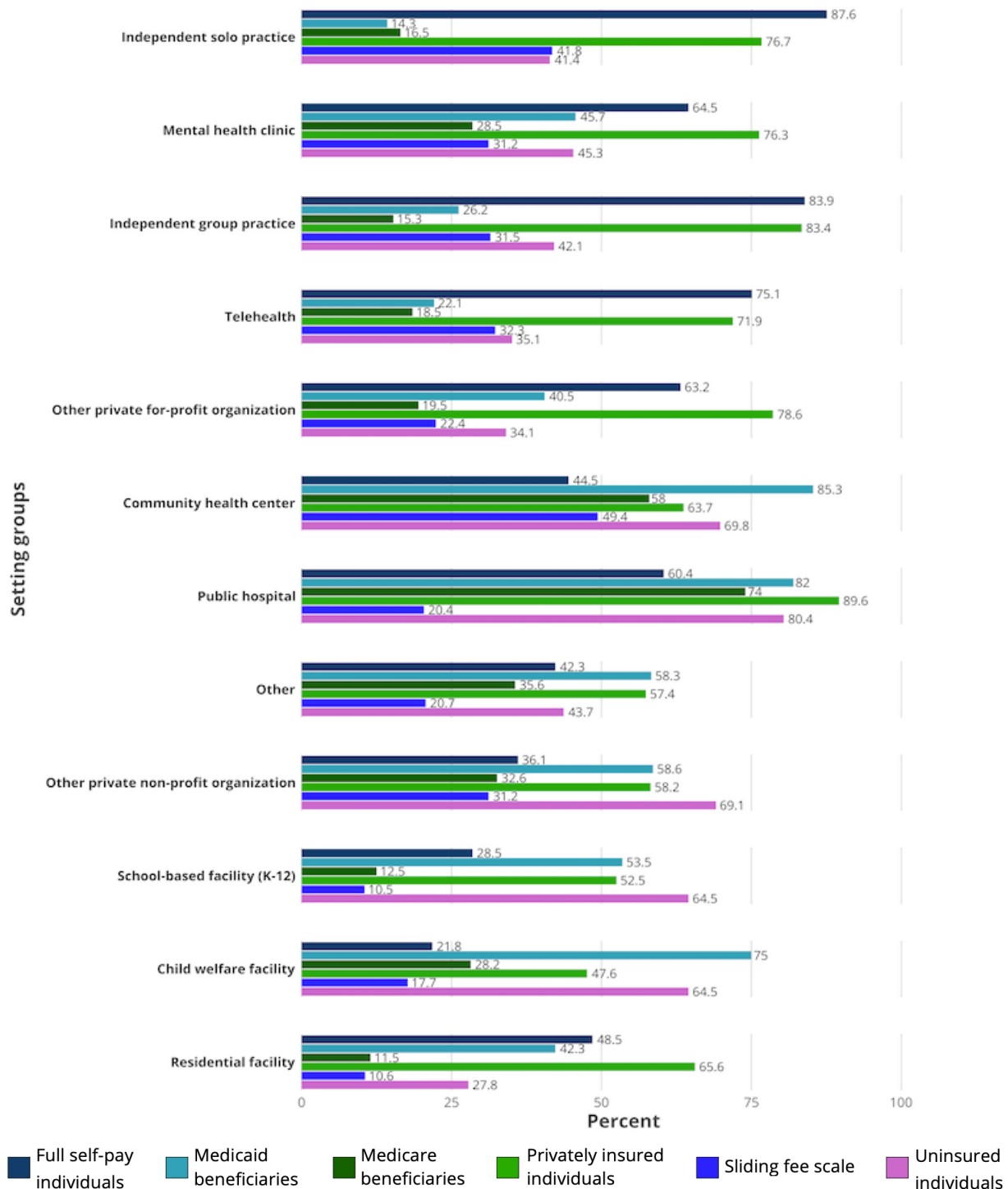
Key takeaway: Marriage & Family Therapists have the highest rate to accept self-payment only method



Behavioral health workforce survey, Utah, 2024

- A large percentage of Social Workers' patients were adults, adolescents (ages 11-19), and families, and accepted privately insured individuals.

Figure 27. Payment acceptance in primary practice settings



Behavioral health workforce survey, Utah, 2024

Figure 27 shows that those working in independent solo practice, mental health clinic, independent group practice, and other for-profit organizations were more likely to accept full self-pay individual and private insurance. About 45.7% of respondents working in mental health clinics and 40.5% of respondents working in other private for-profit organizations were willing to accept Medicaid, but other for-profit oriented settings were lower than 30%. Independent solo practice settings were lower than 16.5% for accepting Medicaid and Medicare. Respondents working for non-profit organizations or facilities were more likely to accept Medicaid and Medicare, especially in public hospitals, up to 82% and 74%, respectively. Respondents working for non-profit organizations or facilities were more willing to accept Medicaid than Medicare. About 85.3% of respondents accepted Medicaid, while 58% accepted Medicare in community health centers. About 75% of respondents accepted Medicaid, while only 28.2% accepted Medicare in child welfare facilities. Notice that this was the payment acceptance willingness, but not the actual payment transaction type in the settings.

Practice characteristics

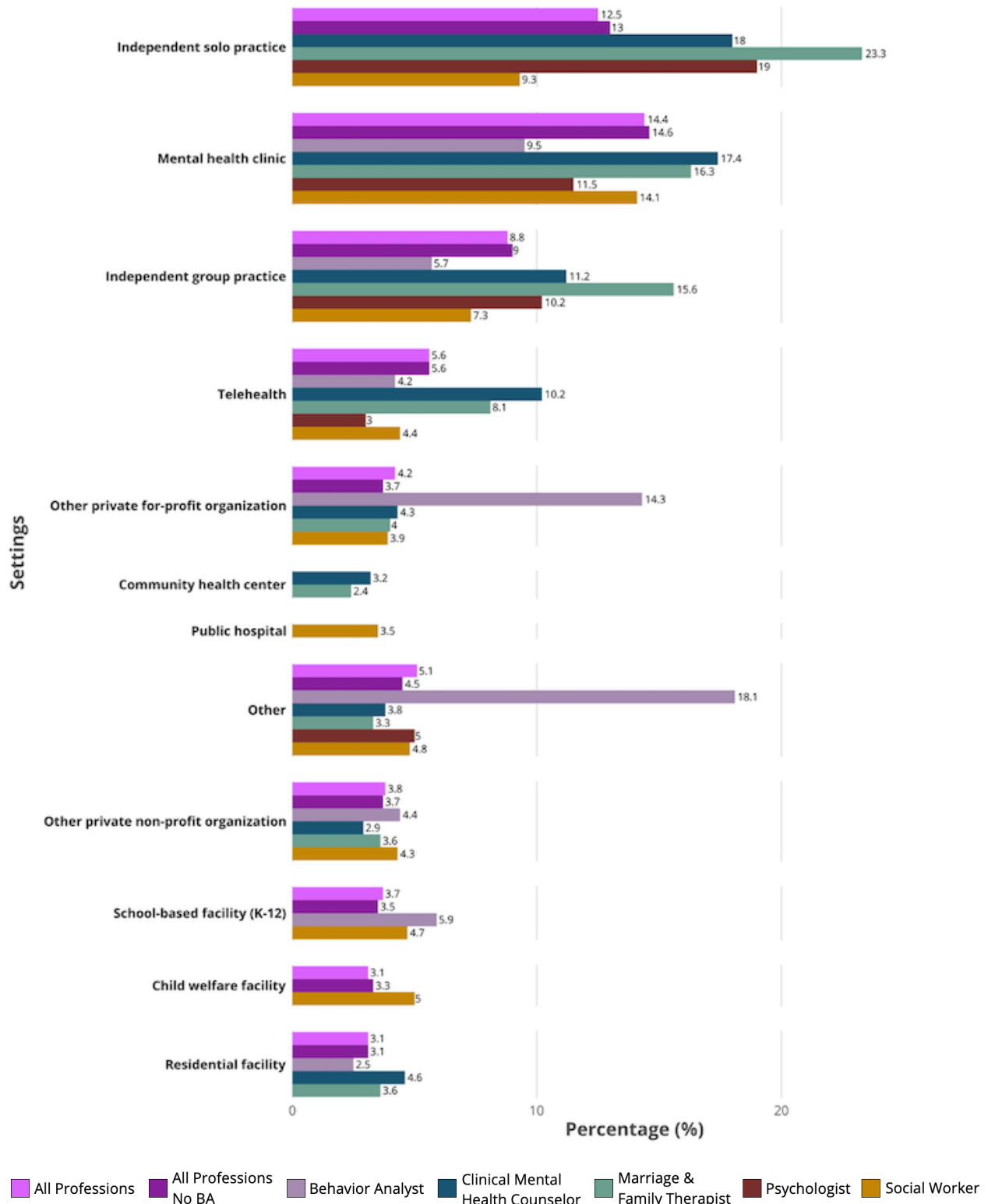
Setting

This section included information on respondents' practice settings. Practice setting played an important role in understanding how and where care was delivered. Analyzing the practice setting helped clarify access to care and highlighted differences in how services were organized across the workforce. While there were many different types of settings, for this report, due to space limitations, only the most common specialties were included in the charts.

Figure 28 displays the percentage of respondents' primary setting, while Figure 29 shows their secondary setting. While approximately 97.5% of participants responded to the question regarding their primary practice setting, only about 77.2% responded to the question regarding their secondary practice setting. According to the data, except for those answers "Not applicable", the top 3 settings were mental health clinic (14.4%, 3.2%), independent solo practice (12.5%, 4.5%), and independent group practice (8.8%, 2.2%) in both primary and secondary practice locations, respectively. Telehealth ranked as the top 5 settings in both practice locations.

Figure 28. Top 10 primary practice location setting by professions

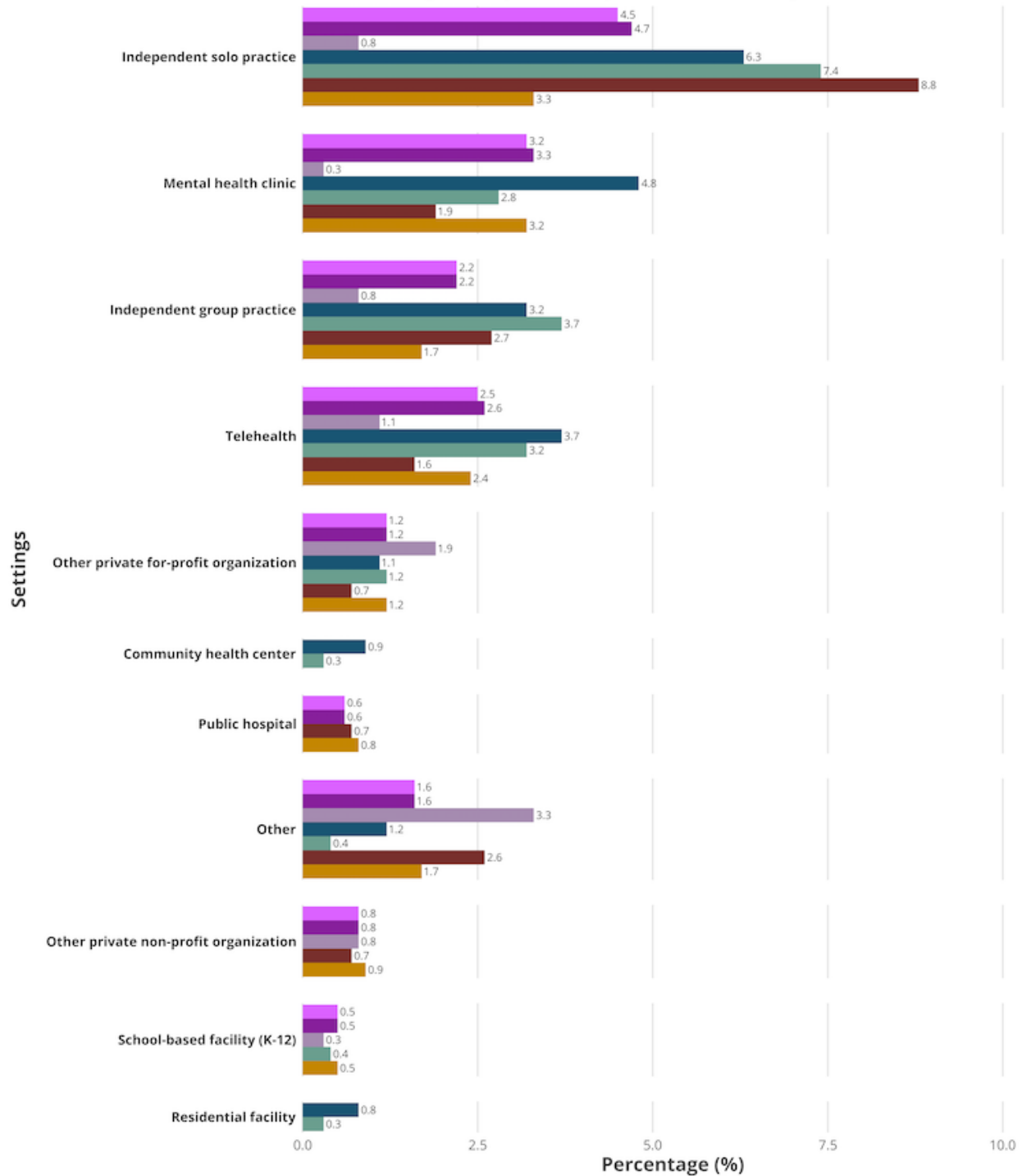
Key takeaway: Most are mental health clinics, independent solo practice, or independent group practice settings



Behavioral health workforce survey, Utah, 2024

Figure 29. Top 10 secondary practice location setting by professions

Key takeaway: Most are independent solo practice, mental health clinics, or independent group practice settings



Behavioral health workforce survey, Utah, 2024

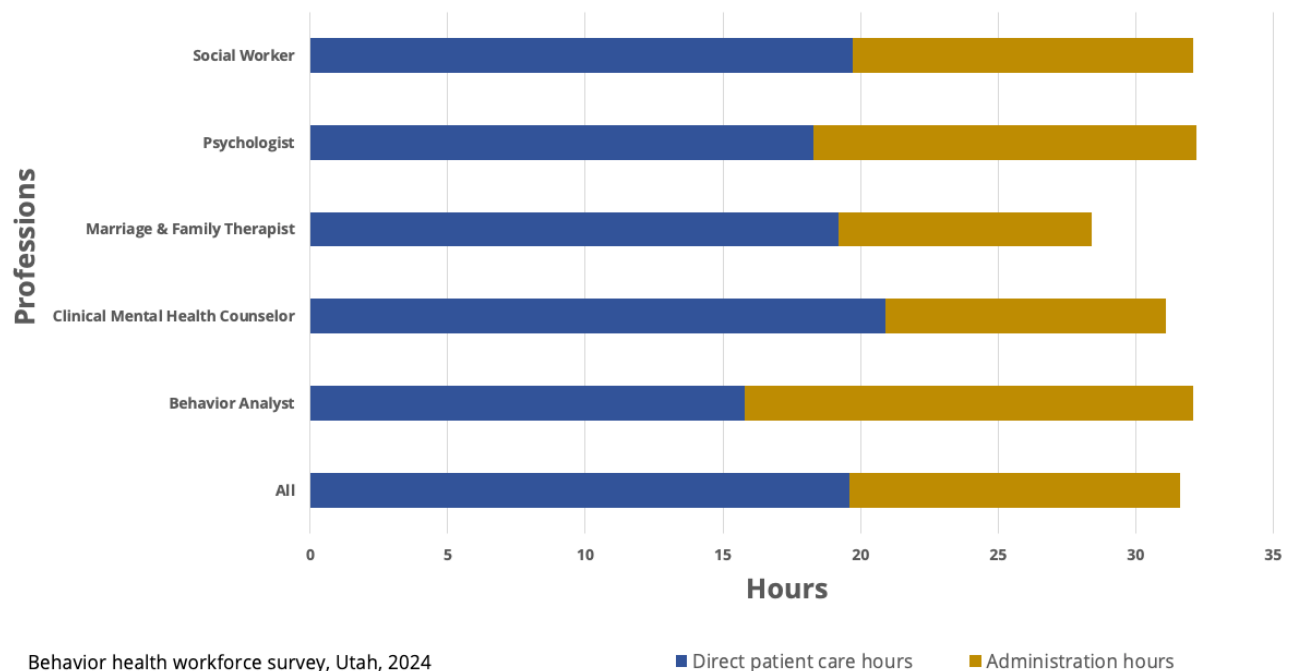
In primary practice settings, the settings differed by rural and urban status. While mental health clinics and independent solo practice were the top settings in all areas, the independent group practice setting (12.6%, 9.6%) was popular in urban and rural areas, but not in frontier areas. School-based facilities (K-12) (10.5%) and community health center (8.4%) ranked at the top 5 settings in frontier areas¹.

FTE and direct patient care hours

The average of the respondents' average working hours was 31.5. Marriage & Family Therapist (28.3 hours) and CMHCs (31.3 hours) were slightly below average. According to Figure 30, respondents spent over 37.8% of their working hours in administration; behavior analysts spent slightly more time on administration than direct patient care (16.3 vs 16.5). Psychologists' administration hours were close to half (18.3 vs 13.9). Reducing the administration burden would be one of the ways to improve the behavioral health providers' efficiency and allow more time to spend on direct patient care. The survey only collected data on primary and secondary practice locations, so it might miss some working hours in other locations. Figure 31 shows that respondents in rural and frontier areas spent more time than those in urban areas, except psychologists in rural areas, who spent about 3 hours less than the respondents who worked in urban areas.

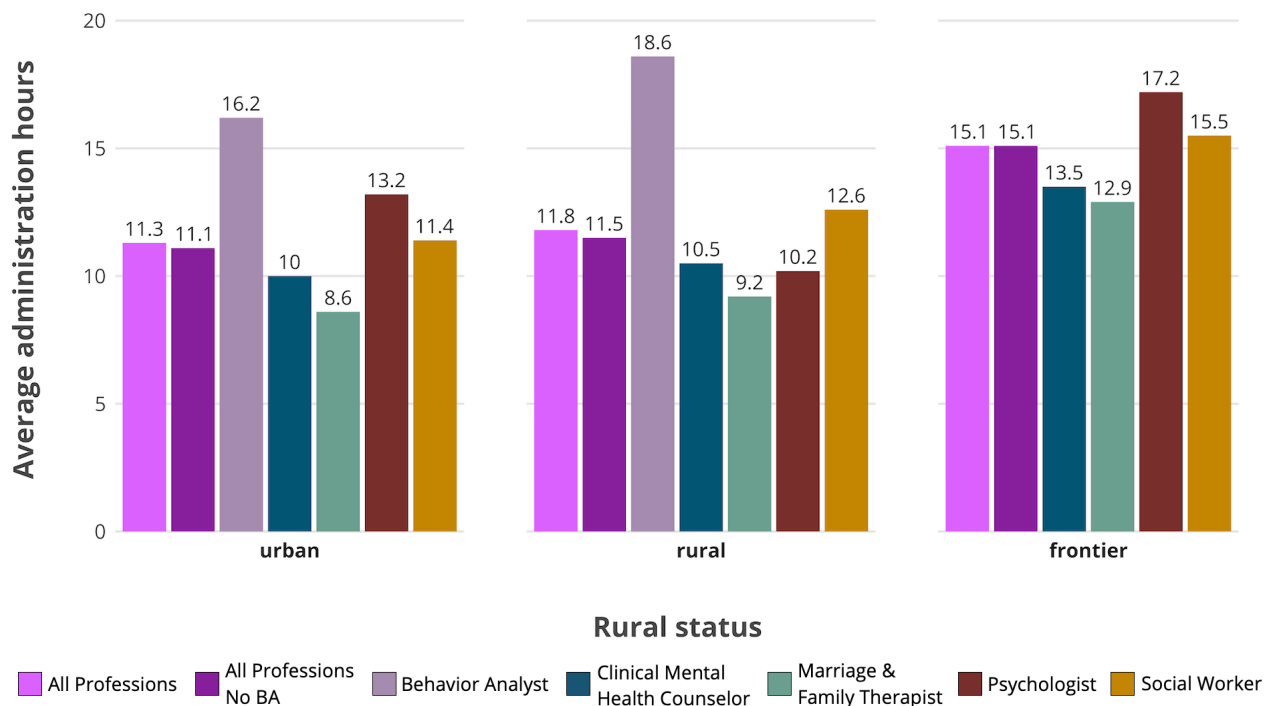
Figure 30. Direct patient care hours vs administration hours

Key takeaway: Behavior Analysts spend about half of working hours in administration work



¹ Behavioral health workforce survey, Utah, 2024.

