BHWC
BEHAVIORAL HEALTH WORKFORCE CENTER

Confidence and Training Needs of Providers in Community Mental Health Agencies in Illinois

October 2024

Contents

Executive Summary

The Community Mental Health Provider Survey collected data from 555 providers in outpatient community mental health agencies, certified community behavioral health centers, and other publicly funded outpatient mental health programs across Illinois to assess provider confidence, training adequacy, intervention use, and barriers to professional development. This summary highlights key findings and their implications for enhancing outpatient community mental health services. To ensure statewide representation, the state was divided into six regions and a stratified random sample of 120 sites was selected, with 20 sites from each region. Of the eligible sites, 74 (80.4%) agreed to participate and had staff submit surveys.

Key Findings

Confidence in Providing Services: Providers had the lowest levels of confidence for service provision to children aged 0-3 and 4-12 compared with adolescents and adults of all ages. Overall, respondents were confident in providing services to diverse racial/ethnic groups. However, significant regional differences emerged regarding confidence in service provision to unhoused individuals, individuals with substance use disorders, criminal justice system-involved individuals, and DCFS-involved youth, with suburban Cook County reporting lower levels of confidence than the rest of the state.

Perceived Adequacy of Training: Providers felt satisfied with their training for adult depression and anxiety, however, a higher proportion felt that they received inadequate training for providing services to children, consistent with their lower levels of confidence in service provision to children.

Use of Interventions: Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) were commonly used, while newer therapies like Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT) were less utilized. More experienced providers reported more use of Solution-Focused Brief Therapy (SFBT) than those with less experience.

Participation in Additional Training: Providers reported a strong likelihood of participating in further training to address specific presenting problems, learn evidence-based interventions, and gain support in employment-related issues. There was particularly strong interest in training on substance use disorders, suicidal ideation, and psychiatric conditions, as well as burnout prevention and stress management.

Barriers to Training: Cost was the primary barrier to attending training, followed by time constraints and productivity expectations. Time constraints were particularly significant in

Chicago, while productivity expectations were a significant concern in region 2. Region 4 reported the most technology-related barriers.

Conclusions

This report underscores the need for targeted training initiatives to enhance provider confidence, address gaps in intervention use, and overcome barriers to professional development. Providing targeted training in the areas identified in these findings has the potential to support better stress management, provider retention, and job satisfaction, as well as greater use of evidence-based interventions.[1,2,3] By focusing on providing training in these areas, the mental health workforce in Illinois can be better equipped to meet the needs of their clients and improve outcomes for those in need of services across Illinois.

> *"...I feel that I could benefit from some more professional trainings to enhance my level of experience. I want to make sure that I am equipped with the proper trainings and skills in order to better assist people in need of services."*
>
> Provider Feedback in Open-Ended Question

[1] Rollins, A. L., Eliacin, J., Russ-Jara, A. L., Monroe-Devita, M., Wasmuth, S., Flanagan, M. E., Morse, G. A., Leiter, M., & Salyers, M. P. (2021). Organizational conditions that influence work engagement and burnout: A qualitative study of mental health workers. *Psychiatric rehabilitation journal*, *44*(3), 229–237. https://doi.org/10.1037/prj0000472

[2] Adams, D. R., Williams, N. J., Becker-Haimes, E. M., Skriner, L., Shaffer, L., DeWitt, K., Neimark, G., Jones, D. T., & Beidas, R. S. (2019). Therapist financial strain and turnover: Interactions with system-level implementation of evidence-based practices. *Administration and policy in mental health*, *46*(6), 713–723. https://doi.org/10.1007/s10488-019-00949-8

[3] Bass, E., Salyers, M. P., Hall, A., Garabrant, J., Morse, G., Kyere, E., Dell, N., Greenfield, J., & Fukui, S. (2024). Why do stayers stay? Perceptions of white and Black long-term employees in a community mental health center. *Administration and policy in mental health*, 10.1007/s10488-024-01387-x. Advance online publication. https://doi.org/10.1007/s10488-024-01387-x

Introduction

As established in the Illinois Healthcare and Human Services Reform Act (Public Act 102-0004, effective April 27, 2021), the Behavioral Health Workforce Center of Illinois (BHWC) seeks to increase access to effective behavioral health services through innovative initiatives to recruit, educate, and retain qualified and diverse behavioral health providers. One component of the center's work is assessment of the behavioral health workforce to better understand key shortage areas and providers' retention and training needs.

