Utah Medical Education Council
230 South 500 East, Suite 210
Salt Lake City, Utah 84102

«FULL_NAME»
«ADDR_LINE_1» «ADDR_LINE_2»
«CITY», «STATE», «ZIP»

Utah Medical Education Council
2015 Mental Health Workforce Survey

Dear «Prefix» «LAST_NAME»

The Utah Medical Education Council (www.utahmec.org) was created in 1997 with the mission to conduct healthcare workforce research. The UMEC's advises on Utah's medical workforce needs, influences graduate medical education financing policies, and works with state legislators, universities, and numerous healthcare organizations to ensure that Utah's healthcare workforce is sufficient to serve Utah's communities.

The UMEC, in conjunction with the Utah Department of Health, Utah Division of Occupational and Professional Licensing, the University of Utah, Utah State University, Brigham Young University, as well as the National Association of Social Workers-UT, Utah Association for Marriage and Family Therapy, the Utah Mental Health Counselors Association, and the Utah Psychological Association would like to invite you to participate in the first comprehensive survey of the mental health workforce in Utah. Your participation in this survey is crucial for determining the active mental health workforce makeup and distribution throughout the state. This information is critical for schools of mental health, the Utah legislature, and countless mental health organizations to prepare for current and future workforce needs. We are committed to maintaining your privacy. Only de-identified, aggregate data will be published.

For any questions regarding this survey please contact the UMEC at 801-526-4567 or by email at jennac@utah.gov. **Please return the completed survey to the UMEC within 30 days** in the enclosed postage paid envelope.

Sincerely,

Richard Campbell
Executive Director
Utah Medical Education Council

Iona M. Thraen, PhD, ACSW
Utah State Innovation Model Director
Utah Department of Health

Tom Mullin, PhD
President
Utah Psychological Association

Paul Carver, CMHC, CFMHE
Past-President
Utah Mental Health
Counselors Association

Jonathan Sandberg, PhD
Board Member
Utah Association for
Marriage and Family Therapy

Emily Bleyl, LCSW
Executive Director
National Association of
Social Workers-UT

31. Please indicate if you treat the following disorders: 1. Never; 2. Sometimes; or 3. Frequently

__ Neurodevelopmental Disorders	__ Dissociative Disorders	__ Gender Dysphoria
__ Schizophrenia & Psychotic Disorders	__ Somatic Symptom Disorders	__ Disruptive, Impulse & Conduct Disorders
__ Bipolar & Related Disorders	__ Feeding & Eating Disorders	__ Substance Use & Addictive Disorders
__ Depressive Disorders	__ Elimination Disorders	__ Neurocognitive Disorders
__ Anxiety Disorders	__ Sleep-Wake Disorders	__ Personality Disorders
__ Obsessive-Compulsive Disorders	__ Sexual Dysfunctions	__ Paraphilic Disorders
__ Trauma- & Stressor-Related Disorders	__ Co-occurring Disorders (NOT including diabetes & obesity)	__ Co-occurring Disorders (including diabetes & obesity)

32. Please estimate the percentage breakdown of source referrals for your client caseload *(should total 100%):*

____% Primary Care Clinician ____% Specialty Clinician ____% Self-referral ____% Workplace
____% School ____% Behavioral HMO ____% Other therapist ____% Other: _____

33. Do you coordinate your care with patients' other providers? ☐ Yes ☐No

a. If yes, please estimate the percentage of your caseload you coordinate care for: _____%

b. Please indicate the professionals you work with to coordinate care *(select all that apply)***:**

☐ Primary Care provider	☐ Care Coordinator	☐ Care Navigator
☐ Psychiatrist	☐ Care Manager	☐ Community Health Worker
☐ Nurse Practitioner	☐ Case Manager	☐ Other _____

34. Who is your main point of contact for prescribing medication? *(please mark only one)*

☐ Primary Care Physician	☐ Primary Care Physician Assistant	☐ Primary Care Advanced Practice Nurse
☐ Psychiatrist	☐ Psychiatric Physician Assistant	☐ Psychiatric Advanced Practice Nurse
☐ Other Physician	☐ Other Physician Assistant	☐ Other Advanced Practice Nurse