Figure 31. Average administration hours in rural areas



Behavioral health workforce survey, Utah, 2024

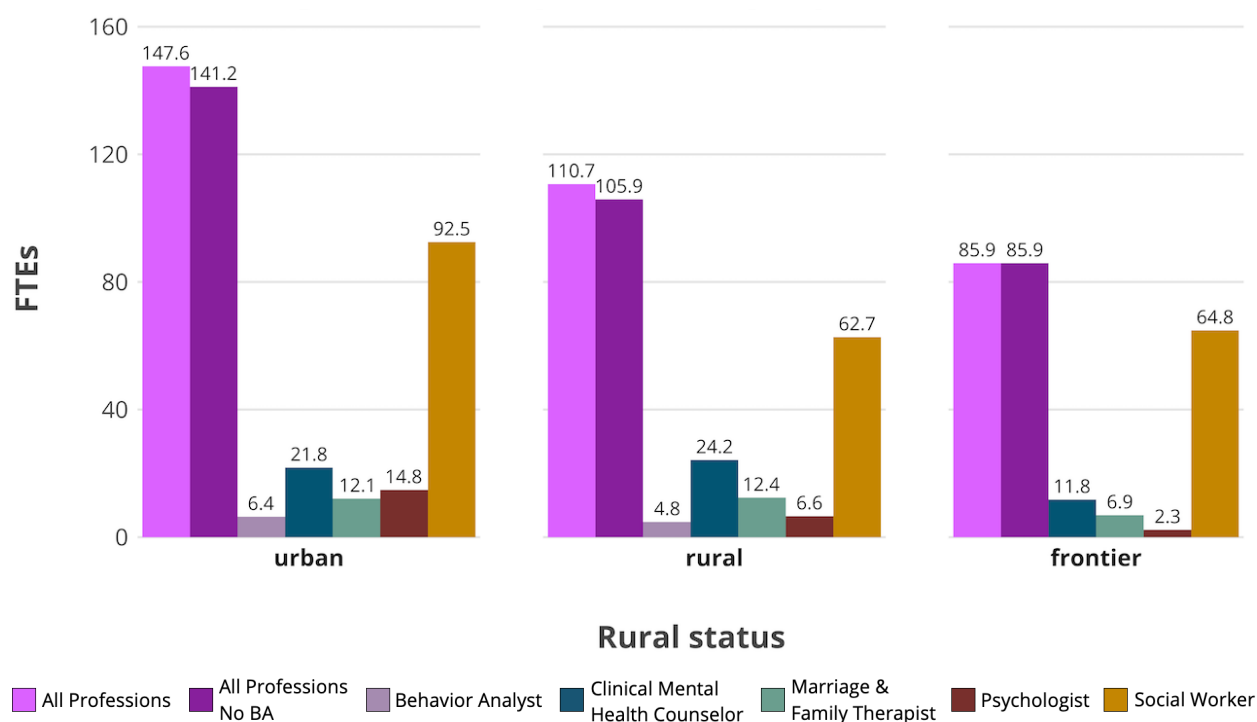
FTE was reported in three ways:

- **Total Hour FTE:** This calculation simply adds up hours across primary and, if applicable, secondary sites and divides by a "standard" 40-hour work week (e.g., 60 hours would equate to 1.5 FTEs, 20 hours would be 0.5 FTEs). Total Hour FTEs grew by 47% between 2016 and 2021. This was the method used to calculate FTEs for the 2016 Mental Health Workforce Report.
- **Standardized FTE:** Used by the Health Resources and Services Administration (HRSA), this calculation counted anything 40 hours or more as 1 FTE, and anything less than 40 hours in the same manner as the Total Hour FTE (e.g., 60 hours equates to 1 FTE, 20 hours equates to 0.5 FTEs)
- **Adjusted Standardized FTE:** Operated like the Standardized FTE, but when a provider reported only a secondary location in Utah, they were assigned .33 FTEs, regardless of hours reported. As of July 2021, there were 157 respondents for whom this was the case.

There were 4912.9 total hours FTE in 2024, 4774 standardized FTE, and 4771.2 adjusted standardized FTE. According to the standardized FTE in 100,000 population, urban areas were more than rural and frontier, but CMHC had about 2.4 hours more in rural areas than in urban areas. Psychologists had lower FTE in frontier areas compared to other

professions (Figure 32). And remote areas were more likely to spend hours in administration than in urban areas.

Figure 32. FTEs per 100,000 people in rural areas



Behavioral health workforce survey, Utah, 2024

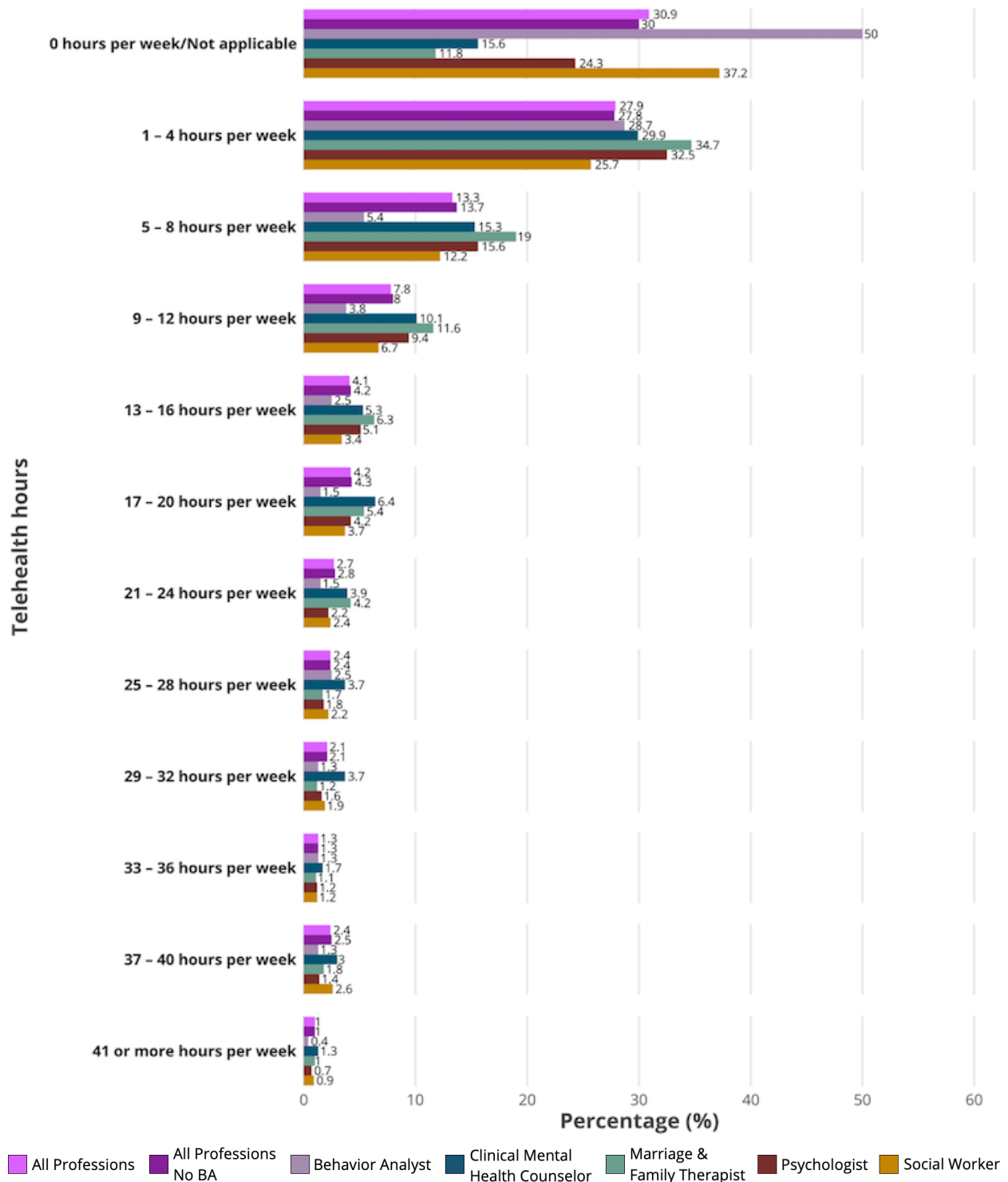
Telehealth services

The figure below shows how often behavioral health providers use telehealth and the number of hours delivered. This information is important because it helps us understand how providers are connecting with patients, especially those who may face barriers to in-person care.

About 70% of respondents used telehealth, as shown in Figure 33. About 50% of behavior analysts and 37.2% of social workers did not use it. About 88% of Marriage & Family Therapists, 84% of Clinical Mental Health Counselors, and 76% of Psychologists reported using telehealth. About 30% of respondents reported using it about 1 to 4 hours per week for direct patient care. On average, respondents spent about 31.5% of their direct patient care hours providing services via telehealth. Behavior analysts and social workers had lower rates than average (17.4%, 29.9%). Respondents reported their hours worked in ranges (for example, 21–24 hours per week). To calculate the averages, the midpoint of

each range was used; for instance, the midpoint of 21–24 hours is 22.5 hours, and these midpoints were averaged across all respondents.

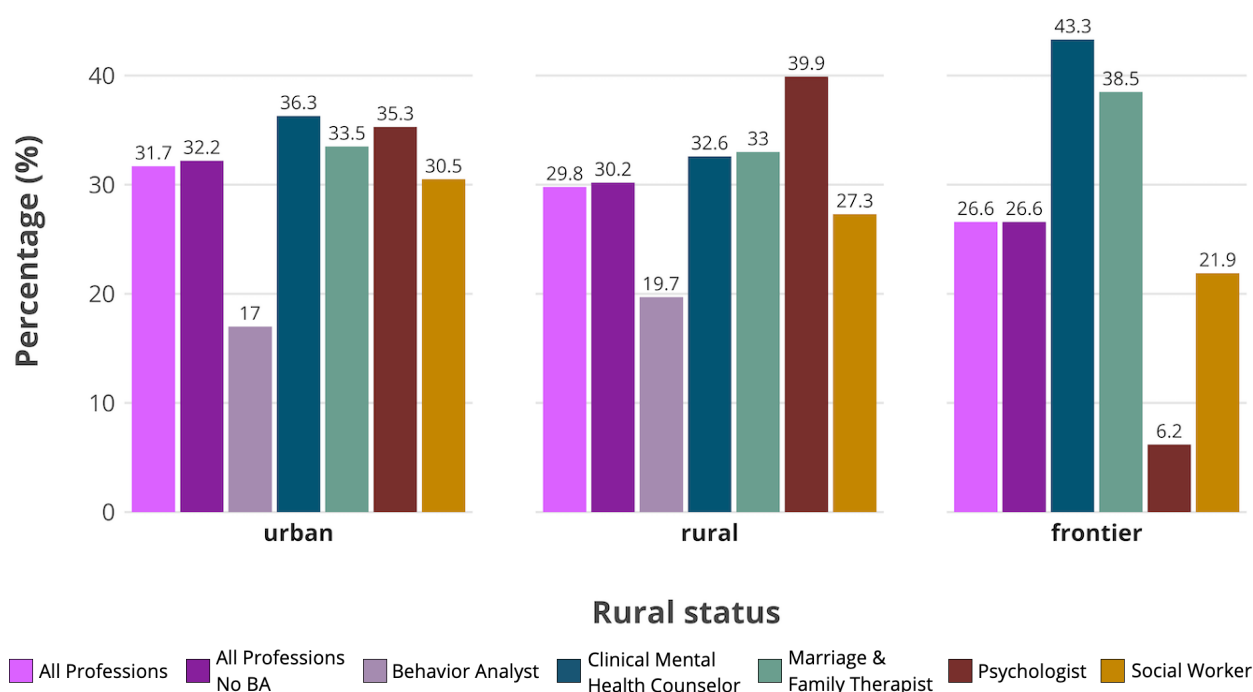
Figure 33. Using telehealth hours distribution



Behavioral health workforce survey, Utah, 2024

Rural and frontier areas did not have higher percentages of telehealth use for direct patient care. In fact, psychologists in frontier areas had the lowest telehealth use at 6.2%. However, CMHCs (43.3%) and MFTs (38.5%) in these areas used telehealth at higher rates than in urban areas (Figure 34).

Figure 34. Percent of direct patient care spent using telehealth



Behavioral health workforce survey, Utah, 2024

Future employment

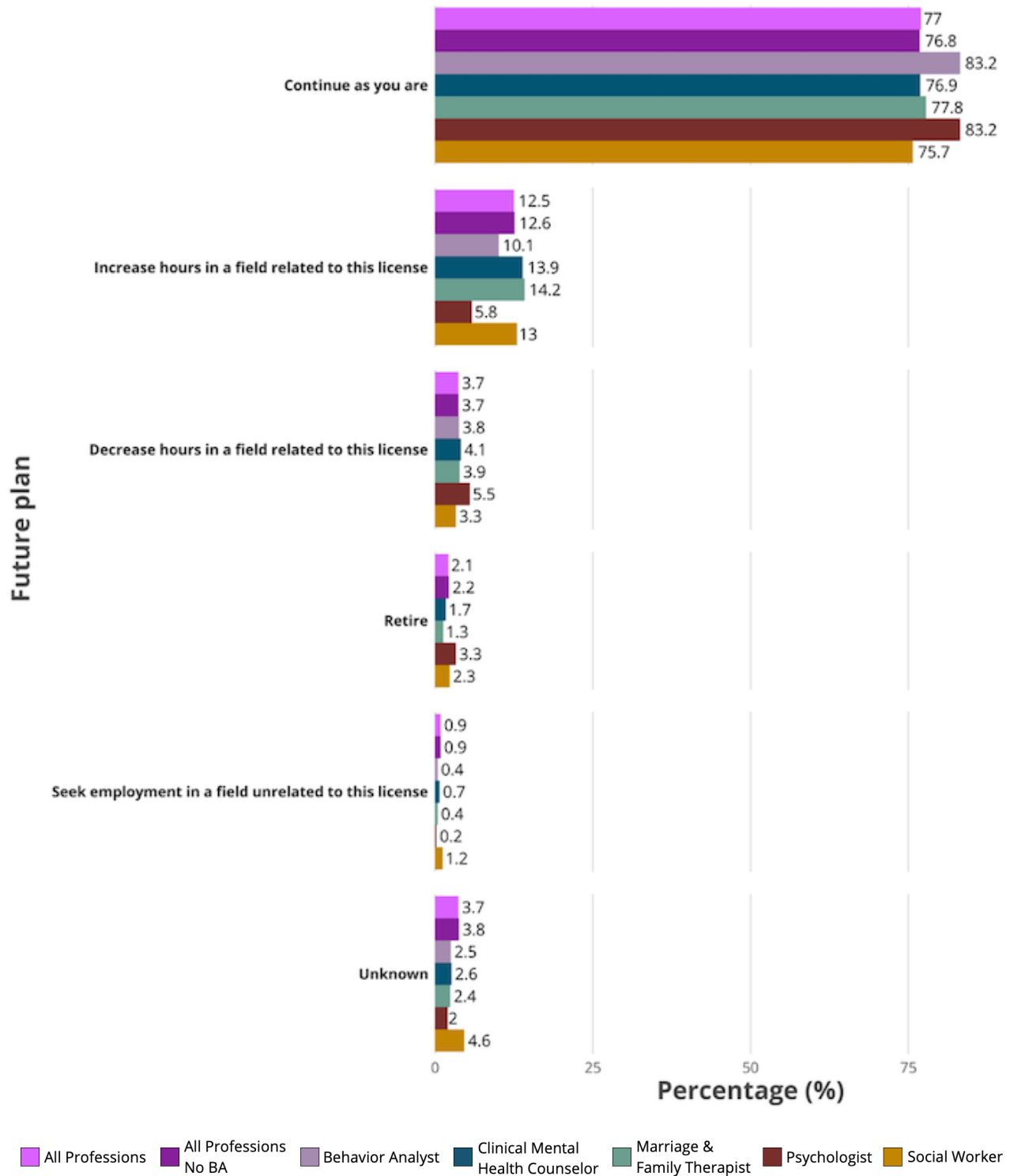
This section included data on future employment intentions, including employment plans for the next two years and anticipated changes in hours worked.

Two-year employment intentions

Most respondents planned to continue working as they currently were with more CMHCs (13.9%) and MFTs (14.2%), intending to increase the working hours. However, more psychologists planned to decrease hours (5.5%) or retire (3.3%) when compared to other professions (Figure 35).

Figure 35. Future plans distribution

Key takeaway: Most respondents will continue as they are



Behavioral health workforce survey, Utah, 2024

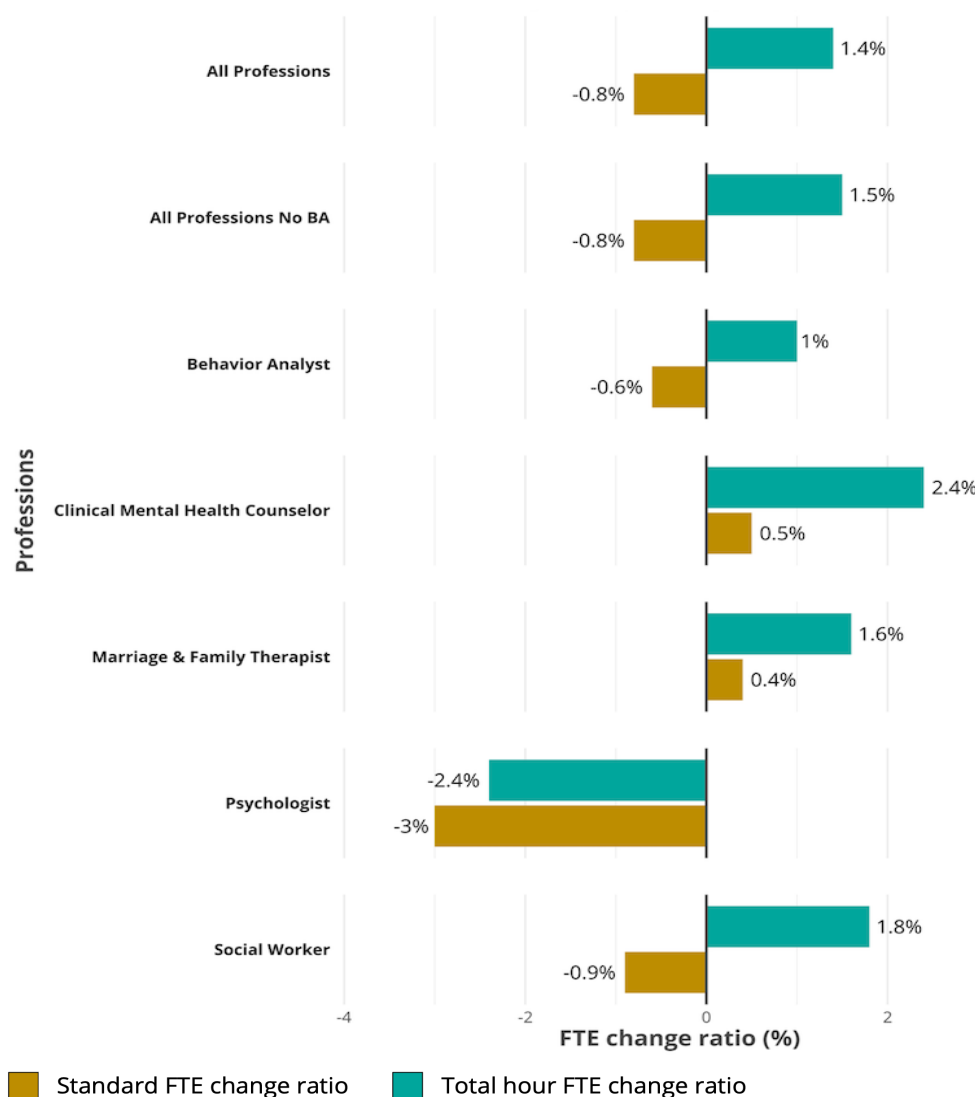
Approximately 77% of respondents indicated they plan to continue working the same hours as they currently do, and about 12.5% indicated they plan to increase their hours, and only about 3.7% indicated they plan to decrease their hours. But 2.1% of respondents planned to retire in the next 2 years, and 0.9% planned to change to a field unrelated to their current licenses.