There is little existing information about behavioral health providers across Illinois. To gain an understanding of the providers and challenges unique to different behavioral health settings, BHWC at the University of Illinois Chicago (UIC) created initiatives focused on providers in community mental health, child and adolescent services, integrated care, serious mental illness services, and substance abuse and recovery. For each area, provider advisory groups provide input and help direct assessment activities. Surveys of providers were initiated to gain a broader understanding of provider characteristics and needs.

> *"Certified Comprehensive Community Mental Health Centers (CMHCs) respond to the unique mental health needs of the community with a continuum of services ranging from prevention/promotion through treatment and recovery. CMHCs collaborate with other social service and health care providers to deliver integrated care to individuals in the identified geographic service area. CMHCs must be nonprofit or local government entities."*
>
> Illinois Department of Human Services, Part 132 Medicaid Community Mental Health Services Program

This report presents findings on provider confidence and training needs from a statewide survey of behavioral health providers employed in outpatient community mental health settings in 2023-24. Examining the potential deficits in the confidence and training of providers is crucial to ensure high quality service provision by the behavioral health workforce in Illinois. This information allows for targeted interventions to address specific gaps and needs, ensuring that services are effective, culturally relevant, and accessible to all community members.

Methods

This assessment sought to obtain a statewide, representative sample of behavioral health providers working in community mental health agencies. The sampling frame was built by

starting with the Illinois Division of Mental Health (DMH) list of Community Mental Health (CMH) agencies, which includes Certified Community Behavioral Health Clinics, non-profit organization, hospital-based clinics, programs within Federally Qualified Health Centers, county health departments, and other municipally funded programs and centers. Research staff expanded the list to include all the physical locations within each organization that provide direct services across the state and added locations of any new and eligible programs. Sites were included if they provided traditional outpatient mental health services and accepted publicly funded health insurance, such as Medicaid and managed care, for therapy services.[4] Private practice groups were not included. After listing physical locations across the state, staff identified 444 potential sites in the sampling frame.

To ensure statewide representation, the Illinois Department of Human Services regional map was used as a guide, separating Illinois into five regions. Region 1 was then divided into two categories, Chicago and suburban Cook County, creating a total of 6 regions. A stratified random sample of 120 sites was selected. For each of the regions 2-5 identified by Illinois DMH, 20 sites were randomly selected. For region 1, 20 sites were randomly selected from Chicago and an additional 20 from suburban Cook County.

Each selected site was contacted by email and, if necessary, by phone to determine eligibility for the survey. As shown in Table 1, 92 of the selected sites were eligible. Of the eligible sites, 74 (80.4%) agreed to participate and had staff submit surveys. The exact percentage of eligible staff at each site who submitted surveys is unclear.

Table 1. Site Response by Region (*N* = 120)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Total
Agreed	14	13	15	10	12	18	82
Responses Received	13	11	14	10	12	14	74
No Response	1	2	1	0	0	4	8
Ineligible	4	6	4	6	6	2	28

[4] Because separate surveys of providers working in substance use recovery programs and community-based programs for people with serious mental illness are being conducted, programs were only eligible if one component included traditional outpatient therapy.

Declined	1	0	0	3	2	0	6
Unknown	1	1	1	1	0	0	4

Reasons for ineligibility included reports that the site had no current providers, provided other services but not individual therapy, or provided only SUD services; that the location had been closed; and that the location was administrative only. Reasons for declining included that the administrator reported that they were not interested in the topic, did not have time to forward this survey, did not think their staff had time to complete the survey, or their agency's administration had denied the request for participation.

Once site eligibility was confirmed, the sites were provided with survey information to distribute to all their behavioral health service providers. Only staff providing services to people with mental health challenges were eligible, across levels of experience and education. Participants were given a $20 gift card as an incentive to complete the survey. The survey was completely anonymous, gathering no metadata about the participants. To receive compensation, participants were redirected to a separate form that was not connected to the actual survey.