35. Would you say your access to a prescribing partner is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

SECTION 4: YOUR FINANCIAL OUTLOOK/JOB SATISFACTION

36. Within the past two years, have you experienced any of the following *(check all that apply):*

☐ Voluntary Unemployment	☐ Involuntary Unemployment
☐ Switched employers/practices	☐ Worked two or more positions at the same time
☐ Worked part-time or temporary positions, but would have preferred a full-time or permanent position	☐ Considered leaving the mental health field for something else (not including retirement)

37. What is your average gross compensation? *(before taxes and excluding benefits)*

☐ Less than $10,000	☐ $30,000-$39,999	☐ $60,000-$69,999	☐ $90,000-$99,000
☐ $10,000-$19,999	☐ $40,000-$49,999	☐ $70,000-$79,999	☐ $100,000-$109,999
☐ $20,000-$29,999	☐ $50,000-$59,999	☐ $80,000-$89,999	☐ $110,000 or more

38. Do you plan to completely retire from mental health work? ☐ Yes ☐No

a. If yes, at what age do you plan to retire? _____

39. Do you plan to reduce the number of hours you practice per week before or in lieu of retirement? ☐ Yes ☐No

If yes, please specify:

a. How many years from now do you plan to reduce your hours? _____ Yrs

b. How many hours per week will you practice after reducing your hours? _____ Hrs/Wk

40. Overall, how satisfied are you with your *current* employment situation?

☐ Very satisfied ☐ Somewhat satisfied ☐ Somewhat dissatisfied ☐ Very dissatisfied

Thank you for your participation. Please return the survey in the enclosed envelope.

Utah Medical Education Council ● 230 S. 500 E. Ste. 210, Salt Lake City, Utah, 84102
Phone: (801)-526-4554/ Fax: (801)-526-4551 ● www.utahmec.org ● «LIC_7»

Utah's Mental Health Workforce Survey 2015

SECTION 1: GENERAL INFORMATION, BACKGROUND, AND EDUCATION

1. Please mark the mental health license you currently hold in the state of Utah:

☐ CMHC	☐ MFT	☐ LCSW	☐ Psychologist
☐ Temporary CMHC	☐ Temporary MFT	☐ CSW	☐ Psychologist Assistant
☐ Associate CMHC	☐ Associate MFT	☐ Temporary LCSW	☐ Temporary Psychologist
☐ Associate CMHC Extern	☐ Associate MFT Extern	☐ CSW Intern	☐ Psychology Resident
☐ Volunteer CMHC		☐ CSW Extern	

2. Are you providing direct or indirect mental health services in Utah (including administration, teaching, etc.)? ☐ Yes ☐ No

a. ***If NO, please specify why you maintain a Utah license.***

_____

b. If NO, on a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the individual factors that have influenced your choice to work outside of Utah:

Family _____ Wage/Pay scale _____ Climate _____
Lifestyle _____ Work Environment _____ Other _____ *(specify)*_____

IF YOU DO NOT PROVIDE DIRECT OR INDIRECT MENTAL HEALTH SERVICES IN THE STATE OF UTAH, PLEASE STOP HERE AND RETURN THE SURVEY IN THE INCLUDED PRE-PAID ENVELOPE.

3. On a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the following factors that have influenced your choice to practice in Utah:

Family in Utah _____ Practice Environment _____ Lifestyle _____ Utah Graduate _____
Military _____ Practice Opportunities _____ Other _____*(specify)*_____

4. Are you of Hispanic ethnicity? ☐ Yes ☐No

5. What is your race? (*please mark only one*)

☐ American Indian/Alaska Native	☐ African American	☐ Asian
☐ Native Hawaiian/Pacific Islander	☐ White/Caucasian	☐ Other *(specify)*_____