For those who reported increasing hours, about 56% planned to increase hours by about 1 to 12 hours, including about 24% of respondents who planned to increase by 5-8 hours. In respondents who claimed to decrease hours, about 43.6% were in the range of 5-12 hours. About 15.8% planned to decrease by 1-4 hours, and 11.7% planned to decrease by 17-20 hours.²

As indicated in Figure 36, most respondents, regardless of profession, reported an increase in total FTE hours of about 1% - 2.4% in the next 2 years, except psychologists, whose total FTE hours dropped 2.4%. The standard FTE hours for CMHCs and MFTs reported an increase of 0.5% and 0.4%, respectively, over the next two years. In contrast, other professions dropped by about 0.4% to 0.9%, and psychologists dropped by 3%. These data suggest that while the volume of work the respondents planned to do was going up, the standard FTE was not moving or dropping, meaning that growth would be coming from overtime and increased workload for current respondents, not more providers entering the workforce. There may be a widening gap between labor volume and workforce capacity. If there were no new entries into the behavioral health professions, it could lead to future burnout and eventual exit from the field.

² Behavioral health workforce survey, Utah, 2024.

Figure 36. Percent change in standardized and total hours FTE future plans



Behavioral health workforce survey, Utah, 2024

While not shown here, most (60.7%) respondents who planned to increase hours were 35-54 years old, and the age at which most were planning to decrease hours varied by profession. Behavior analysts (83.4%) and social workers (41.6%) who planned to decrease hours tended to be younger than other professions, around 25-44; half of psychologists who planned to decrease hours were older than 65. There were no respondents among behavior analysts who retired in the next 2 years, which is likely because about 99.5% of respondents were under 64, as indicated in Figure 2. The average projected retirement age

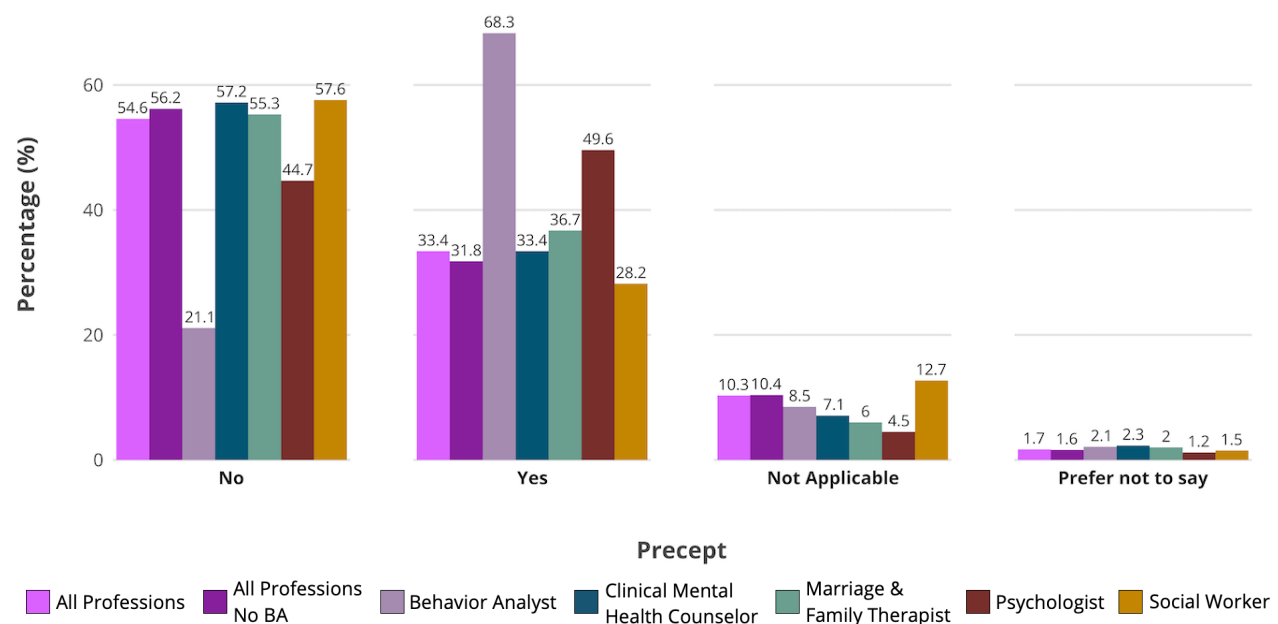
was 66.8. Social workers' retirement age was the youngest at 66. Psychologists' average retirement age was 70.³

Precepting

33.4% of respondents reported precepting, and 54.6% said they had not precepted. Behavior analysts reported the highest precepting rate at 68.3%. About half of the psychologists' respondents reported precepting (49.6%) (Figure 37).

Figure 37. Precepting students' distribution

Key takeaway: Over half respondents won't precept students



Behavioral health workforce survey, Utah, 2024

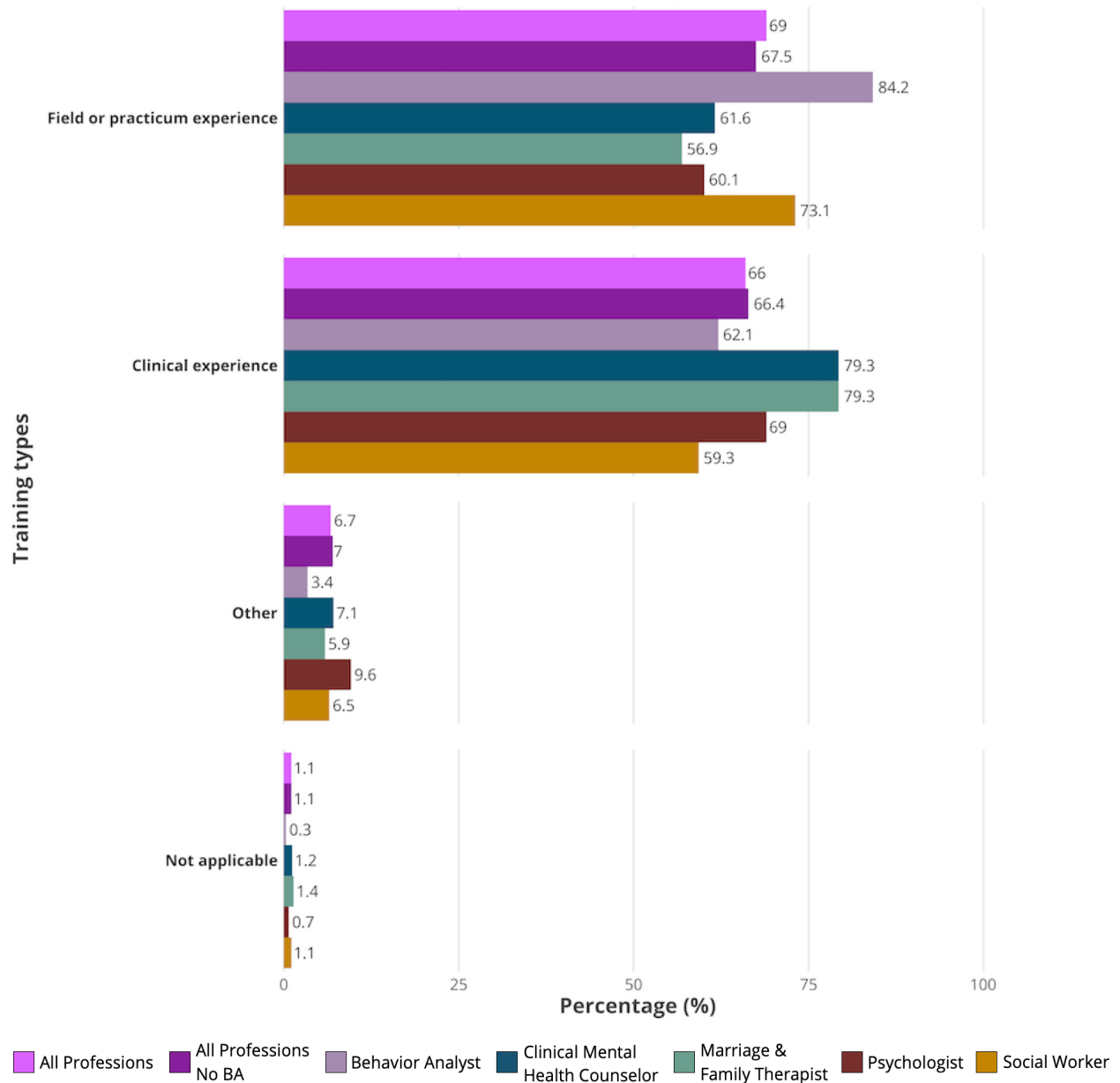
Most respondents provided training types in their field experience or practicum experience for behavioral health students before graduation (69%) and clinical experience supervision for graduates/associate licensees who were pursuing full clinical licensure (66%). However, behavior analysts (84.2%) and social workers (73.1%) were more likely to provide field or practicum-based training, while the other professions were more focused on clinical

³ Behavioral health workforce survey, Utah, 2024.

supervision experiences (Figure 38). While not shown, about 41.8% of respondents did multiple types of precepting.⁴

Figure 38. Training types for precepting students

Key takeaway: Most respondents provide multiple training types



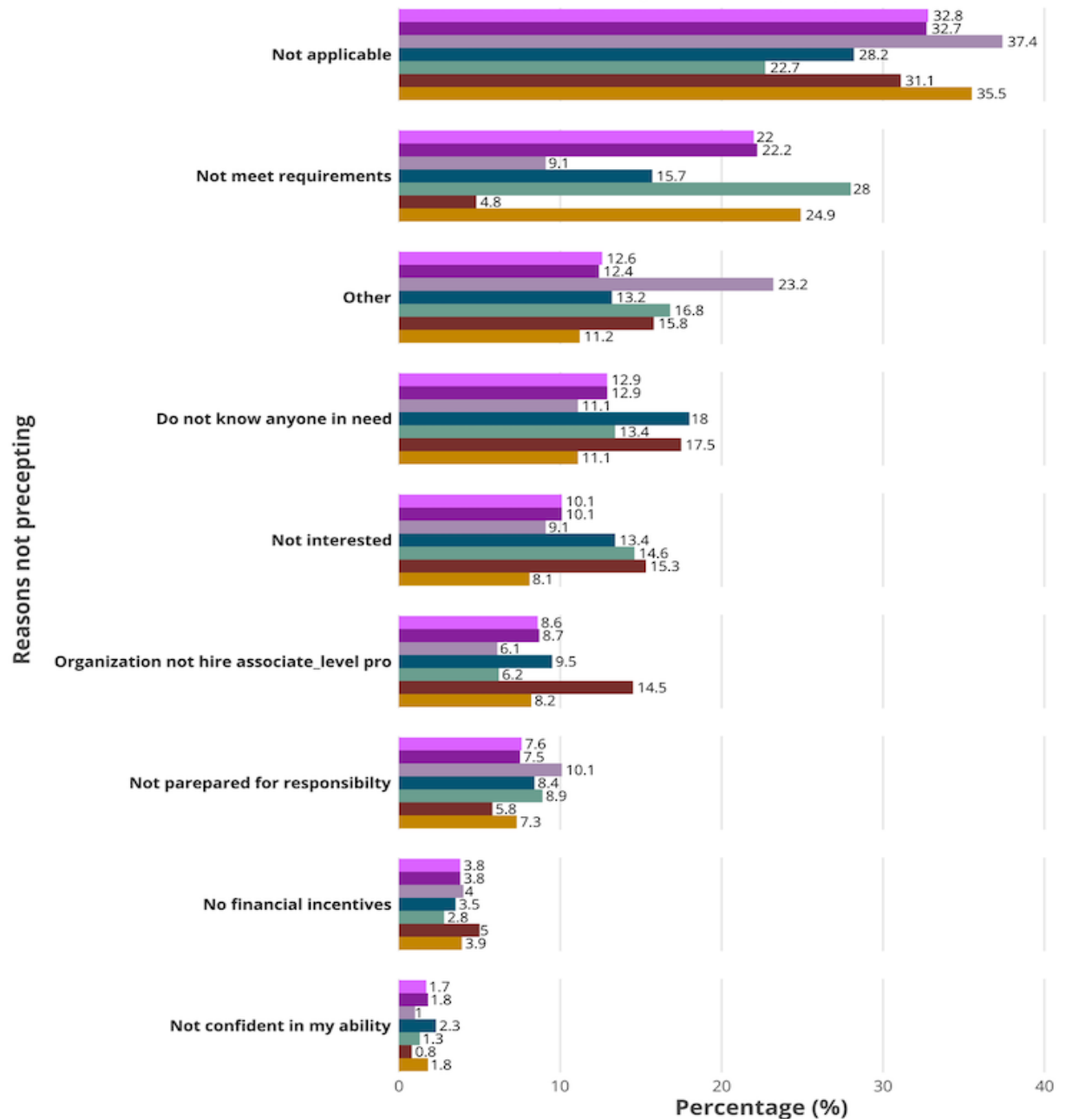
Behavioral health workforce survey, Utah, 2024

⁴ Behavioral health workforce survey, Utah, 2024.

As seen in Figure 39, excluding “Not applicable” and “Other”, the top two reasons that respondents wouldn’t precept were not meeting requirements (22%) and didn’t know anyone in need (12.9%). About 9.2% respondents had more than one reason not to precept.

Figure 39. Reasons for not precepting students

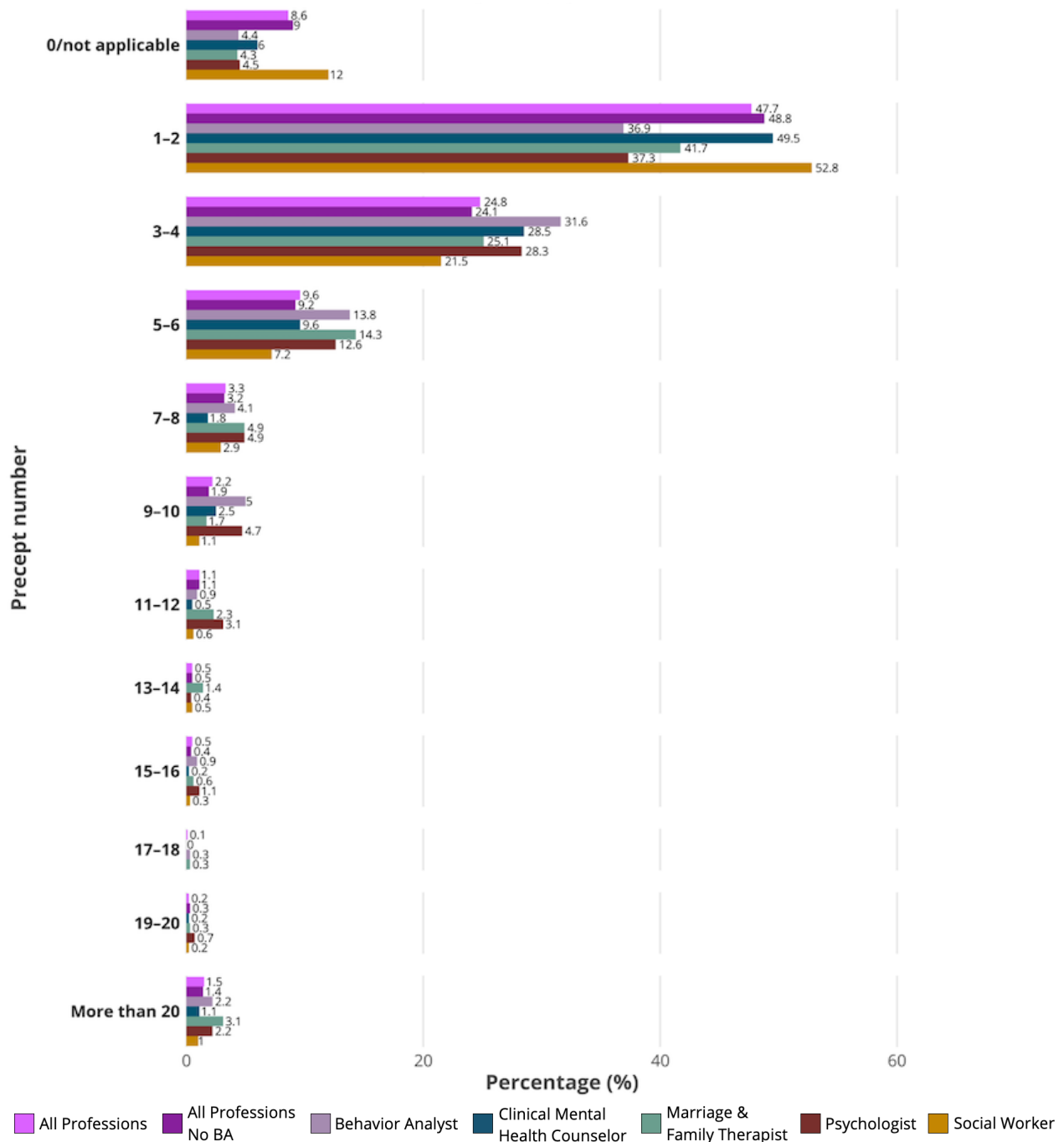
Key takeaway: The top two reasons are not meet requirements and unknown anyone in need



Behavioral health workforce survey, Utah, 2024

As shown in Figure 40, most of the respondents reported precepting 1 or 2 students in the last 2 years (47.7%). Less than 73% of respondents precepted no more than 4 students. According to the respondents' claim number transformation (1-2 would be transformed to 1.5 for easy calculation purposes), it would be expected that there were about 11,076 students under precepting in the last two years.

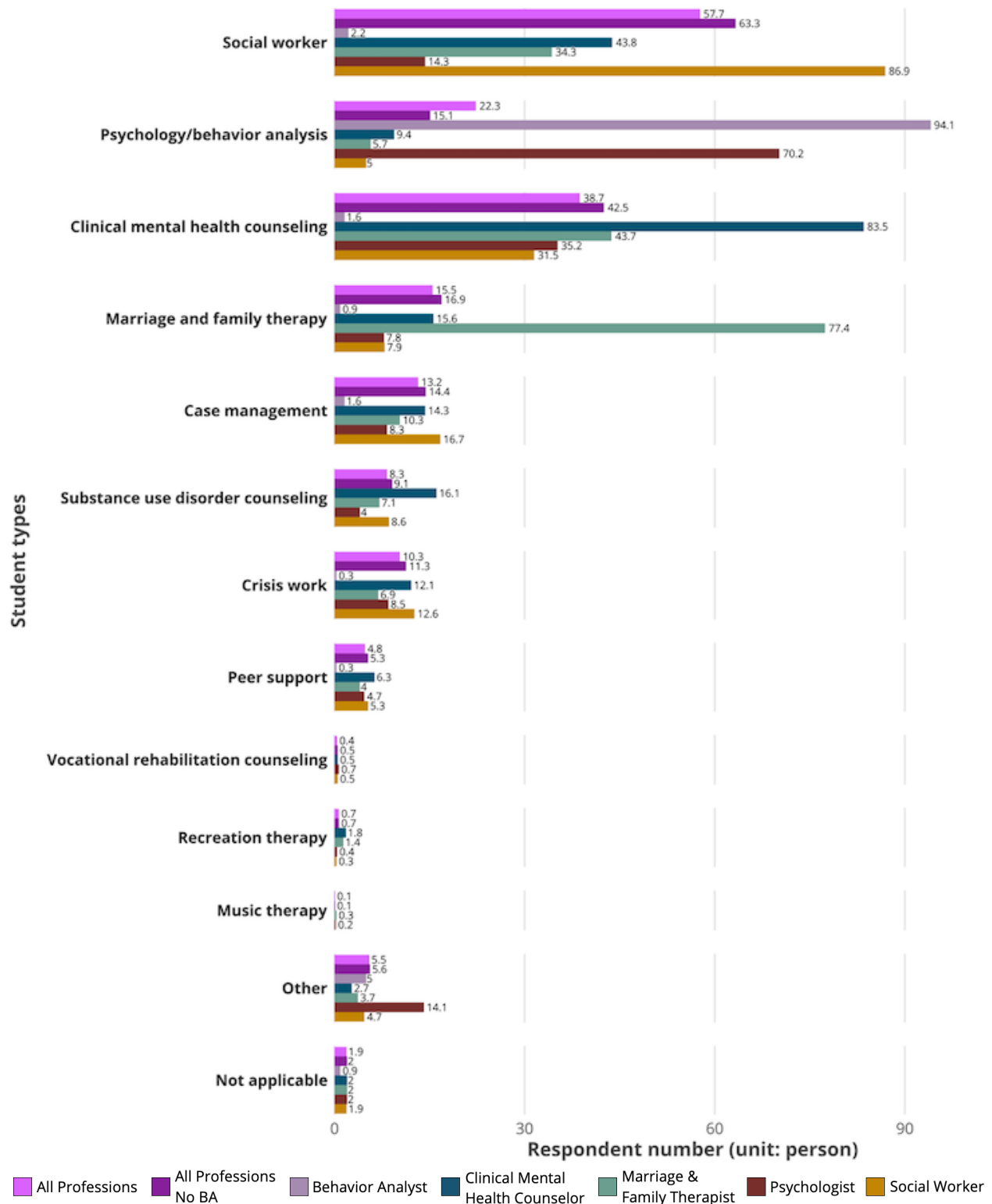
Figure 40. Precepting student number



Behavioral health workforce survey, Utah, 2024

Figure 41. Precepting student's types

Key takeaway: Most respondents precept multiple type of students and their profession related types