A total of 555 participants responded to the survey. Responses for statewide analyses were weighted to reflect the state. Regional analyses are not weighted. For regional analyses, chi-square likelihood ratio tests were used to determine statistically significant differences between the regions on categorical variables (gender, race, education, etc.). For continuous variables (age, years of experience, and years at an agency), statistically significant differences were determined with independent sample t-tests or one-way ANOVA tests. Similarly, differences between the sample and Illinois' population within different regions were tested using chi-square tests for categorical variables. All tests were two-tailed and used $p < 0.05$ to identify statistically significant differences. Statistically significant differences are differences that are not likely to be due to chance and would be likely to be replicated in another similar sample.

Results

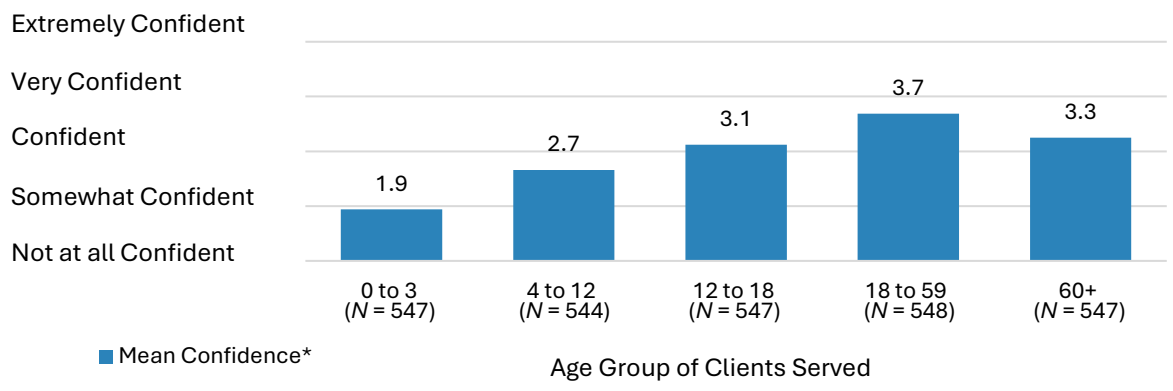
Confidence in Providing Services

Participants were asked to indicate their confidence in providing mental health services to individuals from a variety of populations on a scale ranging from (1) "Not at all confident"

to (5) “Extremely confident”. Mean confidence levels were determined using the average level of confidence on this scale.

Examining all providers revealed a statistically significant difference in providers' confidence in their service provision across different age groups. Overall, confidence increases as the age of the client increases until older adult clients. Confidence in serving older adults was slightly lower than confidence in serving adults 18-59.

Figure 1. Average Confidence In Providing Mental Health Services Across Age Groups



*One-way ANOVA test, $F(4, 2728) = 212.358$, $p < .001$

When looking at providers’ confidence working with children ages 0-18, no difference in confidence level was found between providers with a certificate and/or license as compared to uncredentialled providers. However, for adults 18-59 and older adults, providers with a certificate and/ or license reported higher levels of confidence than those without the credentials. No regional differences were found in confidence levels for different age groups. See Appendix A for more details on confidence levels across age groups.

Overall, providers were confident in providing services to diverse racial/ethnic groups, with 85.5% of professionals stating they were at least “confident” in providing services to this group. Providers had slightly lower, but still high, confidence related to serving LGBTQIA+ individuals, with 74.2% stating they were at least “confident” in working with clients with these identities. There were no significant differences across regions in confidence levels in providing services to diverse racial/ethnic groups or LGBTQIA+ individuals.

Providers’ confidence in providing services to unhoused/underhoused individuals, criminal justice system-involved individuals and families, Department of Children and Family

Services (DCFS)-involved youth/families (youth-in-care), and individuals with substance use disorders (SUD) was more mixed and varied significantly by region (see Appendix A).

The level of confidence among providers in offering mental health services to unhoused or underhoused individuals was significantly higher in region 4, with 68.2% of providers feeling confident or very confident in their ability to deliver these services. In contrast, suburban Cook County providers had the lowest confidence levels, with almost half (46.8%) feeling only somewhat confident or not at all confident in serving unhoused or underhoused individuals.

> *Suburban Cook's confidence levels in serving unhoused individuals, individuals with substance use disorders, criminal justice system-involved individuals, and DCFS-involved youth were notably low compared to other regions.*

Providers' confidence in serving individuals and families involved with the criminal justice system also varied significantly by region. Region 1 had notably lower levels of confidence, with half (50%) of Chicago providers and nearly half (48.5%) of Suburban Cook providers feeling only somewhat confident or not at all confident. Similarly, region 1 indicated the lowest levels of confidence in providing mental health services to youth and families involved with DCFS, with providers in Chicago (46.9%) and Suburban Cook (46%) reporting feeling only somewhat confident or not at all confident.