6. Please describe the area where you spent the majority of your upbringing *(when you lived there):*

State _____ ☐ Rural ☐ Suburban ☐Urban/Metropolitan

7. What is the highest mental health degree you have obtained?

☐ Master's in Counseling	☐ PhD in Counseling	
☐ Master's in Marriage & Family Therapy	☐ PhD in Marriage & Family Therapy	
☐ Master's in Social Work	☐ PhD in Social Work	☐ Doctor of Psychology (PsyD)
☐ Master's in Psychology	☐ PhD in Psychology	☐ Other *(specify)*_____

8. Where and when was your degree conferred?

State:_____ Year of degree:_____ Check one that applies: ☐ State School ☐Private School

9. Please enter a code from the list below to indicate the amount of your CURRENT student debt and TOTAL student debt from your mental health schooling (undergraduate and graduate). Current _____ Total _____

01=$0.00	04=$20,000 to $29,999	07=$50,000 to $59,999	10=$80,000 to $89,999
02=$0.01 to $9,999	05=$30,000 to $39,999	08=$60,000 to $69,999	11=$90,000 to $99,999
03=$10,000 to $19,999	06=$40,000 to $49,999	09=$70,000 to $79,999	12=$100,000 or more

10. Did/do you participate in a loan forgiveness/repayment program (LRP)? ☐ Yes ☐No

a. If yes, which one(s)?

☐ Public Service LRP	☐ National Health Services Corps LRP	☐ Employer Based LRP
☐ Pediatric Specialty LRP	☐ AmericaCorps	☐ Volunteers in Service to America (VISTA)
☐ Military LRP	☐ Federal Employee LRP	☐ Other_____

SECTION 2: YOUR WORK SETTING/ SPECIALTY

11. Which best describes your primary work status? *(please check **one** of the following)*

☐ Employed in a mental health position that requires a license
☐ Employed in a mental health position that does not require a license
☐ Involuntary unemployment
☐ Voluntary unemployment
☐ Employed NOT in mental health
☐ Retired (with or without volunteer work)
☐ Volunteer work only

12. Which best describes your current employment arrangement at your primary practice location?

☐ Self-employed ☐ Hourly employment ☐ Salaried employment ☐ Locum tenens/temporary

13. Please list the city and zip code of your primary practice setting and secondary practice setting *(if applicable).*
Please also estimate the total hours worked per week at each location.

Primary Practice City _____ Zip _____ Total hours/week _____
Secondary Practice City _____ Zip _____ Total hours/week _____

14. Please enter a code from the list to describe your Primary _____ and Secondary _____ practice settings:

01= Public Hospital	09= Child Welfare Facility	18= Organization/Business Setting
02= Private Hospital	10= Criminal/Juvenile Justice Facility	19= Rehabilitation Facility
03= Psychiatric Hospital	11= Correctional Facility	20= Residential Facility
04= Mental Health Clinic	12= Hospice Setting	21= School Based Facility
05= Primary or Specialist Medical Facility	13= Independent Solo Practice	22= Community Health Center
06= Substance Abuse Treatment Facility	14= Independent Group Practice	23= State Mental Health Agency
07= College/University Counseling/Health Center	15= Academic Institution (teaching)	24= Other private for-profit organization
	16= Veterans Facility	25= Other private non-profit organization
08= Methadone Clinic	17= Long-term Care Facility	26= Other _____

15. Have you voluntarily switched employers/practices within the past five years?

☐ YES ☐NO

a. If YES, please use the list of settings above to indicate the practice setting you left and the work setting you moved to: Setting Code Left: _____ Setting Code Moved To: _____

b. If YES, please check the reason(s) for this change of work setting

☐ Better Work/Education Fit ☐ Desire for Change ☐ Higher Pay ☐ More Challenging
☐ Moved Residence ☐ Personal/Family Reasons ☐ Preferred hours ☐ Professional Advancement
☐ Work Responsibilities ☐ Other _____