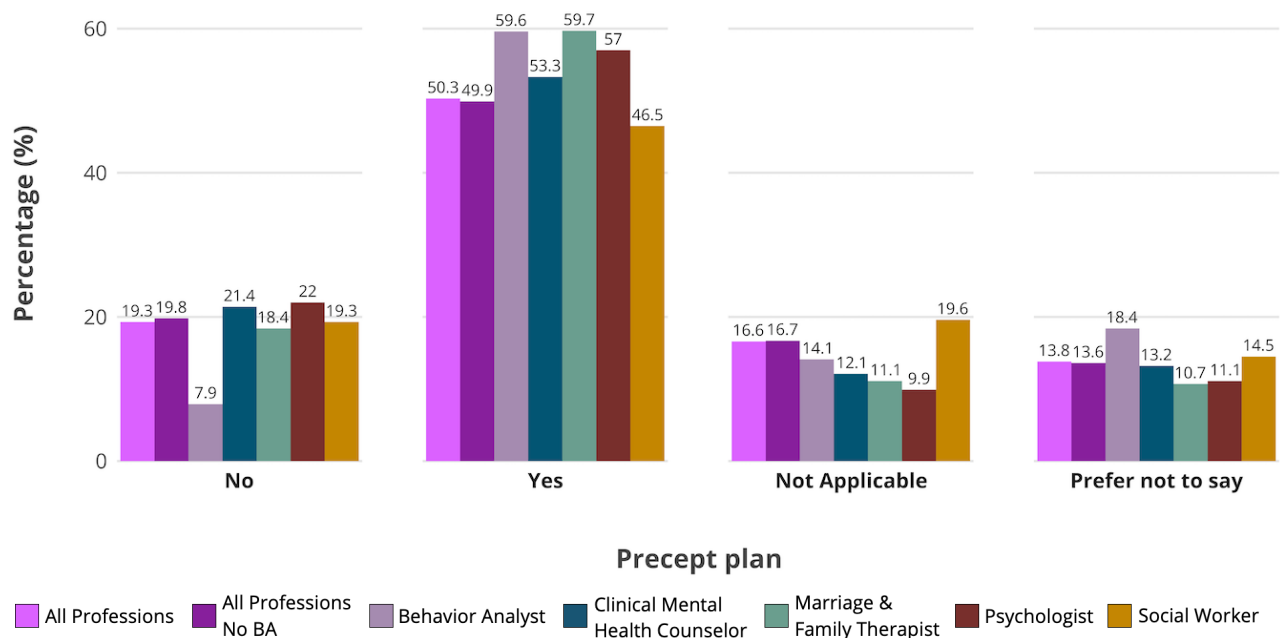
Behavioral health workforce survey, Utah, 2024

Around 43% of respondents claimed that they could precept multiple types of students.⁵ But they still mainly precepted students who related to their own license, as seen in Figure 41.

About half of the respondents (50.3%) claimed to precept in the future, as seen in Figure 42. Compared to Figure 37, the percentage that planned to precept increased dramatically in almost every profession. MFT increased by 23%, then CMHC increased by nearly 20%, psychologists increased by 7.4%, and social workers increased by 18.3%. But Behavior Analysts dropped from 68.3% to 59.6%.

Figure 42. Future plan to precept students

Key takeaway: Over half respondents will precept students



Behavioral health workforce survey, Utah, 2024

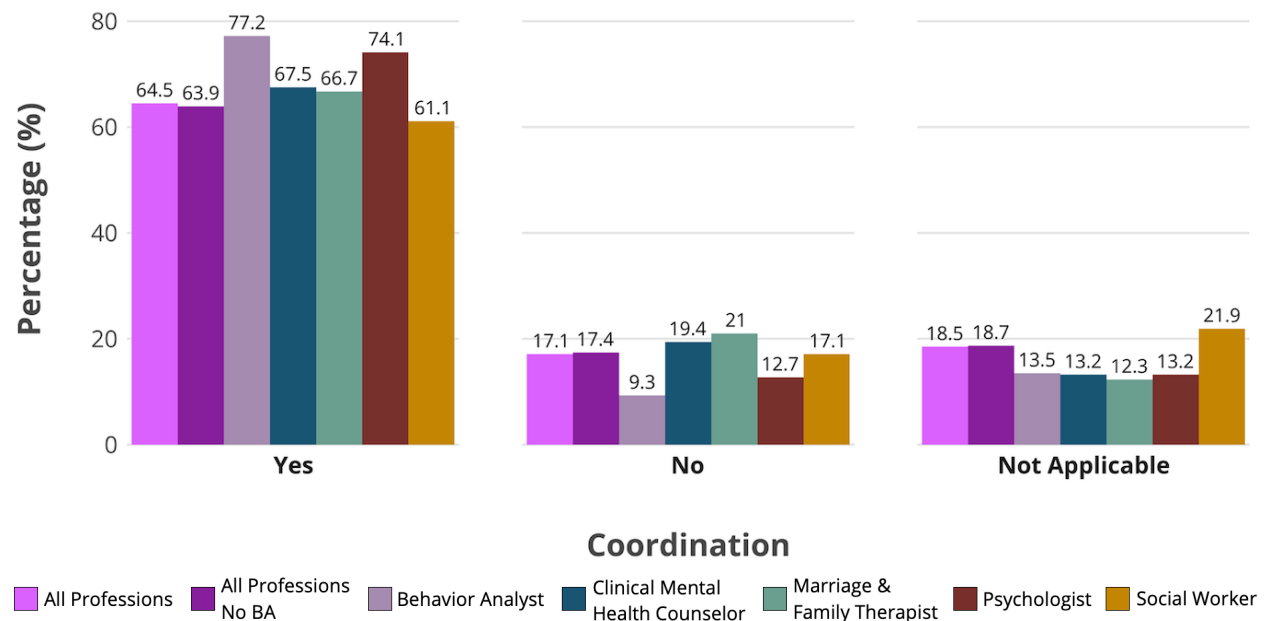
⁵ Behavioral health workforce survey, Utah, 2024.

Care Coordination

About 64.5% respondents coordinated with other providers, especially Behavior Analysts and Psychologists, about 77.2% or 74.1%, respectively.

Figure 43. Percent of those who report care coordination by professions

Key takeaway: Most respondents will coordinate with other professionals

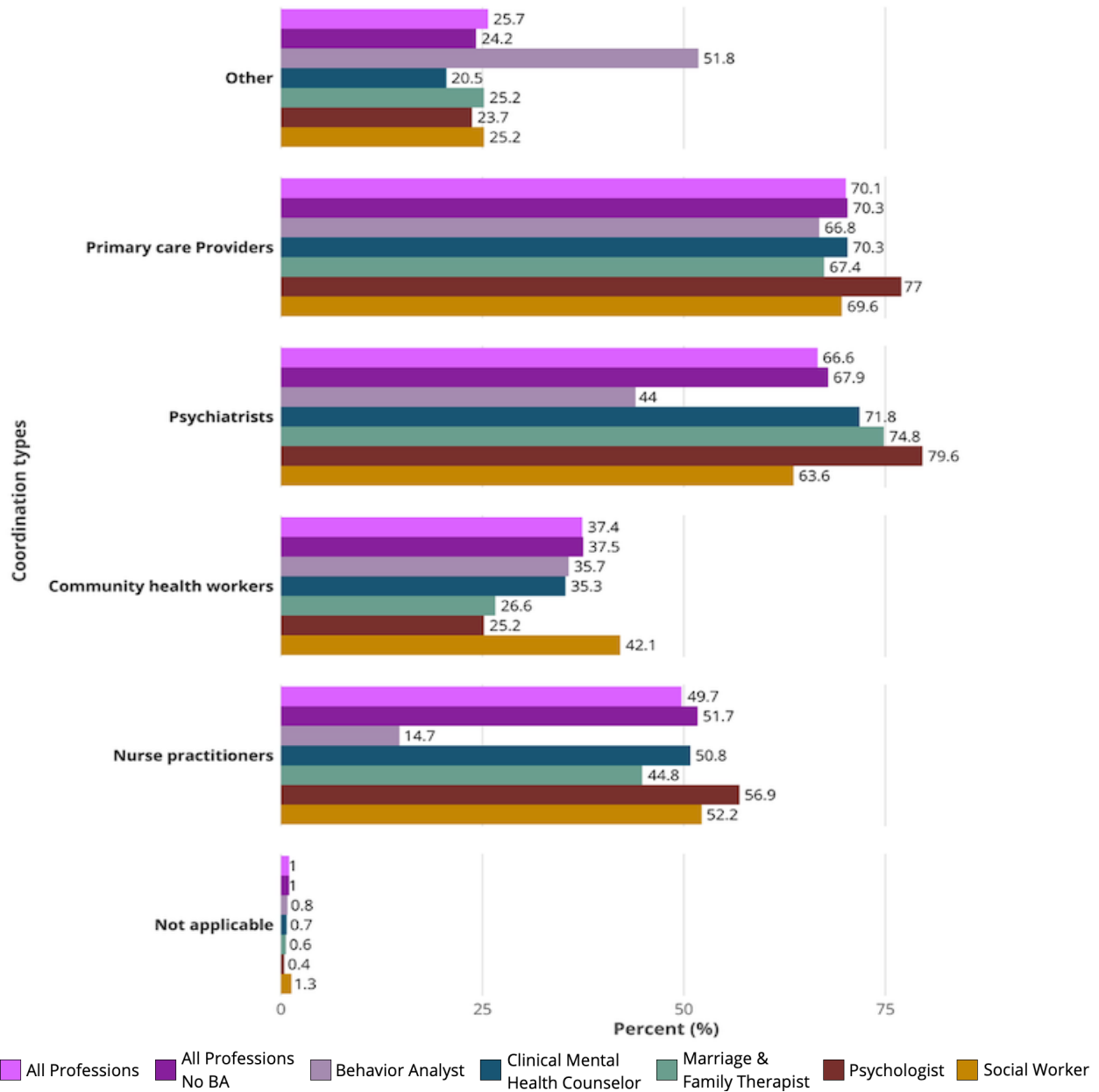


Behavioral health workforce survey, Utah, 2024

Most respondents reported coordinating with multiple providers (64.5%) (Figure 43). As seen in Figure 44, the most common coordination partners also included primary care providers and psychiatrists. Behavior analysts were more likely than other professions to coordinate with providers not specifically listed in the survey.

Figure 44. Coordination with other providers' type

Key takeaway: Most respondents coordinate with multiple provider's types

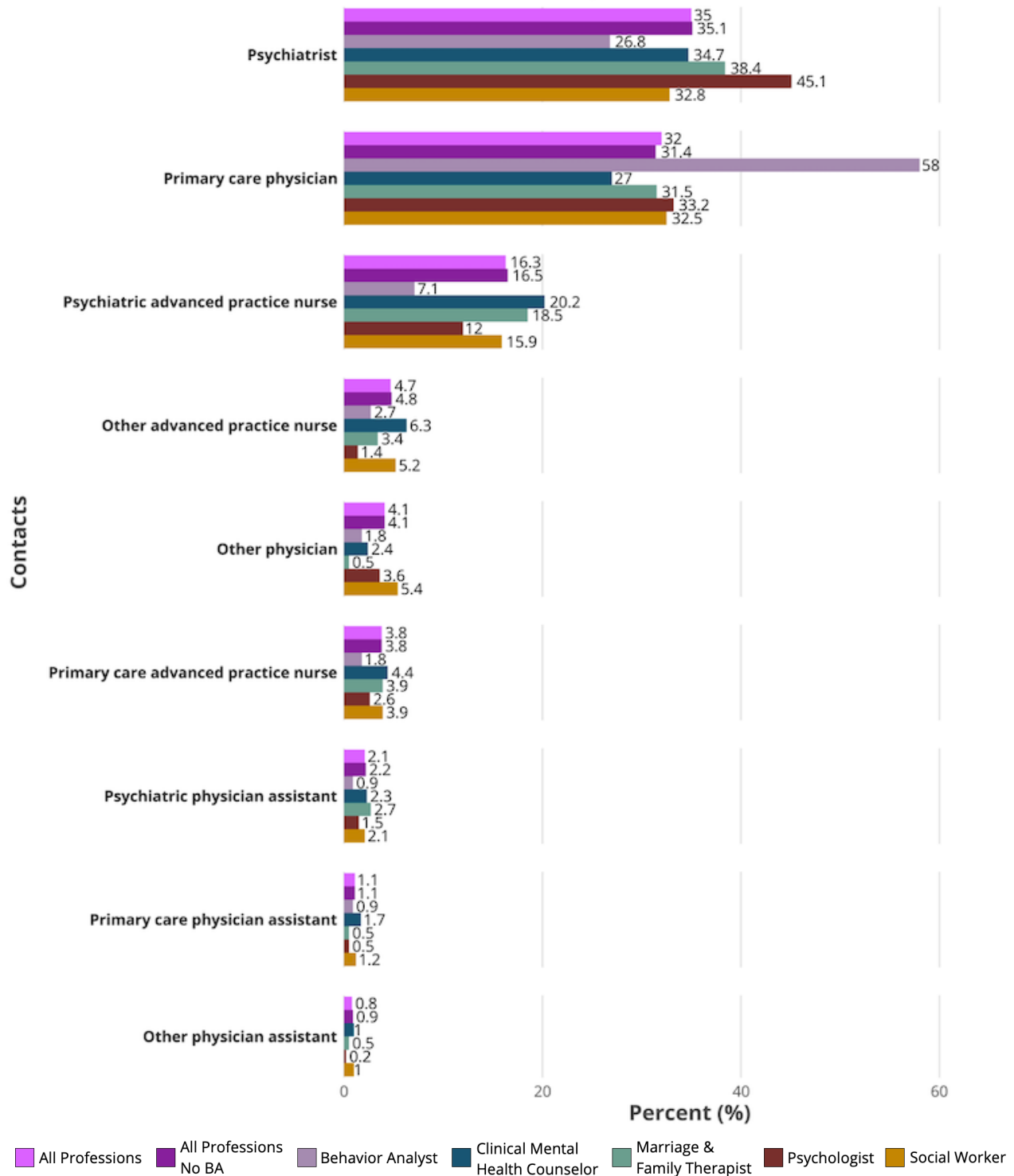


Behavioral health workforce survey, Utah, 2024

The primary sources from which respondents received medication prescriptions were psychiatrists (35%) and primary care physicians (32%) (Figure 45). Additionally, 16.3% of respondents reported working with psychiatric advanced practice nurses for prescribing. Notably, 58% of behavior analysts reported working with primary care physicians for their prescriptions, which was higher than in other professions.

Figure 45. Sources to prescribe medication

Key takeaway: Most respondents to prescribe medication from psychiatrist and primary care physician



Behavioral health workforce survey, Utah, 2024

Paraprofessionals

To address the shortage of the behavioral health workforce, Utah offers eight license types for individual paraprofessionals, as shown in the table below. DUI Education Provider Agencies are licensed organizations rather than individual paraprofessionals.

Table 3. Paraprofessional certificates included in this report

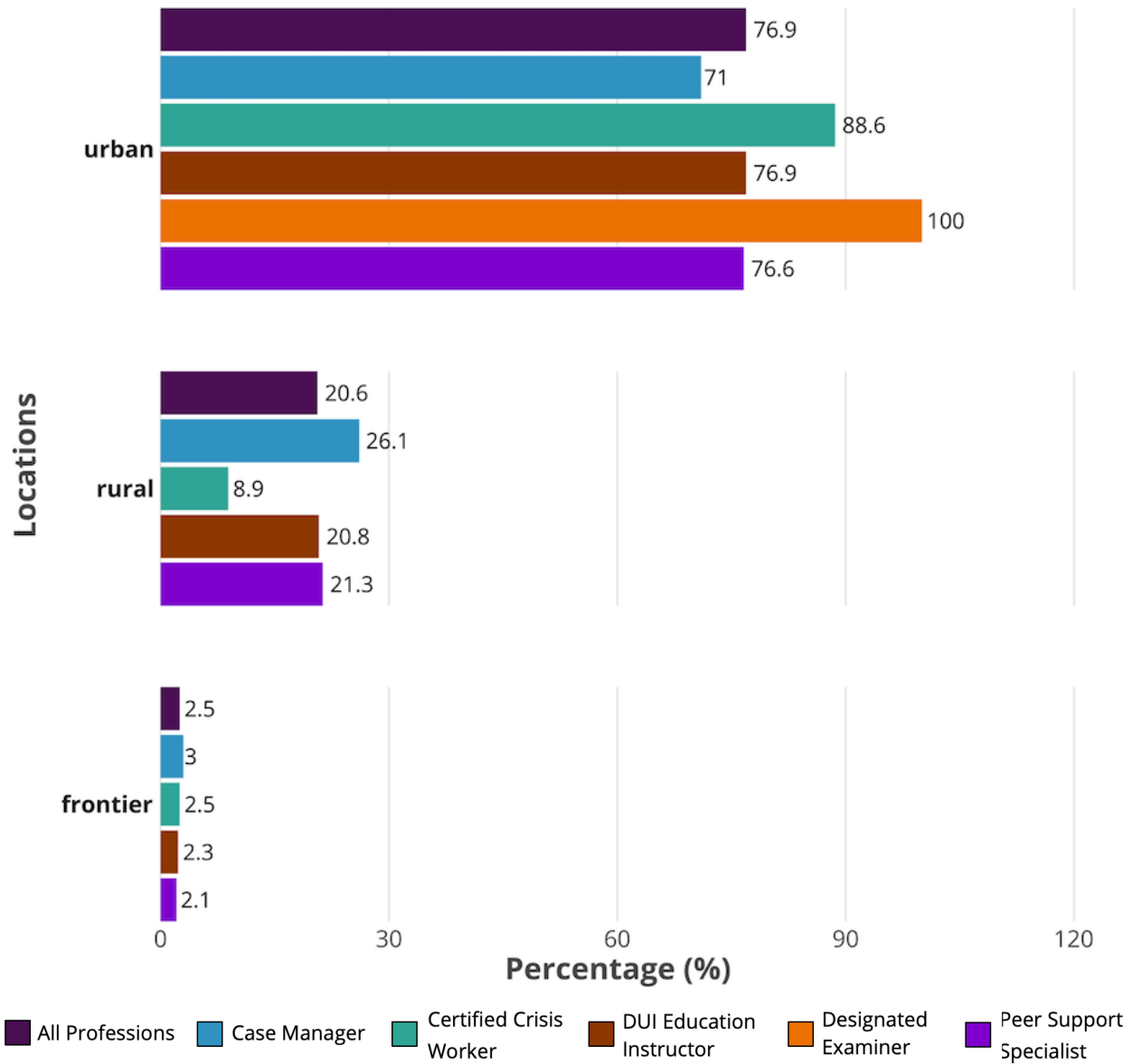
Name	License type	License number	Percentage
Case Manager	Case Manager-Adult Behavioral Health	1555	39.5%
Case Manager	Case Manager-Children Behavioral Health	143	3.6%
Case Manager	Case Manager-Homeless Services	7	0.2%
Certified Crisis Worker	Certified Crisis Worker	681	17.3%
DUI Education Instructor	DUI Education Instructor	173	4.4%
Designated Examiner	Designated Examiner	126	3.2%
Peer Support Specialist	Family Peer Support Specialist - Core Training	134	3.4%
Peer Support Specialist	Peer Support Specialist - Core Training	1116	28.4%
Total		3935	100%

SUMH, UCLAPP, Utah, 2025

There were 3,935 licensed paraprofessionals and 12 DUI Education Provider Agencies in Utah. 39.5% of paraprofessionals were Case Manager-Adult Behavioral Health. Peer Support Specialist - Core Training and Certified Crisis Worker were the next most common (28.4%, 17.3%), representing about 85% of the paraprofessionals. Over half of the paraprofessionals were in Salt Lake County, and only 23.1% paraprofessionals were in rural and frontier areas.