Table 2. Overall Confidence Percentages in Providing Mental Health Services to Different Population Groups

	Unhoused* *N* = 549	Criminal justice system-involved * *N* = 549	DCFS-involved * *N* = 550	Individuals with SUD* *N* = 549
Not at All Confident	7.4	0.9	7.4	4.3
Somewhat Confident	24.6	13.7	24.6	21.6
Confident	38.9	41.5	38.9	36.8
Very Confident	19.7	29.8	19.7	25.7
Extremely Confident	9.3	14.2	9.3	11.7

*Denotes statistically significant regional differences

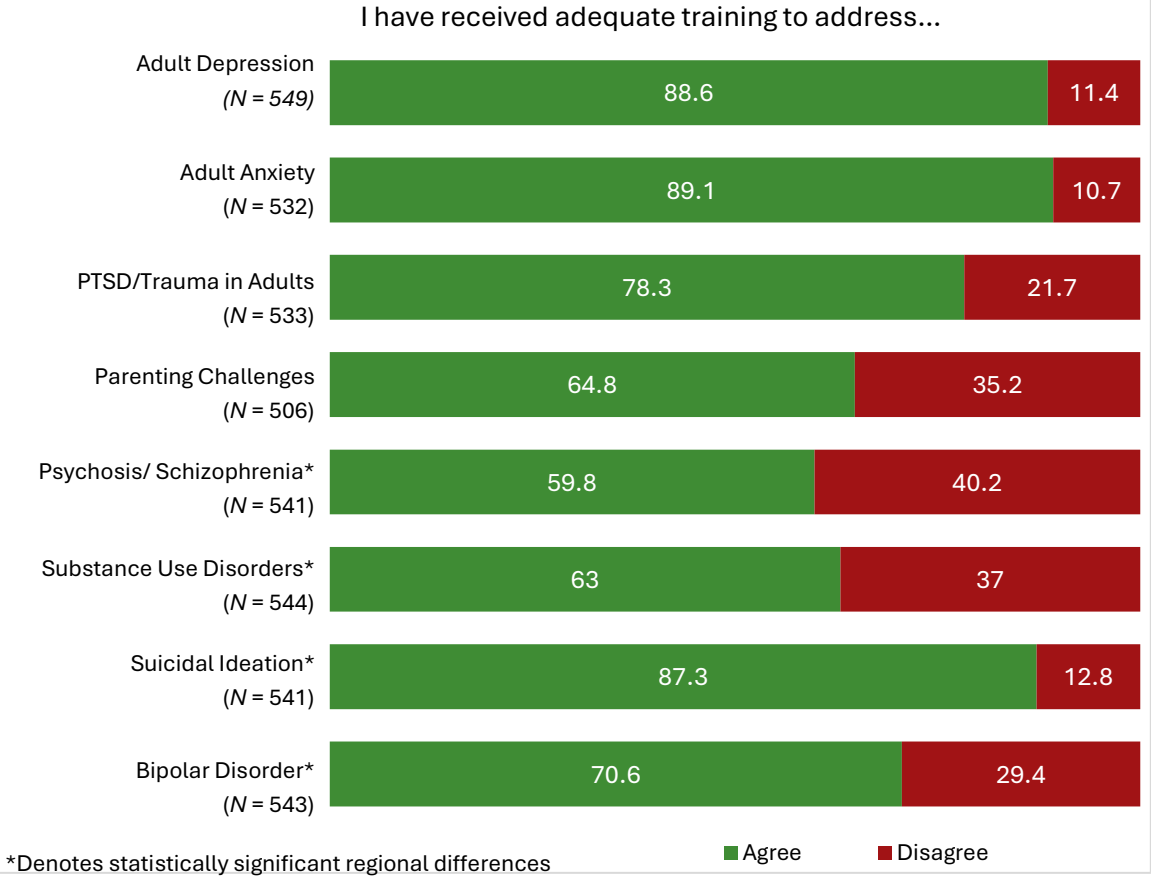
Suburban Cook also demonstrated the lowest levels of confidence in providing services to individuals with substance use disorders (48.4 % somewhat or not at all confident).