16. Are you employed for or contracted by a Behavioral Health Management Organization?

☐ YES ☐NO Specify organization_____

17. What population(s) do you generally serve in your primary setting? *(check all that apply)*

☐ Any/all populations	☐ Children (under 13 years)	☐ Groups
☐ American Indian or Alaska Native	☐ Adolescents (13-17)	☐ Individuals
☐ Asian or Asian American	☐ Young adults (18-34)	☐ Homeless
☐ Black or African American	☐ Mid-adults (35-64)	☐ Rural
☐ Hispanic/Latino/a	☐ Older adults (65-84)	☐ Suburban
☐ Native Hawaiian or Pacific Islander	☐ Elderly (85 and older)	☐ Urban
☐ White	☐ Families	☐ Working poor/unemployed
☐ Refugees/Immigrants	☐ Couples	☐ Other:_____

SECTION 3: YOUR PRACTICE

18. Do you use telemedicine in your practice? ☐ Yes ☐No

a. If yes, do you use telemedicine to interact with a supervisor? ☐ Yes ☐No

b. Do you use telemedicine to provide therapy, consultation, or assessment across state lines? ☐ Yes ☐No

i. If yes, have you come across licensing or practice obstacles across state lines? ☐ Yes ☐No

19. Please indicate the average number of hours you spend in DIRECT CLIENT CARE (including client documentation and treatment) each week:

Primary Practice: _____ Secondary Practice _____

20. In a typical day, how many INDIVIDUAL clients do you see per day?

Primary Practice _____ Secondary Practice _____

21. If you provide group or family therapy, how many GROUPS do you see per day and how large is a typical group?

	Number of Groups	Size of Groups
Primary Practice	_____	_____
Secondary Practice	_____	_____

22. Please indicate the average hours per week you spend in the following NON-CLIENT CARE activities:
(Number of hours between non-client care and direct client care should not exceed the number of hours worked/week)

NON-CLIENT ACTIVITY	Hrs./Wk. PRIMARY SITE	Hrs./Wk. SECONDARY SITE
a. Classroom Training (clinical and/or classroom training of students)	_____	_____
b. Clinical Supervision/Instruction (of interns/students or required clinical hours for licensure)	_____	_____
c. Administration/Management (budgeting, personnel management, NOT in support of client care)	_____	_____
d. Practice Management (budgeting, planning, activities to maintain operation of a practice)	_____	_____
e. Consulting/Research (reports, applications, surveys, etc., NOT in support of client care)	_____	_____
f. Other: _____ (NOT in support of client care)	_____	_____

23. Please estimate the percentage of clients you see from each of the following age groups *(Should equal 100%)*

	0-12	13-17	18-34	35-64	65-84	85+
Primary Practice:	_____%	_____%	_____%	_____%	_____%	_____%
Secondary Practice:	_____%	_____%	_____%	_____%	_____%	_____%

24. What percentage of your clients are: Male _____% Female _____%

25. What percentage of your clients are insured by: *(percentages should add up to 100%)*

	Primary	Secondary		Primary	Secondary		Primary	Secondary
Medicaid	____%	____%	Private Insurance	____%	____%	Charity/No Charge	____%	____%
Medicare	____%	____%	TriCare (Champus)	____%	____%	Self-Pay (full)	____%	____%
Managed Care	____%	____%	Workers Comp.	____%	____%	Self-Pay (sliding scale)	____%	____%

26. On average, how many days must clients wait for an appointment?

Primary Practice: **New Clients**: _____days **Established Clients**: _____days
Secondary Practice: **New Clients**: _____days **Established Clients**: _____days

27. Please indicate a code for the status of your primary_____ and secondary_____ practice location(s).

01= Full (cannot accept additional patients) 03= Unfilled (can accept many new patients, far from full)
02= Nearly Full (can accept a limited number of new patients) 04= N/A (practice site is VA, military, or corrections)

28. Does your primary practice location provide mental health therapy in any language OTHER than English?

☐ Yes ☐No **a. If yes, please specify the language(s):** _____

29. Are YOU able to provide mental health therapy in any language OTHER than English (without an interpreter)?

☐ Yes ☐No **a. If yes, please specify the language(s):** _____

30. What models of therapy do you typically use? *(check all that apply)*

☐ Psychodynamic ☐ Experiential-humanistic ☐ Other*(specify):*
☐ Cognitive-behavioral ☐ Transpersonal _____