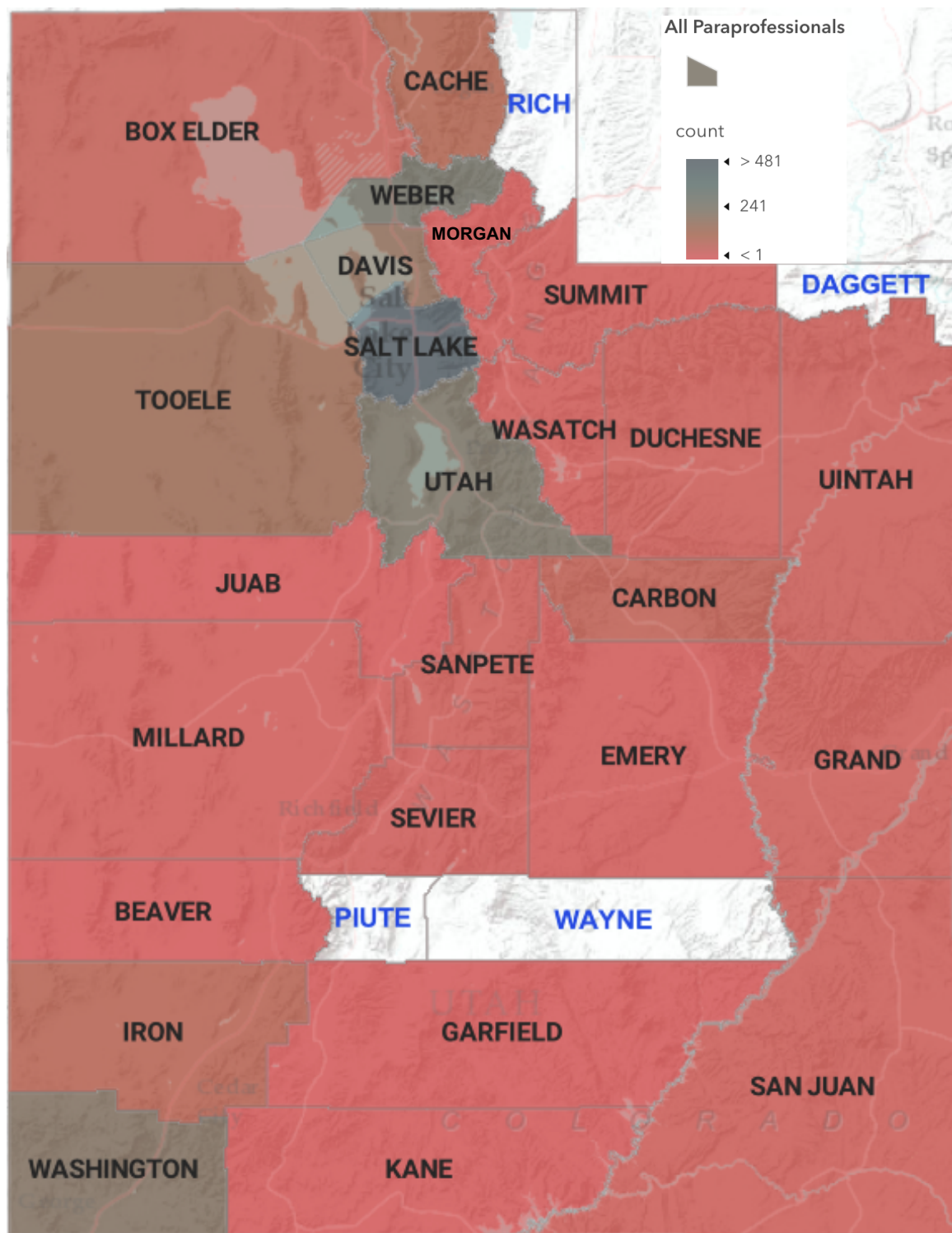
Figure 46. Paraprofessionals in rural

Key takeaway: Most paraprofessionals are in urban areas



SUMH, UCLAPP, Utah, 2025

Map 2. Paraprofessionals' certificate geographic distribution



SUMH, UCLAPP, Utah, 2025

Training programs are available for paraprofessionals, including CPSS training. UAPSS had the highest number of trainees among these programs. Over half (53.7%) of CPSS trainees were based in Salt Lake County, while only 10.5% were from rural and frontier areas. Overall, participants in these training programs tended to come from nearby counties or urban areas. However, Utah State University's hybrid program attracted a higher proportion of participants from rural and frontier regions.

Table 4. CPSS training

Training program	Count	Percent (%)
Davis Behavioral Health	15	9.2
Latino Behavioral Health Services (Spanish)	24	14.7
No Preference	14	8.6
Optum Health CPSS Training	2	1.2
Southwest Behavioral Health Center	2	1.2
Utah Association of Peer Support Specialists (UAPSS)	64	39.3
Utah Department of Corrections	1	0.6
Utah State University (Hybrid)	19	11.7
Utah Support Advocates for Recovery Awareness (USARA)	22	13.5

SUMH, UCLAPP, Utah, 2025

Comparative Insights

DOPL license counts trends

DOPL active licenses were counted between 2020 and 2025, and for 8 active licenses, the total numbers had almost doubled since 2020, as shown in Table 5. However, growth was uneven: behavior analysts increased at a faster rate than psychologists (11.8%) and social service workers (11.5%).

Table 5. DOPL licenses by year and license type

Profession name	License name	2020	2025	Change from 2020	2025 Per 100K population
Behavior Analyst	Assistant Behavior Analyst	76	41	-46.1%	1.2
	Behavior Analyst	482	1,249	159.1%	35.2
Clinical Mental Health Counselor	Clinical Mental Health Counselor	1763	3122	77.1%	87.9
Marriage & Family Therapist	Marriage & Family Therapist	936	1,746	86.5%	49.2
Psychologist	Psychologist	1193	1,334	11.8%	37.6
Social Worker	Certified Social Worker	2255	3,222	42.9%	90.7
	Licensed Clinical Social Worker	4835	7,701	59.3%	216.9
	Social Service Worker	2131	2,375	11.5%	66.9
All Professions	Total	9,995	20,210	52.1%	585.4
All Professions except BA	Total without BA	9,888	19,128	48.7%	549.1

DOPL, Utah, 2025

Table 6 shows the license counts per 100,000 population and their ratio to the total behavioral health workforce from various data sources.

Data limitations contributed to variation in the counts of behavioral health providers across data sources. In particular, the DOPL counts in Table 6 differ from those in Table 5 because the DOPL licensing database is dynamic and updated as license statuses change over time. Table 6 reflects a snapshot of active licenses as of July 17, 2025, whereas historical data cannot isolate active licenses at a single point in time and instead relies on recursive counting based on license issue and expiration dates.

Table 6. Behavioral health provider counts and ratio comparison

Profession name	DOPL count	DOPL counts to pop 100k	DOPL ratio in BH	UI count	UI counts to pop 100K	UI ratio in BH	HRSA count	HRSA counts to pop 100k	HRSA ratio in BH
Behavior Analyst	1101	31.4	5.3%	651	18.6	5.2%	12	0.3	0.3%
Clinical Mental Health Counselor	2868	81.8	13.8%	1438	41	11.6%	60	1.7	1.7%
Marriage & Family Therapist	1597	45.5	7.7%	723	20.6	5.8%	412	11.7	11.7%
Psychologist	1287	36.7	6.2%	724	20.6	5.8%	320	9.1	9.1%
Social Work	11888	339	57%	8025	228.8	64.7%	2211	63	62.8%
Total		534.4			329.6			85.8	
Total without BA		503			311			85.5	

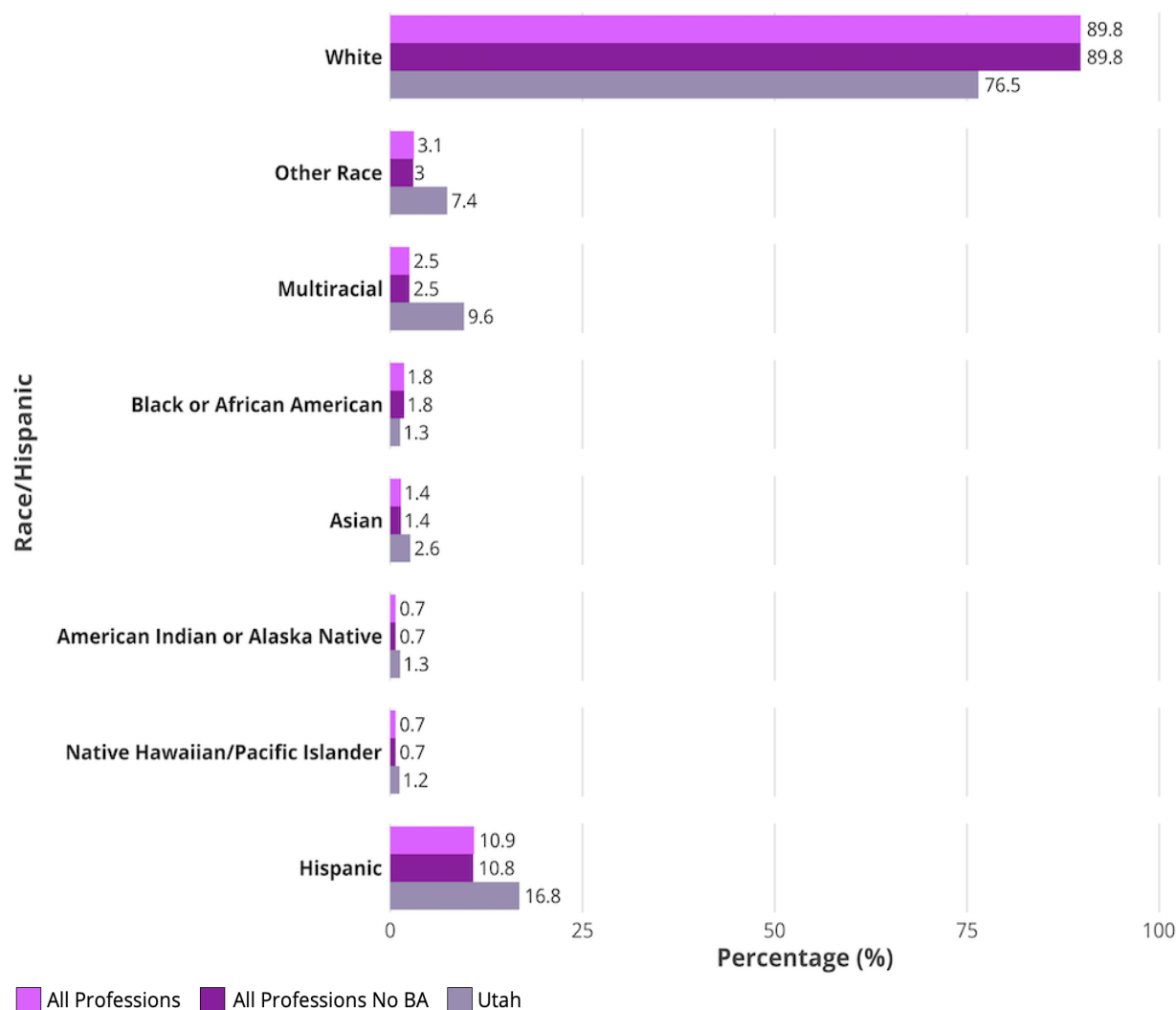
HRSA, 2025; DOPL, Utah, 2025; Unemployment Insurance, Utah, 2024

Gender, Race, and Ethnicity Distribution in Education and Debt

Compared to the racial and ethnic composition of Utah’s population, the proportion of minority and Hispanic respondents was lower than that of the state. Hispanic professionals are underrepresented. They made up about 10.9% of the behavioral health workforce, compared to 16.8% of Utah’s population, even though the proportion of respondents identifying as Hispanic increased from 4.8% in 2016 to 10.9% in 2024.

The report evaluated demographic distributions by comparing the general makeup of each profession to its specific outcomes in education and debt. To analyze how gender, race, and ethnicity intersect with education levels and student debt, we established a baseline respondent ratio for each demographic group within their respective professions. We then compared this baseline to the actual distribution of that group within specific education and debt categories. A “High” marker indicated that a group was overrepresented in a category relative to their presence in the profession, while “Low” indicated underrepresentation. In this context, a “High” marker in education suggested higher academic attainment, whereas a “High” marker in debt indicated a disproportionately higher financial burden.

Figure 47. Race/ethnicity composition vs. Utah population

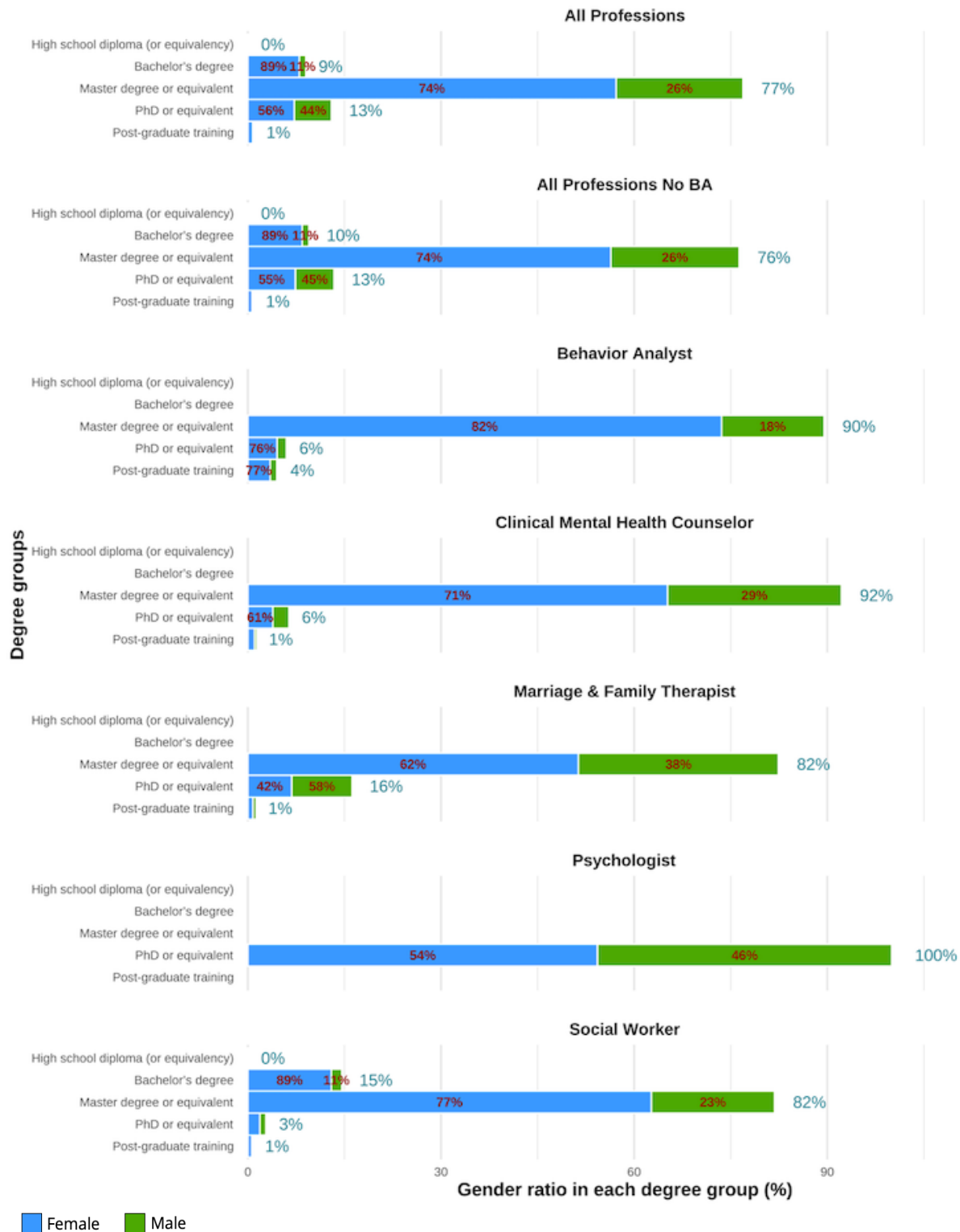


Behavioral health workforce survey, Utah, 2024; Healthy Salt Lake, Utah, 2025

Female respondents were generally less likely to pursue a PhD or equivalent degree. As seen in Figure 48 and Figure 3, except for psychologists, for whom a PhD was required, while there were 72.5% of female respondents, only 56% female had a PhD or equivalent degree. Females were more likely to have no debt (76%), but also were likely to have debt over \$60,001 (about 73.5%), as indicated in Figure 49 and Figure 3 when compared to males.

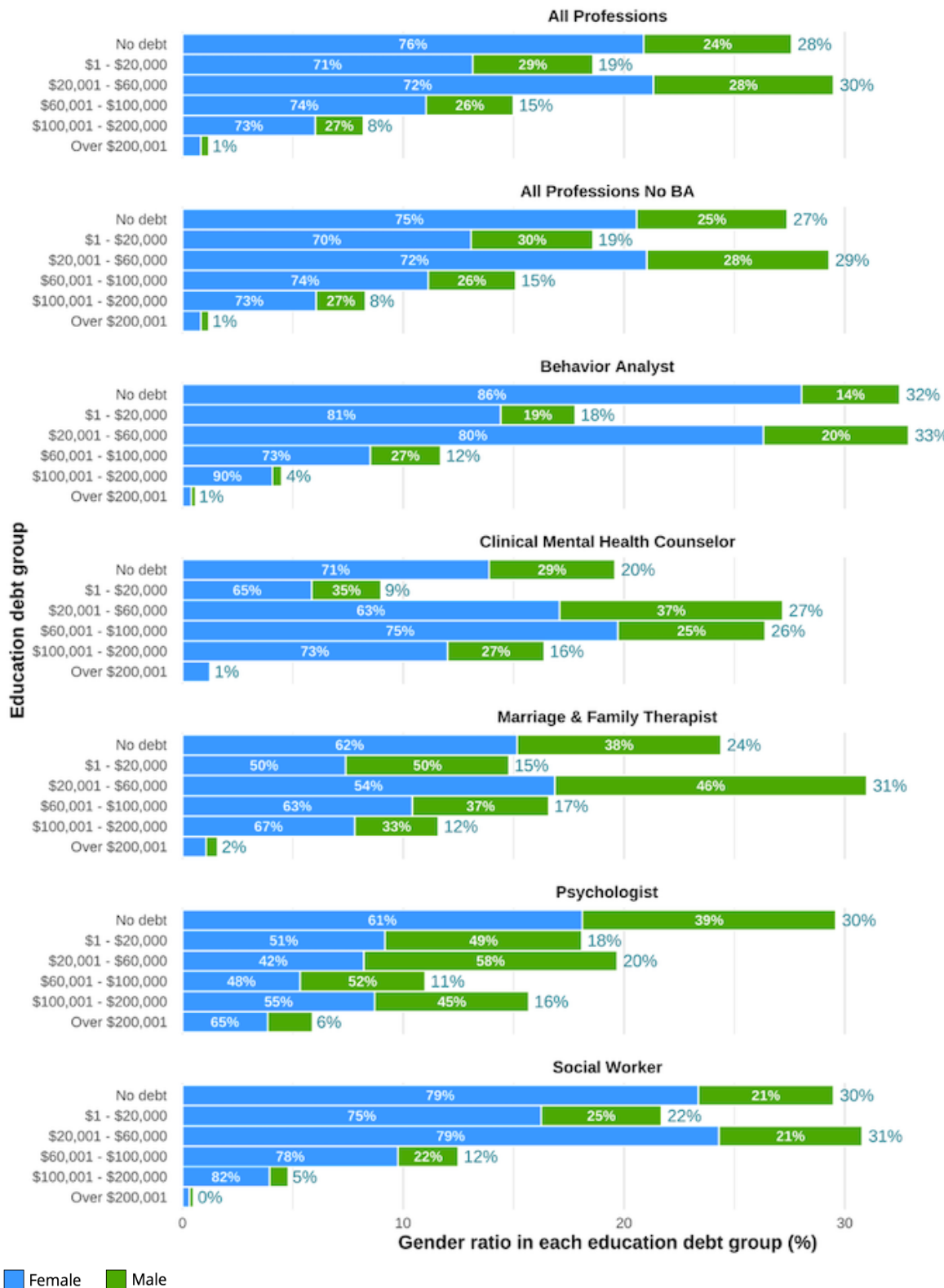
Figure 48. Highest degree and gender distribution by professions