Breakdown of regional data on provision of services to unhoused/underhoused individuals, criminal justice system-involved individuals and families, DCFS-involved youth/families (youth in care), and individuals with SUD can be found in Appendix A.

Perceived Adequacy of Training

Providers indicated how well the training they have received met their needs for serving clients with a variety of concerns. [5] Adequate training was reported by over 85% for adult anxiety, depression, and suicidal ideation, while **over a third reported not being prepared to treat psychosis, parenting issues, and substance abuse**.

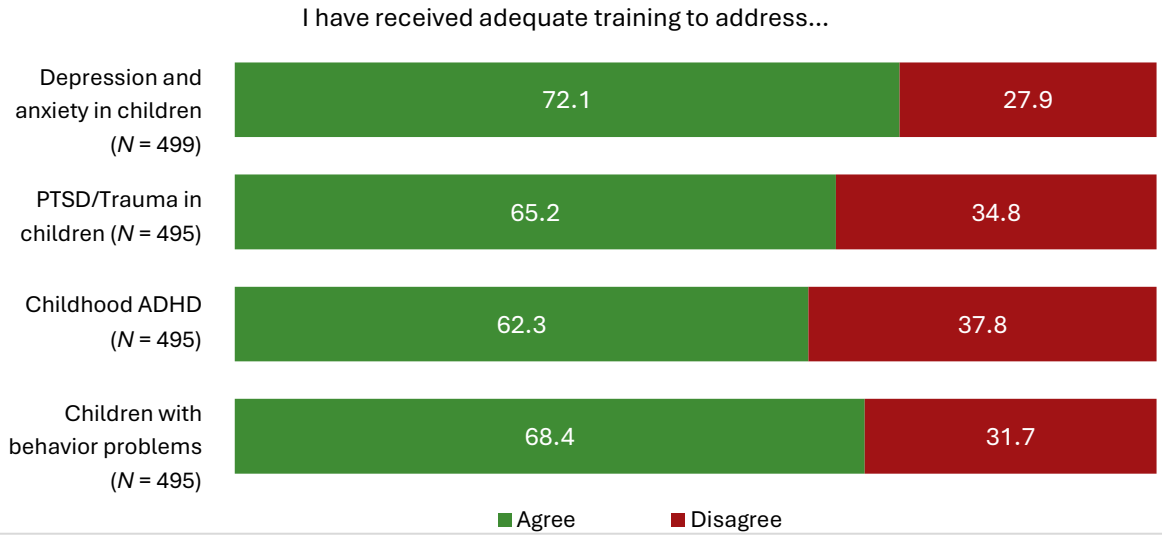
Figure 2. Received Adequate Training on Providing Services To Various Adult Populations (%)



[5] Agreement scales were condensed from Strongly Disagree, Disagree, Agree, Strongly Agree to Disagree and Agree. Strongly Disagree and Disagree became Disagree and Agree and Strongly Agree became Agree.

Notably, a higher proportion of providers felt that they did <u>not</u> receive adequate training for providing services to children, consistent with their lower levels of confidence in their ability to provide services to children, particularly ages 0-3 (45.7% not at all confident). For depression and anxiety in children, 27.9% were not confident, while over 30% were not confident in areas including PTSD/trauma, ADHD, and behavior problems in children. **ADHD in children was rated as the area with the least confidence**, with over one-third indicating that they were not confident in this area. Among providers that serve children and adolescents, no significant regional differences emerged regarding their perceived adequacy of training for serving children with depression and anxiety, PTSD/trauma, ADHD, or behavior problems.

Figure 3. Received Adequate Training on Providing Services to Various Child Populations (%)



The percentage of providers that reported receiving adequate training to address psychosis/schizophrenia, SUD, suicidal ideation, and bipolar disorder differed significantly across regions. Chicago providers were relatively split on the adequacy of training for psychosis/schizophrenia, with over half of Chicago providers reporting that they received inadequate training to address psychosis/ schizophrenia.