Key takeaway: Female respondents are less likely to pursue PhD or equivalent degrees



Behavioral health workforce survey, Utah, 2024

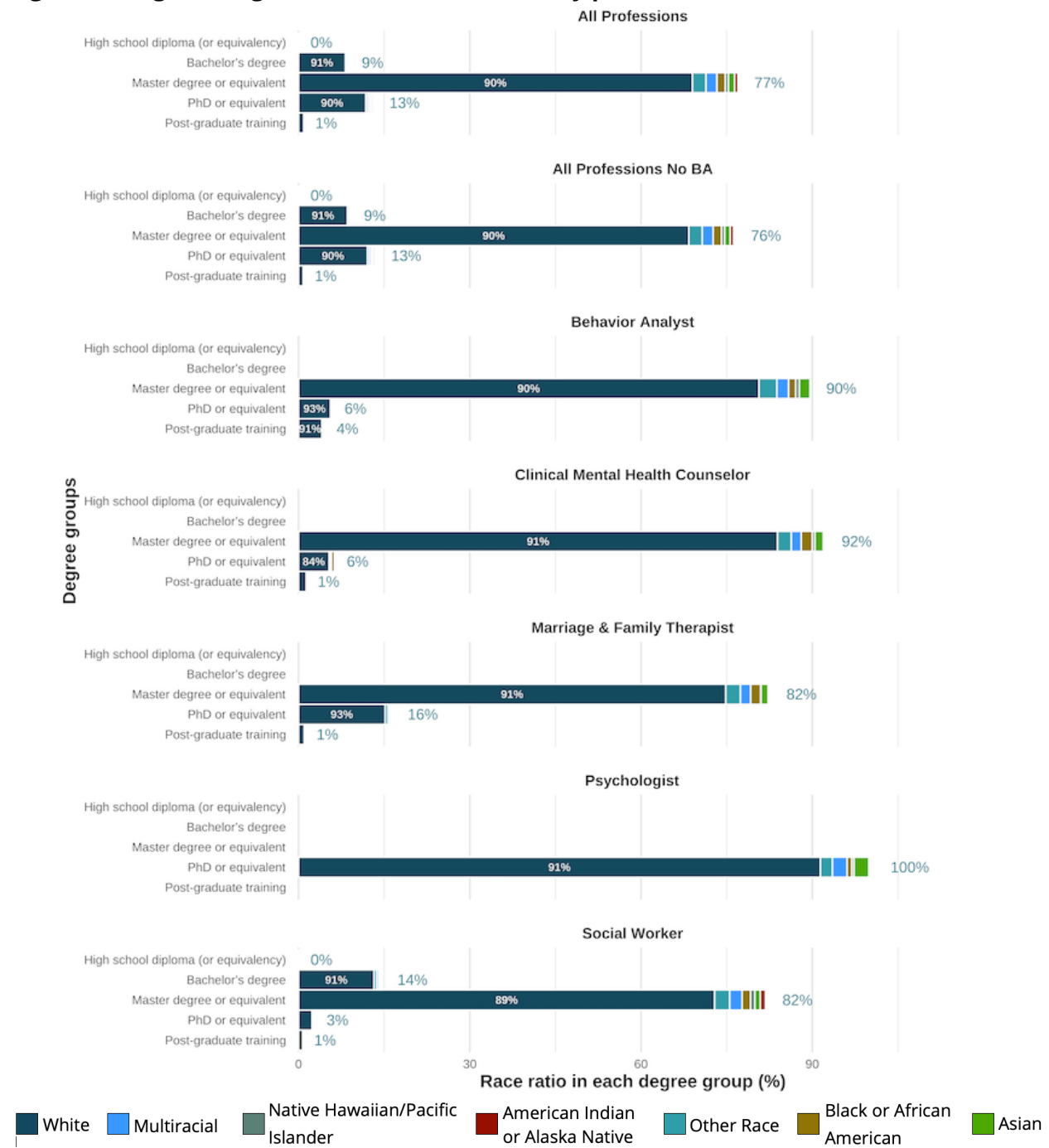
Figure 49. Education debt and gender by professions



Behavioral health workforce survey, Utah, 2024

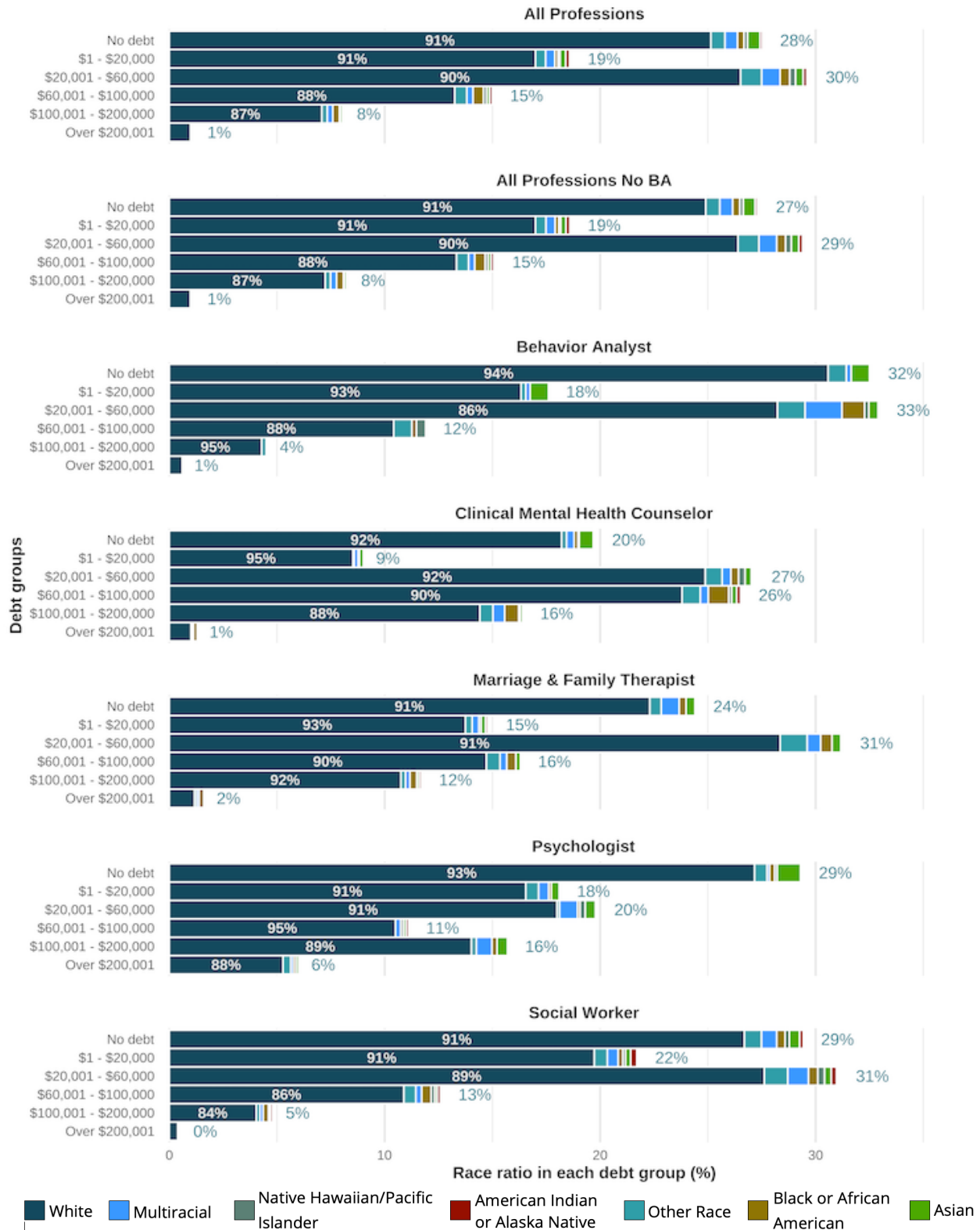
Compared Figure 5 and Figure 50, White and Asian respondents were likely to pursue a Ph.D. or equivalent degree, 90% and 2.3 separately. As Figure 51 shows, they also reported having no educational debt more likely than other racial groups, 91% and 2.1%. Black or African American respondents were more likely to report educational debt exceeding \$40,000 when compared to the percentage of respondents.

Figure 50. Highest degree and race distribution by professions



Behavioral health workforce survey, Utah, 2024

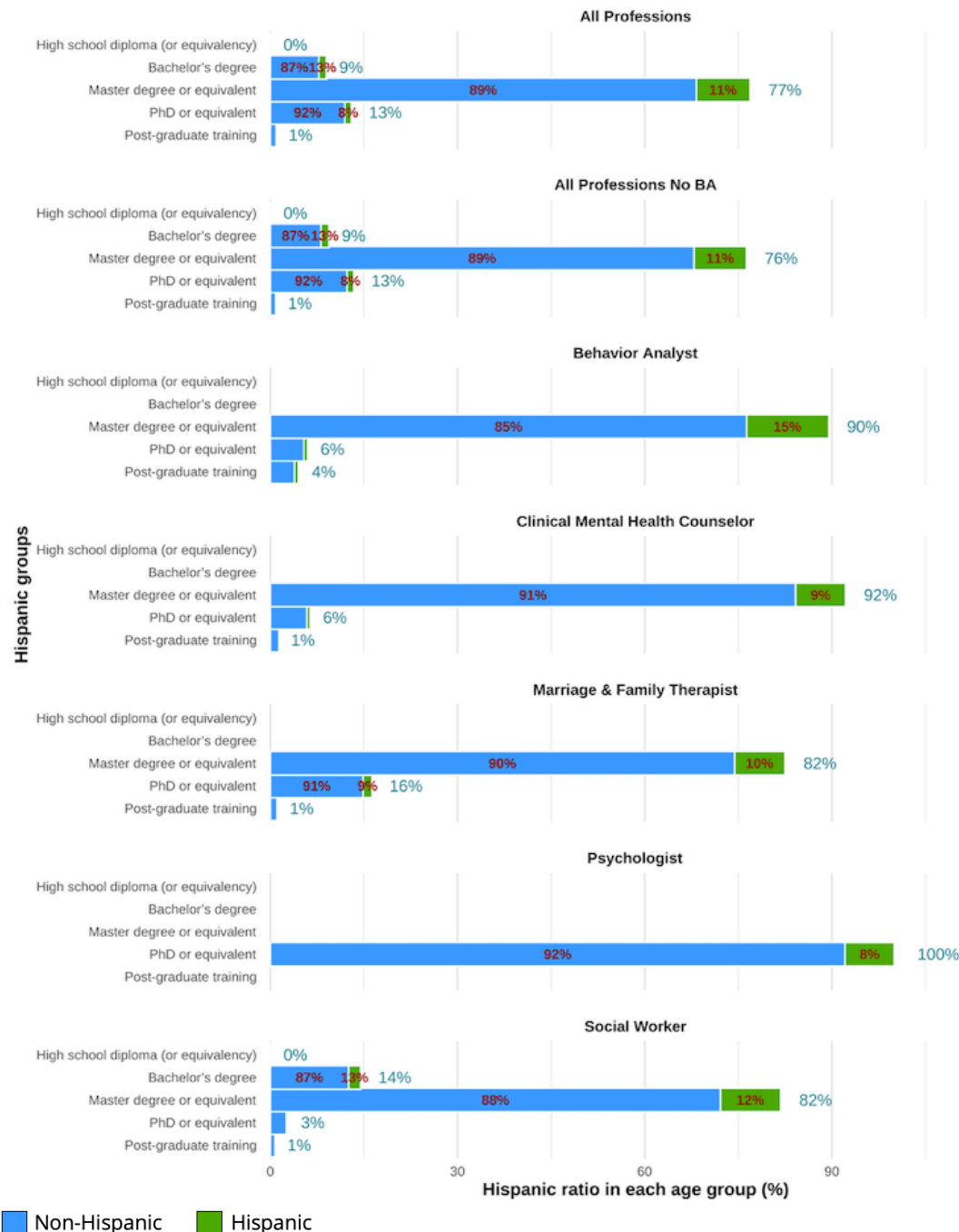
Figure 51. Education debt and race distribution by professions



Behavioral health workforce survey, Utah, 2024

Hispanic respondents were less likely than other respondents to obtain a PhD when compared at the master's and bachelor's degree levels. They were more likely than other groups to report having educational debt. Figure 6 and Figure 52 show that 10.9% of respondents identified themselves as Hispanic; only 8% of those with a Ph.D. or equivalent degrees were Hispanic, but 11% and 13% of respondents with master's or bachelor's degrees identified as Hispanic.

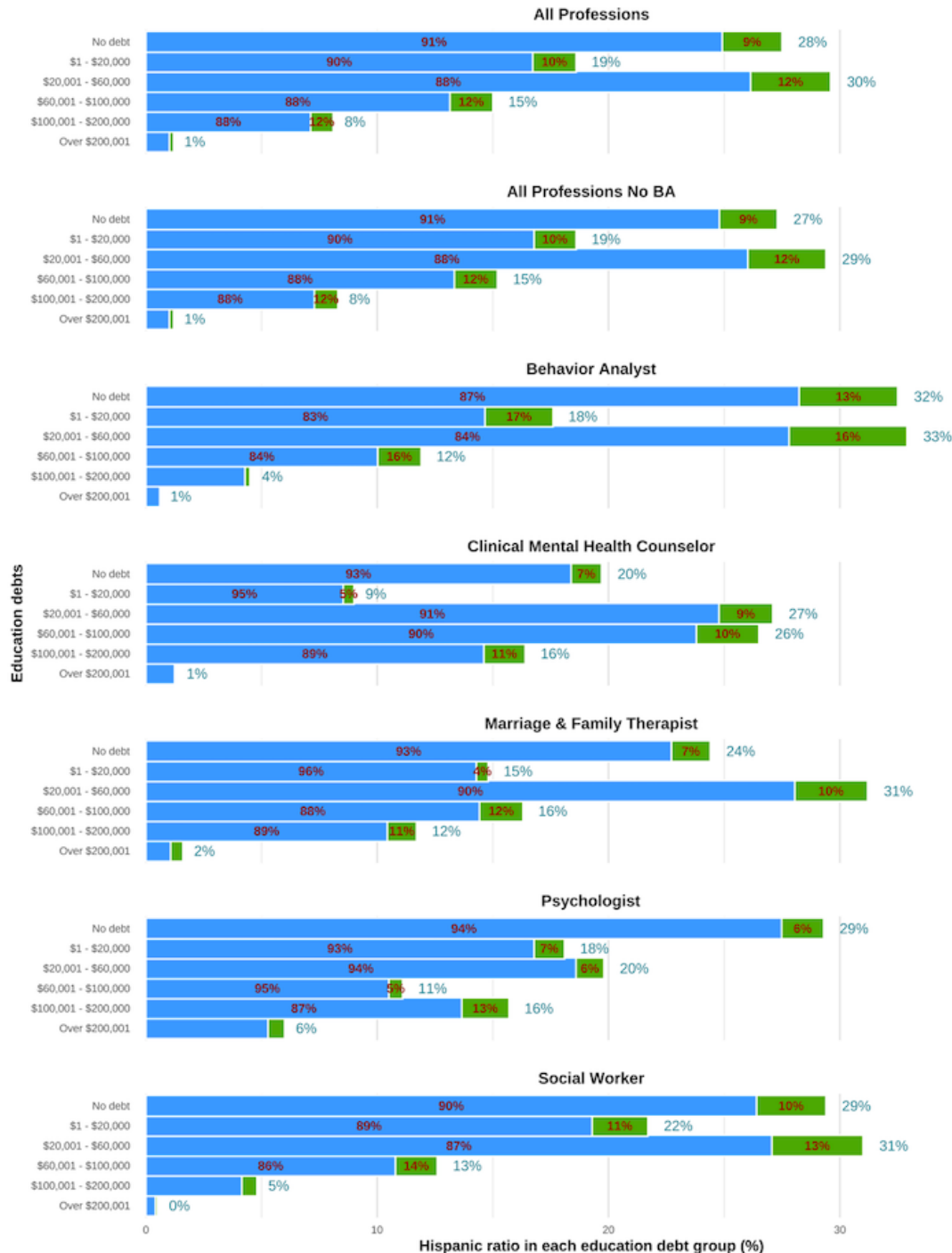
Figure 52. Highest degree and ethnicity distribution by professions



Behavioral health workforce survey, Utah, 2024

Figure 53 shows that only 9% of respondents without debt or with debt lower than \$20,000 identified Hispanic. In contrast, 12% of respondents with debt over \$20,001 identified as Hispanic, and among those with debt over \$200,001, the percentage rose to 14.8%.

Figure 53. Education debts and ethnicity distribution by professions

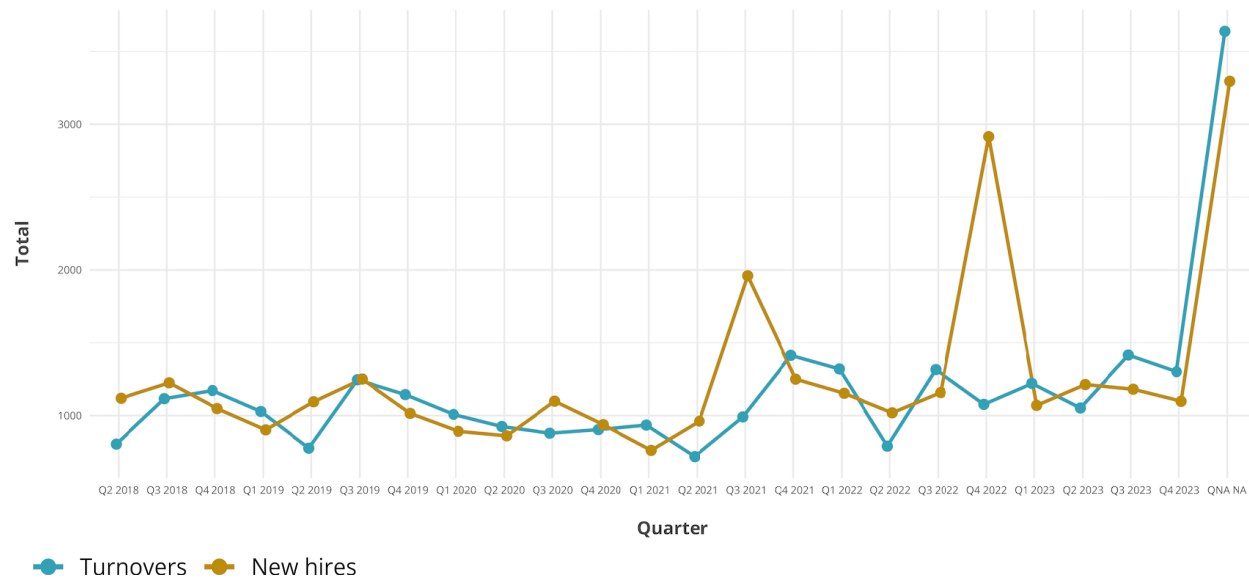


Behavioral health workforce survey, Utah, 2024

Sustainability

Unemployment insurance data was used to determine the general yearly trend of job growth or loss. Figure 54 was based on Unemployment Insurance data. The turnovers and new hires closely tracked each other, and alternating months where either new hires or turnovers were greater than the other. Additionally, many behavioral health professionals

Figure 54. Behavioral health turnovers and new hires



Turnovers New hires

Unemployment insurance data, DWS, 2024

hired in 2022 remained in the workforce.

The added column in Table 7 was the counts of new hires, while the loss column was the counts of providers leaving employment. The net column was simply the sum of the added and loss aggregates. We were seeing a reversal in growth. After years of gains, we experienced a net loss of over 700 workers across 2023 and 2024. Even though many of the behavioral health workforce had been hired during the pandemic seem to have remained in the workforce.

Table 7. Behavioral health providers added/loss

Year	Added	Loss	Net
2018	3,392	3,092	300
2019	4,263	4,194	69
2020	3,790	3,716	74
2021	4,933	4,058	875
2022	6,245	4,503	1,742
2023	4,562	4,990	-428
2024	3,295	3,638	-343

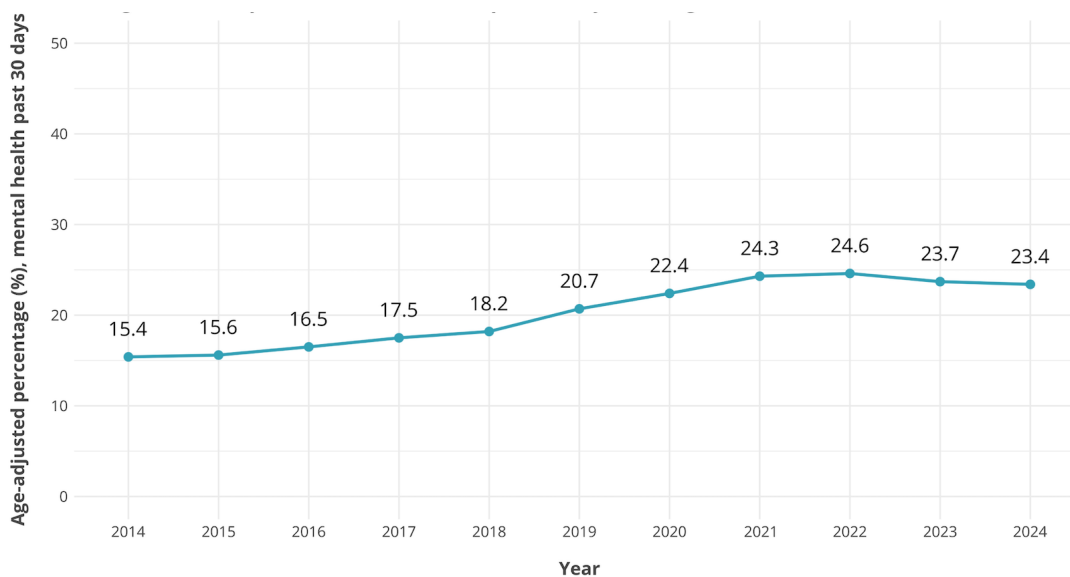
Unemployment insurance data, DWS, 2024

Workforce Supply and Demand

Demand

The demand for mental health services was likely to continue rising, as the percentage of Utahns reporting 7+ days of poor mental health had steadily increased over the past decade, as Figure 55, a statistically significant rise from 15.4% in 2014 to 23.4% in 2024.

Figure 55. The percent of those who report 7+ days of not good mental health, Utah, 2014-2024



Behavioral Risk Factor Surveillance System (BRFSS), Utah, 2014-2024

The market demand was high. According to the Help Wanted Online Job Posting shown in Table 8, CMHCs and social workers had the highest average yearly job postings, which is the average unique job posting numbers from Jan 2020 to Sep 2025. This was substantially higher compared to other professions; for example, APRNs had an average of only about 78 job postings per year in 2024.

Table 8. Help Wanted Online job postings

Profession	Unique Postings (Jan 2020 - Sep 2025)	Median Posting Duration (Days)	Average Yearly Postings
Behavior Analyst	781	27	135.8
Clinical Mental Health Counselor	3851	29	669.7
Marriage & Family Therapist	371	25	64.5
Psychologists	1362	24	236.9
Social Workers	3534	28	614.6
Substance Abuse Counselors	642	31	111.7

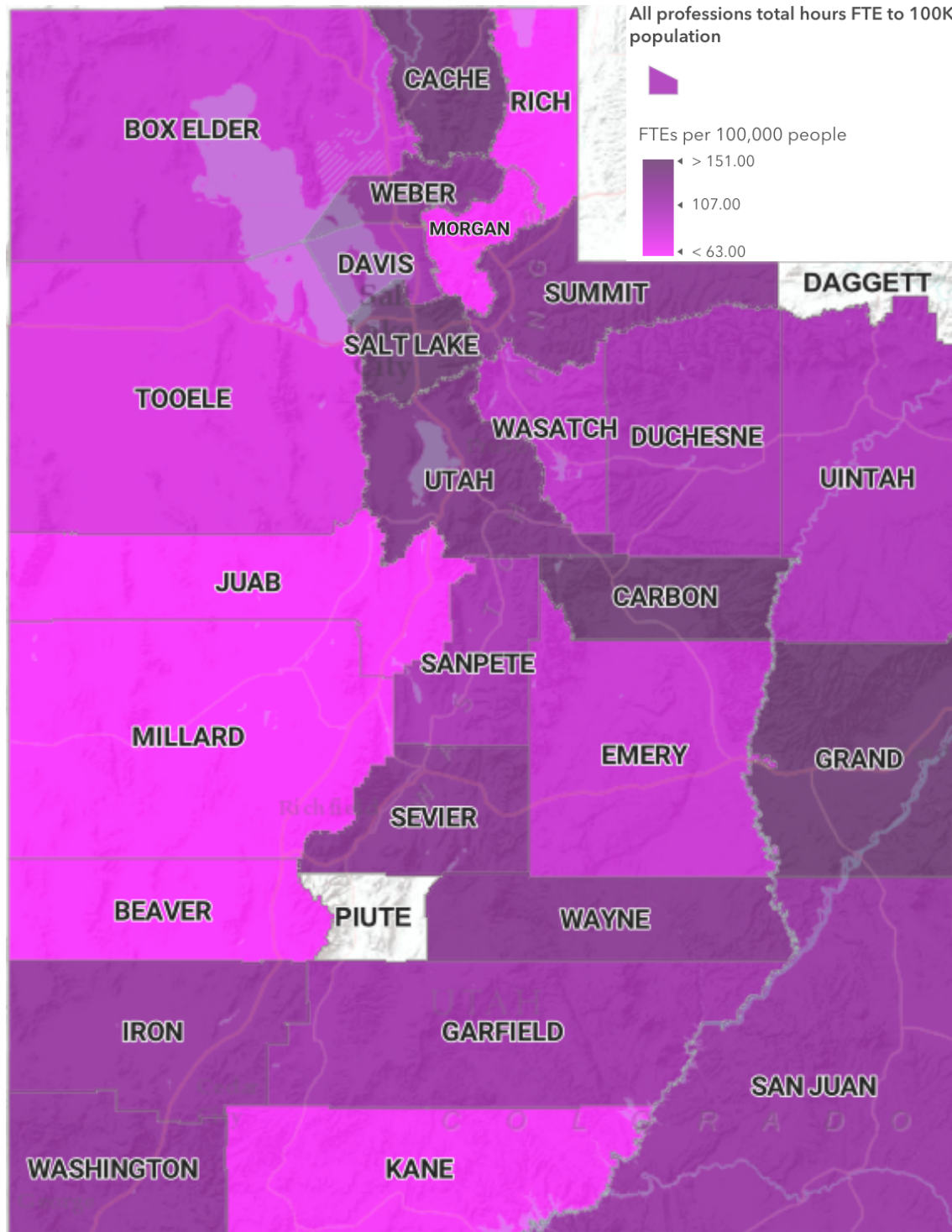
Help Wanted Online, DWS, Utah, 2025

Supply

The workforce supply faced some strains in geographic access, risk of burnout, new entries, and financial barriers.

On the following 4 maps, the darker the color, the higher the value. Supply was defined as the FTE per 100,000 (Map 3). Demand was defined as 7+ days of not good mental health (Map 4). Because mental health was self-reported, cultural norms like 'self-reliance' might cause people to understate their struggles, leading to underestimated data. Some areas appeared to have more providers and lower demand, while others had fewer providers but still showed substantial demand, with patterns varying by location, suggesting that urban centers had high supply, but rural areas were underserved.

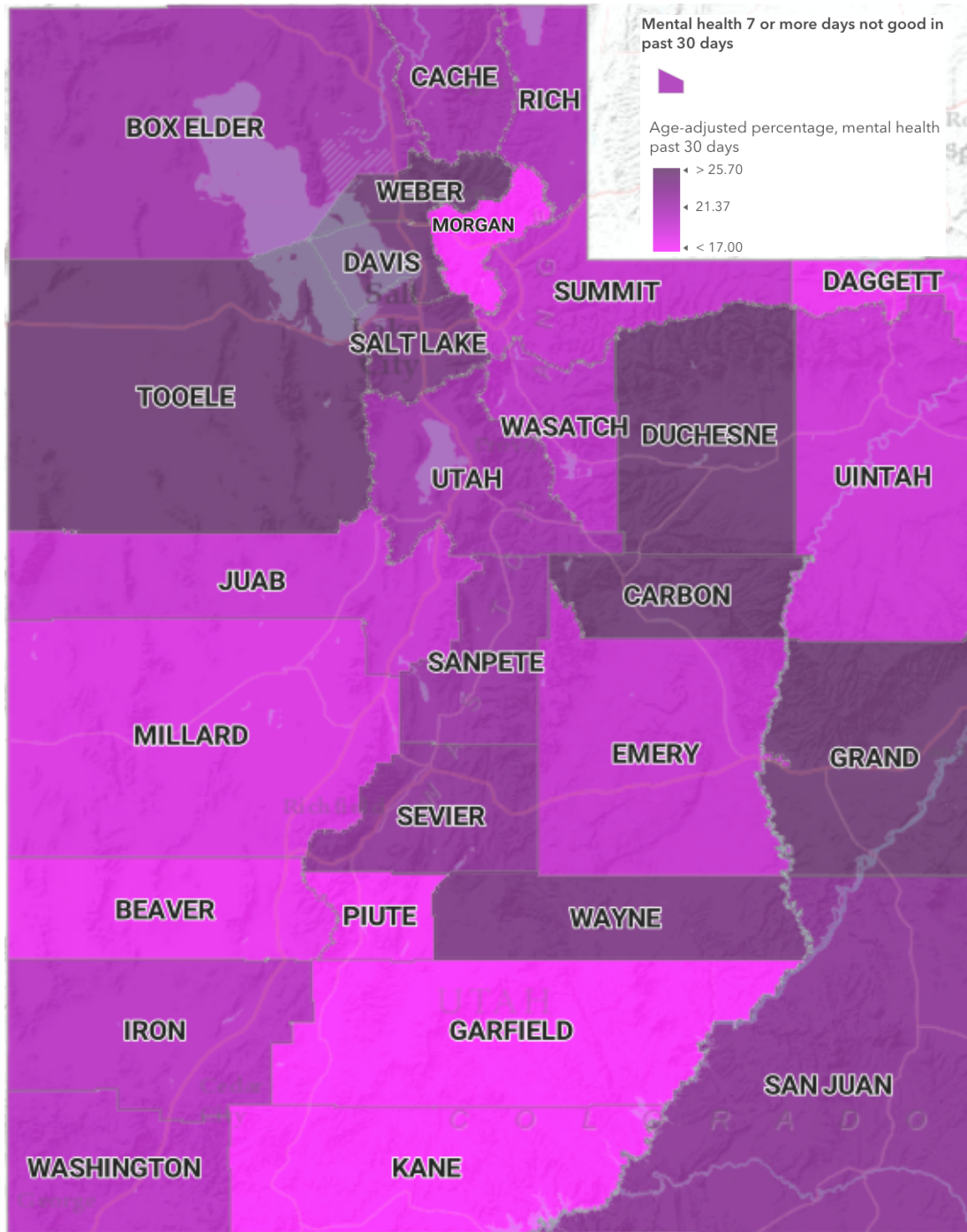
**Map 3. Behavioral Health Workforce FTE Per 100, 000
Utah County, 2024**



Behavioral health workforce survey, Utah, 2024

Behavioral health workforce survey data report, 2024

Map 4. Percent of Those Who Report 7+ Days of not Good Mental Health in the Past 30 Days, Adults (18+), Utah, 2024 ⁶

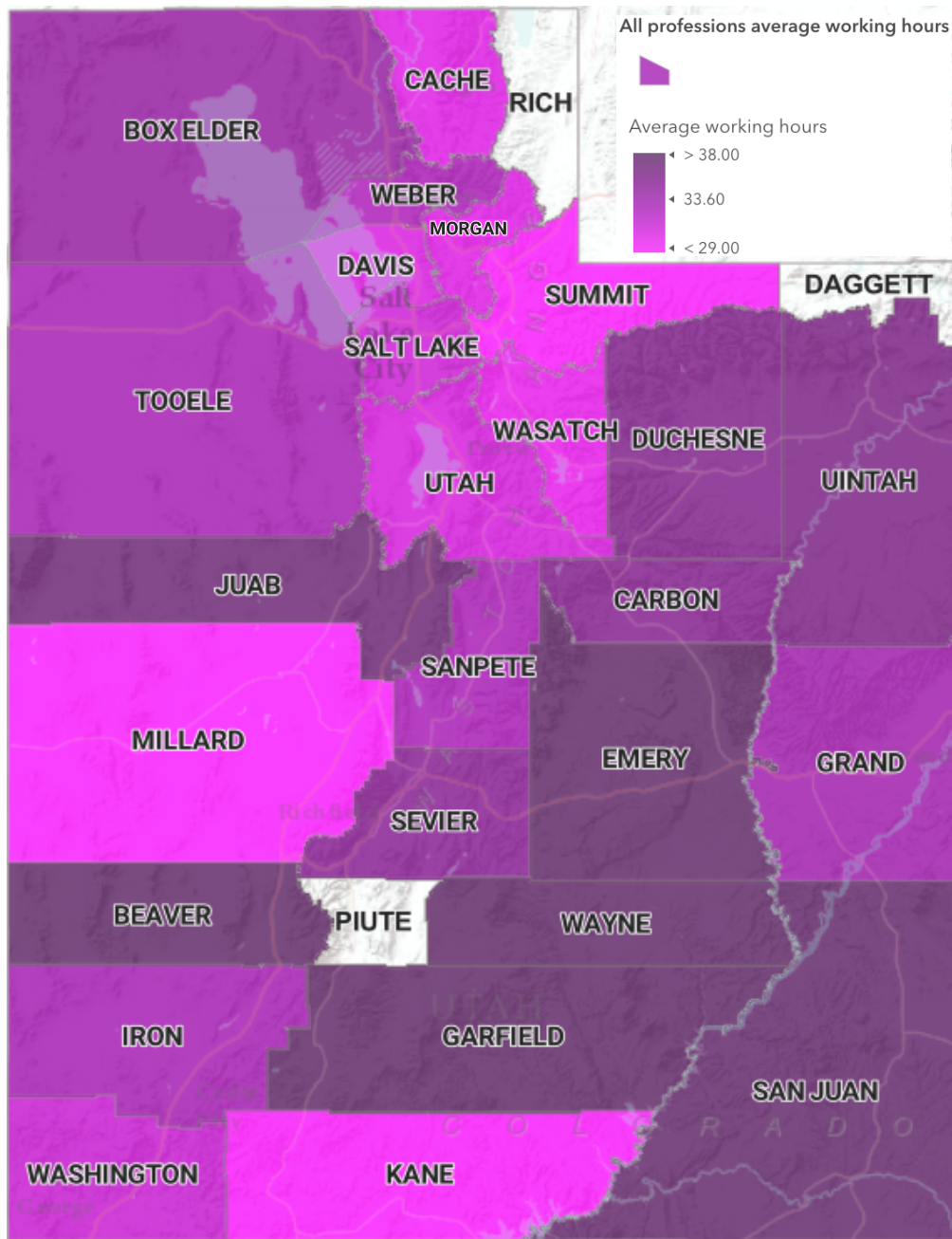


Behavioral Risk Factor Surveillance System (BRFSS), Utah, 2024

⁶ Percents for Daggett, Garfield, Piute, and Rich counties are unreliable and be used caution in interpreting; the estimate has a coefficient of variation > 30% and is therefore deemed unreliable by Utah Department of Health and Human Services standards.

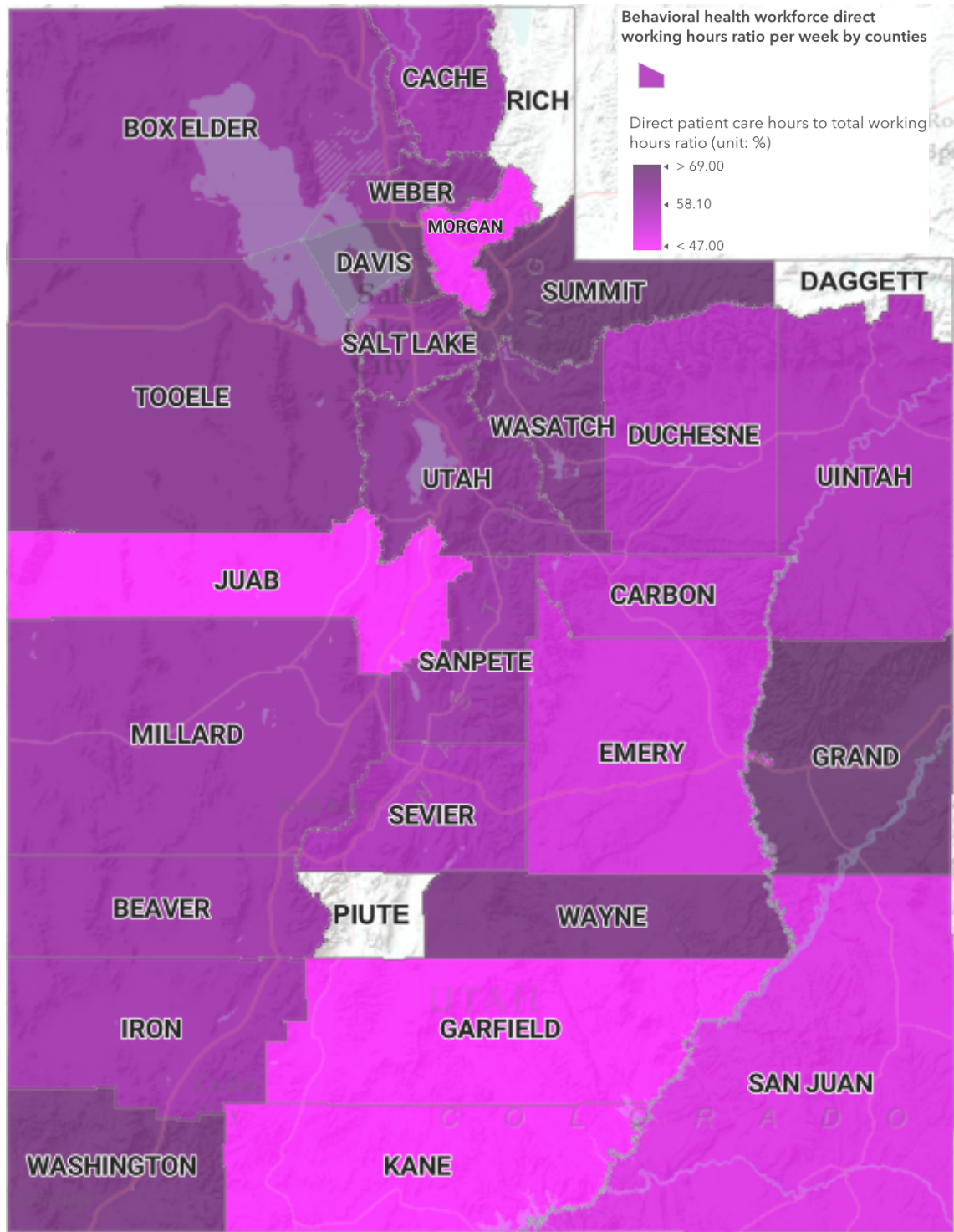
The average working hours on Map 5 shows that in rural counties, limited resources created excessive workloads and high risk of burnout. Additionally, the ratio of direct patient care hours to total working hours, as illustrated in Map 6, suggests that in many counties, a significant portion of working hours is spent on non-clinical tasks. This may reflect the demands of administrative responsibilities.

Map 5. Behavioral Health Workforce Average Working Hours per Week, by Utah County, 2024



Behavioral health workforce survey, Utah, 2024

Map 6. Behavioral Health Workforce Direct Patient Care Hours to Total Working Hours Ratio per Week, by Utah County, 2024



Behavioral health workforce survey, Utah, 2024

Table 9 shows that the number of students completing BH programs only slightly increased over the last 5 years. Social work master's degree, psychology associate, and bachelor's degrees had the largest increase among all the degrees. However, Psychology master's and PhD completions dropped from 61 to 17 and 13 to 7, respectively.