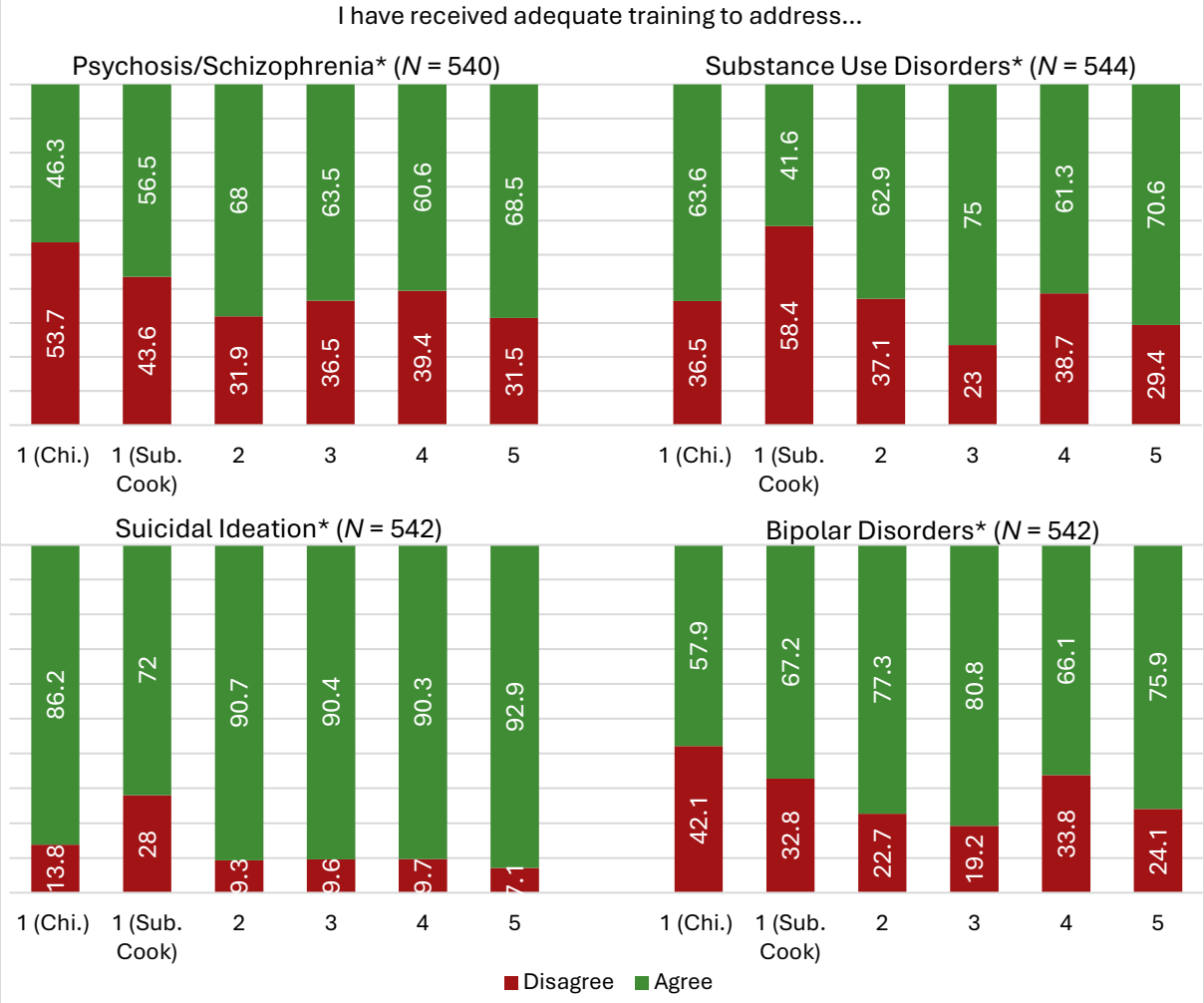
Providers in suburban Cook County reported their training to address SUD and suicidal ideation as more inadequate compared with other regions, with over half disagreeing that they received adequate training on SUD. While training on suicidal

> *"I think I need more practice in general to build more confidence with my clients but more specifically with individuals who struggle with substance use, psychosis, and dissociation."*
>
> Provider Feedback in Open-Ended Question

ideation was reported as adequate by around 90% of providers in other regions (including Chicago), less than three-quarters of providers in Suburban Cook agreed.

Perceived adequacy of training to treat bipolar disorder demonstrated more variability across regions. Only 57.9% of Chicago providers agreed that training was adequate. This was followed by region 4 and Suburban Cook reporting adequate training. Region 3 had the highest agreement on being adequately trained.

Figure 4. Received Adequate Training on to Address Common Presenting Problems by Region (%)



When looking at providers who had a license and/or certificate, some significant differences emerged in their perception of adequacy of their training to address various behavioral health issues. **Providers with a license and/or certificate felt more adequately prepared to address adult depression, SUD, and PTSD/trauma in adults than providers without a license or certificate**. See Appendix B for significance and other details.

Use of Interventions in Therapy/Counseling

Evidence-based practices (EBPs) have been found to be effective in multiple studies for presenting problems like anxiety, depression, or substance use that are commonly treated in CMH agencies. Use of EBPs increases the effectiveness of services; therefore, increasing their use is critical to improving behavioral health outcomes across the state.[6,7] To understand the extent that mental health providers in Illinois use evidence-based practices, we examined information provided by all mental health providers who reported in the CMH survey that one of their primary job duties included therapy/counseling (*N* = 304 for the full sample, *N* =158 for providers that work with children and adolescents). These therapists and counselors were asked about how frequently they use specific therapy interventions, including EBPs.

> *Use of EBPs increases the effectiveness of services. Supporting their use is critical to improving behavioral health outcomes across the state.*

The specific interventions examined as indicators of EBP use include cognitive behavioral therapy (CBT) with adults, CBT with children, motivational interviewing (MI), mindfulness-based stress reduction (MBSR), Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT), solution-focused brief therapy (SFBT), and parent skills training with children and families. As CBT strategies are the basis for DBT, ACT, and many other EBPs in mental health practice with both adults and children, therapists/counselors who are using an evidence-based approach would be expected to use CBT frequently. Similarly, motivational interviewing and parent training with families and children are key evidence-based interventions that will ideally be used frequently.

Overall, MI was the most commonly used intervention, with 65.5% of therapy/counseling providers reportedly using MI often or always. This was followed by the use of CBT with adults (62.4%) and MBSR (50.6%). These, along with SFBT, ACT, and DBT, did not significantly differ across the regions. ACT and DBT were among the least frequently used, with high percentages of practitioners never using them. This is not surprising given that these are newer and more specialized types of treatment. See Appendix C for the full data table.

Providers were also asked about two interventions that have less evidence for effectiveness than CBT approaches, psychodynamic therapy and play therapy. In general, the use of both interventions was fairly low, with more than half of the providers using them rarely or never. **When looking at providers with licenses and/or certificates, people**

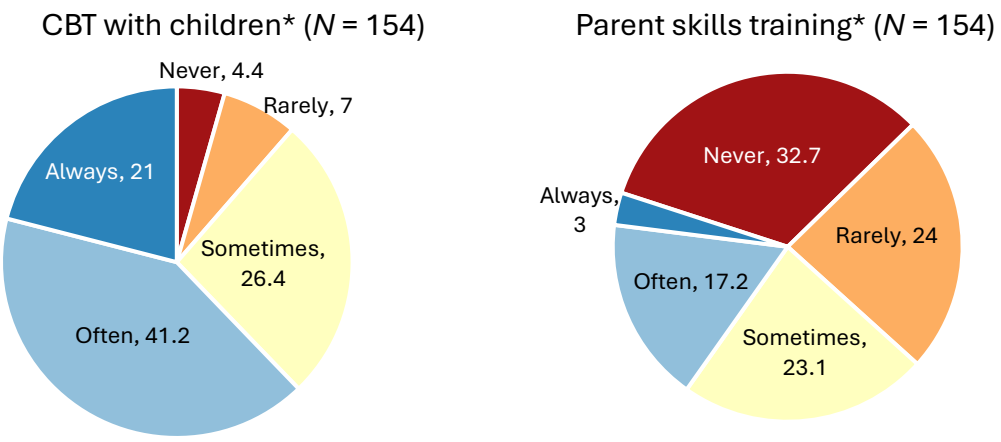
[6] American Psychological Association. (2021). Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care. Retrieved from https://www.apa.org/about/policy/evidence-based-psychological-practice-health-care.pdf

[7] American Psychological Association. (2006). *Evidence-based practice in psychology. American Psychologist, 61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

who had a license were significantly more likely to endorse using psychodynamic therapy more often than those who did not have a license or certificate. See Appendix C for additional information.