Table 9. Utah behavioral health degree completion (2020-2025)

(Unit: person)

Areas in CIP Code	Award Level	2020-21	2021-22	2022-23	2023-24	2024-25
Behavioral Sciences.	Associate's degree				15	110
Behavioral Aspects of Health.	Certificate of Less than 1 Year					26
Mental Health Counseling/Counselor.	Master's degree			21		
Marriage and Family Therapy/Counseling.	Master's Degree	29	42	33	34	37
Counseling Psychology.	Master's degree					23
Psychology, General.	Associate's degree	29	42	54	49	196
Psychology, General.	Bachelor's Degree	58	84	108	98	392
Psychology, General.	Master's degree	61	97	71	58	17
Psychology, General.	Doctor's Degree - Research/Scholarship	13	8	7	17	7
Psychology, Other.	Certificate of Less than 1 Year			29	35	14
Psychology, Other.	Post-Baccalaureate Certificate	30	38			
Social Work.	Certificate of Less than 1 Year			9		
Social Work.	Associate's degree	56	99	84	69	74
Social Work.	Bachelor's Degree	328	331	323	327	330
Social Work.	Post-Baccalaureate Certificate	1				
Social Work.	Master's degree	325	265	396	486	336
Social Work.	Doctor's Degree - Research/Scholarship	7	2	4	3	3
Psychiatric/Mental Health Nurse/Nursing.	Post-Baccalaureate Certificate					1
Total	All Award Level	937	1008	1139	1191	1566

Utah System of Higher Education, Utah, 2025

Based on the number of professionals currently precepting and the number of graduating students, there may be more students than preceptors available. Considering the total estimated number of active preceptors, the average number of students each preceptor took on (about 3–4 every two years), and those who reported not meeting the requirements, the supply of qualified preceptors could be insufficient (Table 10).

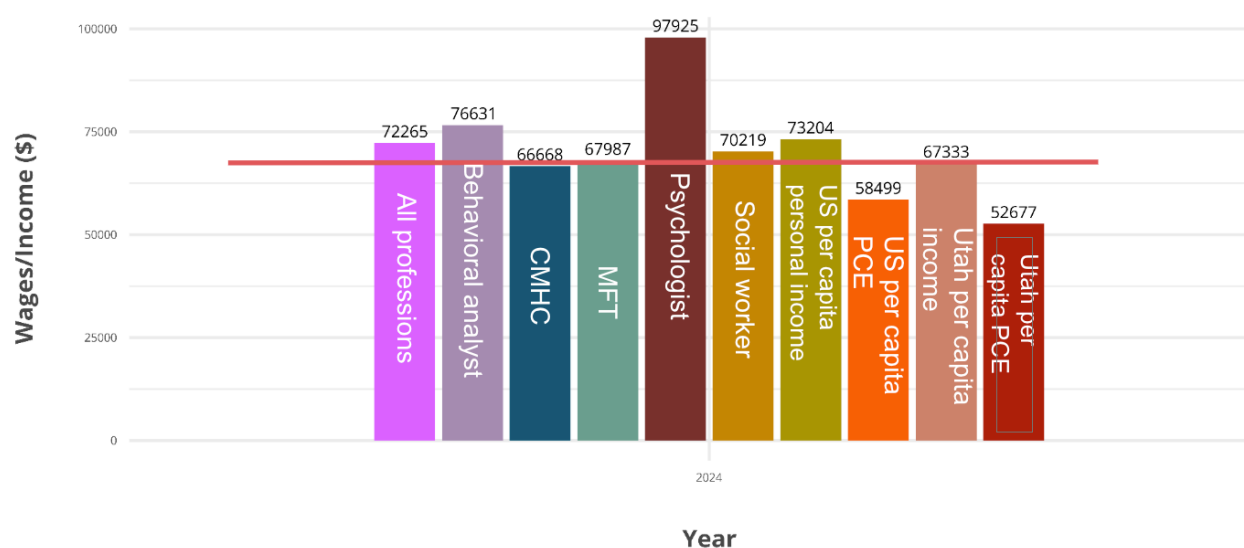
Table 10. Respondents precepting students

Professions	# Respondent	# Student	# Average precepting
All	3478	11076	3
Behavior Analyst	320	1260	4
Clinical Mental Health Counselor	550	1646	3
Marriage & Family Therapist	350	1434	4
Psychologist	445	1886	4
Social Worker	1813	4849	3

Behavioral health workforce survey, Utah, 2024

Personal Consumption Expenditures (PCE) measures the average amount people spend on goods and services, such as housing, food, healthcare, and entertainment. It is used to assess the cost of living and compare it to wages, helping determine whether workers' earnings are sufficient to cover typical expenses. By comparing wages to PCE, policymakers and researchers can evaluate the financial well-being of a workforce. According to Bureau of Labor Statistics data, CMHCs and MFTs earned near or below the state per capita income. Compared to Utah's PCE, once essential expenses were met, there was little left to pay off the education debts mentioned earlier, creating a barrier to workforce stability (Figure 56).

Figure 56. Profession average wages vs. per capita income 2024



Behavioral health workforce survey, Utah, 2024

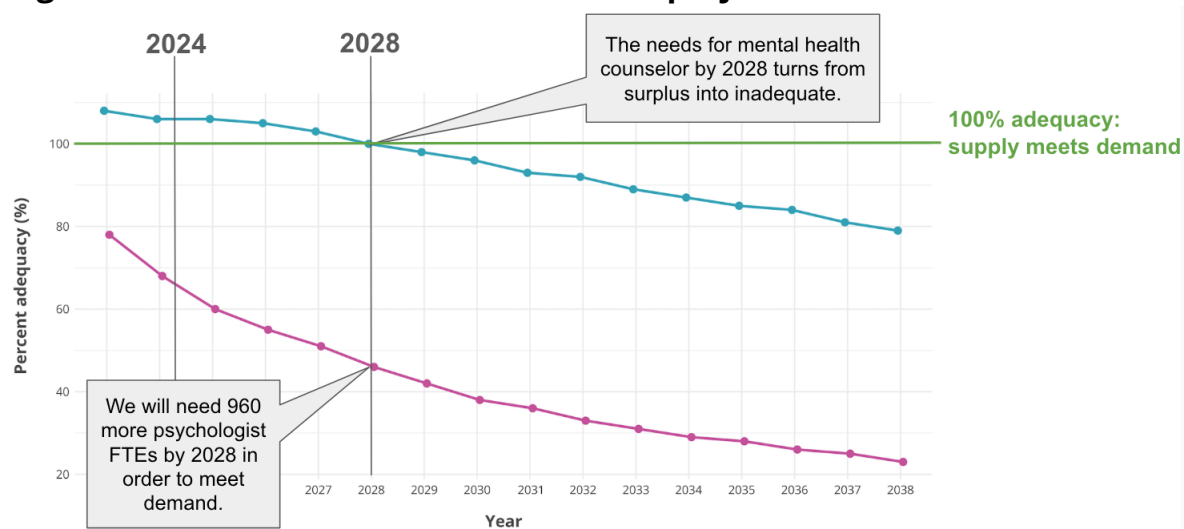
Financial barriers were a major constraint. About 25% of Psychologists carry over \$100,000 in debt. For CMHCs and MFTs, the situation was worse: they carried similar debt but earned significantly lower average wages (\$66,668, \$67,987), making the profession financially difficult to enter (Table 11).

Table 11. Education debt at time of graduation and average wage

Profession type	Percent with +100,000 debt at graduation	Utah yearly average wage
CMHC	18.1%	\$66,668
MFT	13.7%	\$67,987
Social worker	5.4%	\$70,219
Psychologist	25.8%	\$97,925
APRN (advanced practice registered nurse)	16%	\$103,964

HRSA projections showed Utah would fall significantly short of adequacy for psychologists. By 2028, we will need 960 more psychologist FTEs. Our license growth is being overwhelmed by demand. 2028 will be a turning point for Mental health counselors. The supply turns from surplus to inadequate. Unfortunately, HRSA projections have no Utah's supply data for other behavioral health professions, so we can only provide these two professions' projections.

Figure 57. Utah's behavioral health HRSA projection



● Mental Health Counselors ● Psychologists
Behavioral health workforce survey, Utah, 2024

Conclusion

Utah's behavioral health workforce is facing challenges. Demand is up, with more people reporting poor mental health, and employers needing more workers. Supply is down, more people are leaving the workforce, and there's very little, if there is any growth in the number of students graduating with the degrees we need. And there are "supply chain" constraints where wages are comparatively low, educational debt is high, administrative burden is high with many reporting that they spend only half their time in direct patient care, and there's a shortage of professionals who are available to train the next generation and support those currently working. Right now, only about a third of professionals are precepting, and many report that they don't meet the requirements to precept or mentor.

These challenges are particularly pronounced for CMHCs, MFTs, psychologists, and social workers. Our data show that CMHCs and MFTs feel the greatest financial strain because they carry high educational debt while earning lower wages than other professions with similar training. In fact, CMHCs and MFTs' earnings are often below—or just slightly above—Utah's per capita income. Psychologists face their own challenges as well, including a shrinking educational pipeline, lower average yearly wages, and limited access in rural areas.

Utah's behavioral health workforce is facing a growing and multifaceted set of challenges driven by both increasing demand and constrained supply. Demand for services continues to rise as more individuals report poor mental health and employers seek additional behavioral health providers across settings. At the same time, workforce supply is tightening, with more professionals leaving the field and limited growth in the number of graduates entering key behavioral health disciplines. These pressures are further compounded by "supply chain" constraints, including comparatively low wages, high educational debt, and substantial administrative burden. In addition, there is a shortage of experienced professionals available to train and mentor the next generation, further limiting workforce expansion and sustainability.

Overall, Utah's behavioral health workforce is characterized by rising demand, constrained supply, uneven training capacity, and financial and geographic disparities. Addressing these challenges will likely require coordinated investment in workforce retention, compensation, training infrastructure, and data standardization to ensure a sustainable and equitable behavioral health system statewide.

Appendix 1 - DOPL supply survey

Questions were asked about practitioners' Utah status, practice characteristics, demographics, employment plans, and patient population types.

The survey can be found at:

<https://ruralhealth.utah.gov/wp-content/uploads/2024-Behavioral-Health-Survey-Final-1.pdf>

Objectives

The HWAC has developed and adopted, with support from the Data Subcommittee, the Utah cross-profession minimum data set (UCPMDS). The UCPMDS is the underlying set of questions covering the highest priority data elements needed for health workforce planning throughout Utah.

Seven national healthcare regulatory organizations worked with Veritas Health Solutions, a consultant in health workforce data, policy, and planning, to create the UCPMDS. The intent of the UCPMDS is to standardize certain information captured from various health professions to support within-profession and between-profession analyses to better inform health policies and strategies. The UCPMDS serves as a fundamental data system, upon which individual profession-specific tools are being developed and implemented into the re-licensure process.

Profession-specific surveys are being created for all licensed health professions. They are optional and are being implemented into the application process through the Division of Professional Licensing.

Target population

The DOPL behavior health licenses in this survey are listed in Table 1.

Response rates

Observing the count of eligible practitioners provided by DOPL, the survey response rate was approximately 53.6%.

The following item response rates are based on those who provided a valid license number and responded to at least one question rather than those who were eligible to receive the

survey. Accompanying the item response rate is the question text. The question text displayed is as it appeared on the survey instrument

Table 12. Item response rates

Number	Text	%
1	What is your sex?	99.9
2	What is your race? Mark one or more boxes.	99.6
3	Are you of Hispanic, Latina/o, or Spanish origin?	99.6
4	What type of degree/credential first qualified you for this license?	99.9
5	Year completed qualifying education?	99.5
6	Where did you complete the education program/degree that first qualified you for this license? (Note: for online programs, please select the location where this program was housed)	99.9
7	In which city & country did you complete the education program/degree?	0.2
8	What is your highest level of education?	99.9
9	Please mark the amount of educational debt you had AT THE TIME OF GRADUATION from your behavioral health program (exclude non-behavioral health and non-educational debt).	98.9
10	Did/do you participate in a loan forgiveness/repayment program (LRP)?	99.4
11	If yes, which loan forgiveness/repayment program(s) did you participate in?	17.6
12	Some federal loan repayment programs require a full license in order to be eligible. If you participated in a federal loan repayment program, did you have to begin repaying student loans post graduation while completing training to obtain full licensure?	17.7
13	Does your employer offer a program that discounts or reimburses tuition?	99.4
14	What is your employment status?	97.4
15	What best describes your employment plans for the next 2 years?	98.1

Number	Text	%
16	If you indicated you plan to increase or decrease hours in a field related to this license in the next 2 years, please estimate the change in the total number of hours per week you expect compared to your current hours per week. If this does not apply, please select "not applicable."	15.8
17	Of the hours per week spent in direct patient care, estimate the average number of hours per week delivering patient care via telehealth.	99.1
18	Please indicate the population groups to which you provide clinical services. Please check all that apply.	98.5
19	What is your primary practice location? If this does not apply, please enter "N/A".	91.6
20	Which of the following best describes your current employment arrangement at your principal practice location?	98.1
21	Please identify the role/title(s) that most closely corresponds to your primary employment/practice type.	98.0
22	Which of the following best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	97.5
23	Estimate the average number of hours per week spent at your primary practice location. If this does not apply, please select "not applicable." Does not include time on call.	97.9
24	Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your primary practice location. If this does not apply, please select "not applicable."	97.7
25	What is your secondary practice location? If this does not apply, please enter "N/A".	78.1
26	Which of the following best describes your current employment arrangement at your secondary practice location?	73.7
27	Please identify the role/title(s) that most closely corresponds to your secondary employment/practice type.	71.9

Number	Text	%
28	Which of the following best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable".	77.2
29	Estimate the average number of hours per week spent at your secondary practice location. If this does not apply, please select "not applicable." Does not include time on call.	82.5
30	Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your secondary practice location. If this does not apply, please select "not applicable."	82.1
31	Have you mentored/precepted students within the last two years?	97.7
32	If you have mentored/precepted students within the last 2 years, what type of training did you provide?	32.5
33	If you have not mentored/precepted students within the last two years, what are your reasons for not choosing to do so?	52.9
34	If you indicated that you mentor/precept students, how many advanced practice students have you precepted in the last two years?	32.2
35	If you indicated that you mentor/precept students, which student types have you provided this service for in the last two years?	32.2
36	Would you like to precept in the future?	97.1
37	Do you coordinate your care with patients' other providers?	97.3
38	If you answered "Yes" to working with other professionals to coordinate care, what professionals do you work with?	62.4
39	Who is your main point of contact for prescribing medication?	50.3

References

- Kem C. Gardner Policy Institute (2024). *Utah addresses need for more accessible, equitable, and aligned behavioral health services*, (<https://gardner.utah.edu/news/behavioral-health-master-plan/#:~:text=Limited%20Access%20to%20Care%20%E2%80%93%20Many,receive%20necessary%20services%20or%20treatment>)
- Mental Health America (2025). *The State of Mental Health in America 2025*, (<https://mhanational.org/the-state-of-mental-health-in-america/>)
- The Utah Medical Education Council (2016). *Utah's Mental Health Workforce, 2016*, (<https://hwic.utah.gov/wp-content/uploads/Mental-Health-Workforce-2016-1.pdf>)
- The Utah Medical Education Council (2021). *Utah's Mental Health Workforce 2021*, (http://umec-shiny-prod-alb-79075571.us-west-2.elb.amazonaws.com/projects/Mental_Health/)
- Utah Department of Health and Human Services (2022). *Confirmatory Factor Analysis of the 2022 Utah Adult Mental Health Statistics Improvement Program (MHSIP) Survey & Comparison of Structures for Mental Health and Substance Use Clients*, (https://dsamh-training.utah.gov/_documents/reports/UtahMHSIPFactorAnalysis.ada.pdf)
- Bureau of Health Workforce Health Resources and Services Administration (HRSA) (2025). *Designated Health Professional Shortage Areas Statistics*, (<https://data.hrsa.gov/default/generatehpsaquarterlyreport>)
- Utah Department of Commerce Office of Professional Licensure Review (2023). *2023 Periodic Review Behavioral Health*, (<https://www.oplr.utah.gov/2024/01/08/2023-periodic-review-behavioral-health-field-level-report/>)
- Utah Behavioral Health Commission (2025). *Utah Behavioral Health Commission Strategic Plan*, (https://dsamh-training.utah.gov/_documents/behavioralhealthplanning/Behavioral%20Health%20Commission%20Draft%20Strategic%20Plan%20May%202025.pdf)
- Office of the Legislative Auditor General (2025). *A Performance Audit of the Utah's Behavioral Health Workforce*, (<https://mhanational.org/the-state-of-mental-health-in-america/>)
- Health Disparities Research Team and Utah Division of Substance Abuse & Mental Health (2021). *Health Disparities in Utah's Public Mental Health and Substance Use Treatment Systems Needs Assessment*, (<https://le.utah.gov/interim/2022/pdf/00002557.pdf>)

The Utah Behavioral Health Coalition (2024). *Utah Behavioral Health Assessment & Master Plan*, (<https://d36oiwf74r1rap.cloudfront.net/wp-content/uploads/2024/01/BehaviorHealthPlan-Jan2024-Final.pdf>)

The Children's Center Utah (2022). *A Pathway for Improving Early Childhood Mental Health in Utah*, (https://childrenscenterutah.org/images/pdfs-doc/Events/Report_-_A_Pathway_for_Improving_Early_Childhood_Mental_Health_in_Utah.pdf)

Centers for Medicare & Medicaid Services (2025). *IBH (Innovation in Behavioral Health) Model*, (<https://mhanational.org/the-state-of-mental-health-in-america/>)

Tier McCullough. (2025). Trends in State Strategies to Improve the Behavioral Health Workforce. *National Academy for State Health Policy*, (<https://nashp.org/trends-in-state-strategies-to-improve-the-behavioral-health-workforce/>)

Bureau of Labor Statistics (2024). *Occupational Employment and Wage Statistics*

Healthy Minds (2024). *Understanding integrated behavioral health care and the Collaborative Care Model*, (<https://www.healthymindspolicy.org/research/understanding-integrated-behavioral-health-care-and-the-collaborative-care-model#:~:text=The%20Collaborative%20Care%20Model%20is,manager%20and%20a%20consulting%20psychiatrist>)

National Conference of State Legislatures (2024). *Behavioral Health Workforce Shortages and State Resource Systems*, (<https://www.ncsl.org/labor-and-employment/behavioral-health-workforce-shortages-and-state-resource-systems#:~:text=Read%20More-Embrace%20Peer%20Support%20Specialists,by%20Medicaid%20reimbursement;%20at%20least>)

HRSA Health workforce (2024). *State of the U.S. Health Care Workforce, 2024*, (<https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-health-workforce-report-2024.pdf>)

HRSA Health Workforce (2022). *Scoring Shortage Designations*, (<https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring>)

Utah State Legislature. (2024). *Finding Hope: Recent Investments in Behavioral Health Services*, (<https://budget.utah.gov/finding-hope/#:~:text=The%20service%20is%20available%2024,were%20resolved%20over%20the%20phone>)

National Council for Mental Wellbeing. (2023). *National Council for Mental Wellbeing Industry Workforce Shortages Research*, (https://www.thenationalcouncil.org/wp-content/uploads/2023/04/Workforce-Shortage-Survey-Results-1.pdf?gfaaction=event_send&category&action&label&entryid=0&nonce=99b4b1a96d)

SimiTree (2025). *Understanding the Behavioral Health Workforce Shortage: Causes, Impact, and Data* (<https://simitreehc.com/simitree-blog/understanding-the-behavioral-health-workforce-shortage-causes-impact-and-data-2/#:~:text=High%20vacancy%20rates%20persist%20across,roles%20essential%20to%20program%20operations>)

Heather Saunders, Madeline Guth, and Gina Eckart (2023). A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs. *KFF*, (<https://www.kff.org/mental-health/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/#:~:text=Reducing%20Administrative%20Burden,higher%20rates%20of%20Medicaid%20acceptance>)

Margaret Woolley Busse, Jeff Shumway (2024). Monthslong waitlists and high costs: Why many Utahns are struggling to get mental health treatment. *Deseret News* (<https://www.deseret.com/opinion/2024/1/14/24033770/mental-health-care-resources-utah-legislature/#:~:text=Train%20smarter,more%20flexibility%20in%20continuing%20education>)

Myers and Stauffer Certified Public Accountants. (2023). *Medicaid Reimbursement Rate Comparative Analysis – Physician and Psychology Services*, (<https://medicaid-documents.dhhs.utah.gov/stateplan/prr/05%20-%20Physician%20and%20Psychology%20Utah%20Rate%20Study%20Report%20Final.pdf>)

TheraThink (2026). Gender and health. *Mental Health Reimbursement Rates by Insurance Company* [2026] (<https://therathink.com/reimbursement-rate-comparison/#search>)

Contact information

Holly Uphold: huphold@utah.gov
Jiehong Jiang: jjiang@utah.gov
Matt Cottrell: mattc@utah.gov
Jordan Miller: jordanmiller@utah.gov

Department of Health and Human Services
Multi-Agency State Office Building
195 North 1950 West
Salt Lake City, Utah
84116

<https://hwic.utah.gov/>
Phone: 801-538-9375