When specifically looking at providers that do therapy/counseling with children and adolescents, the two most pertinent EBPs are CBT and parent skills training, which is the primary evidence-based intervention for children's behavior problems. In this sample, more than half of providers reported using CBT with children often or always. In contrast, **less than half of the providers who work with children and adolescents reported using parent skills training**.

Figure 5. Child/Adolescent Providers' Intervention Use (%)



*Denotes statistically significant regional differences

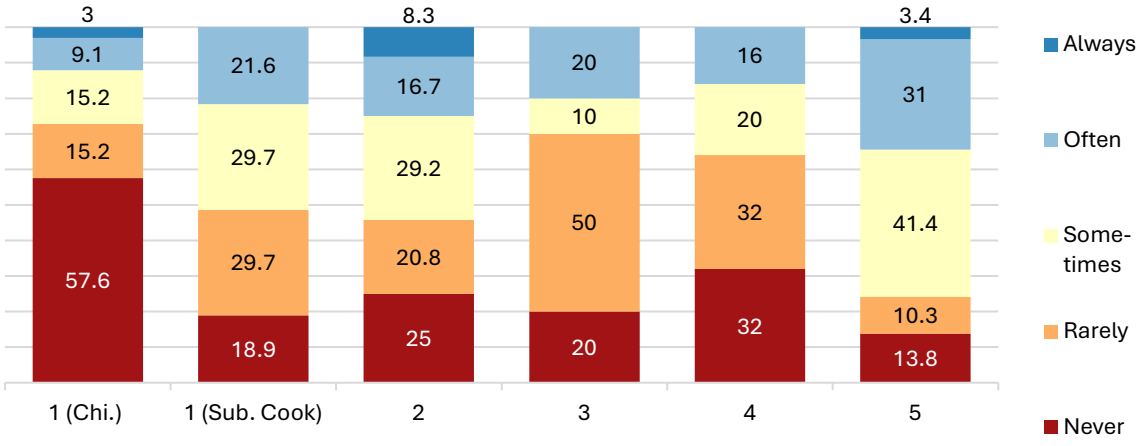
Overall, parent skills training was used the least frequently of all the interventions in this survey, with over half of the providers who work with children and adolescents rarely or never using it when serving children and adolescents. This points to a significant training need, as this intervention is the most effective intervention to manage children's behavior problems, which are one of the most common reasons that parents and caregivers seek treatment for their children.[8]

Use of parenting interventions varies across different regions. **Parent skills training was reported to be used least in Chicago**, with just over half of providers never using it. While this intervention was generally used infrequently by providers, it was used much more frequently in region 5, as three-quarters used parent skills training at least sometimes,

[8] Tkacz, J., & Brady, B. L. (2021). Increasing rate of diagnosed childhood mental illness in the United States: Incidence, prevalence and costs. *Public health in practice (Oxford, England)*, *2*, 100204. https://doi.org/10.1016/j.puhip.2021.100204

and, in fact, 31% used it often. This is important to note as it may help inform where to find successful programs as well as areas of the state to target for potential training and/or funding opportunities.

Figure 6. Child/Adolescent Providers' Use of Parent Skills Training By Region (%)



Likelihood Ratio X^2 (20, N = 158) = 43.3, p = 0.002

In addition to parent skills training, child/adolescent providers' use of CBT with children and all providers' use of psychodynamic therapy varied significantly across regions. **At least half of the providers reported using CBT with children often or always in all regions except Chicago.** Compared with other regions, providers in Chicago had relatively infrequent use of CBT with children, with only 36.3% using it often or always. With respect to psychodynamic therapy, providers in suburban Cook County reported the highest use. For more details on the regional differences in the use of CBT with children and psychodynamic therapy, see Appendix C.

When looking at the providers' years of experience, there were no statistically significant differences among the use of CBT with adults, MI, MBSR, ACT, and DBT. Interestingly, the mean years of experience significantly varied only for the frequency of use of SFBT, with providers with more years of experience reporting more frequent use. See Appendix C for more information.

Likelihood of Attending Training

Providers were informed that the Behavioral Health Workforce Center will support training in evidence-based practices at no cost to them. They were asked to rate their likelihood of participation in training on working with clients with a variety of concerns. [9]

Additional Training for Specific Presenting Problems

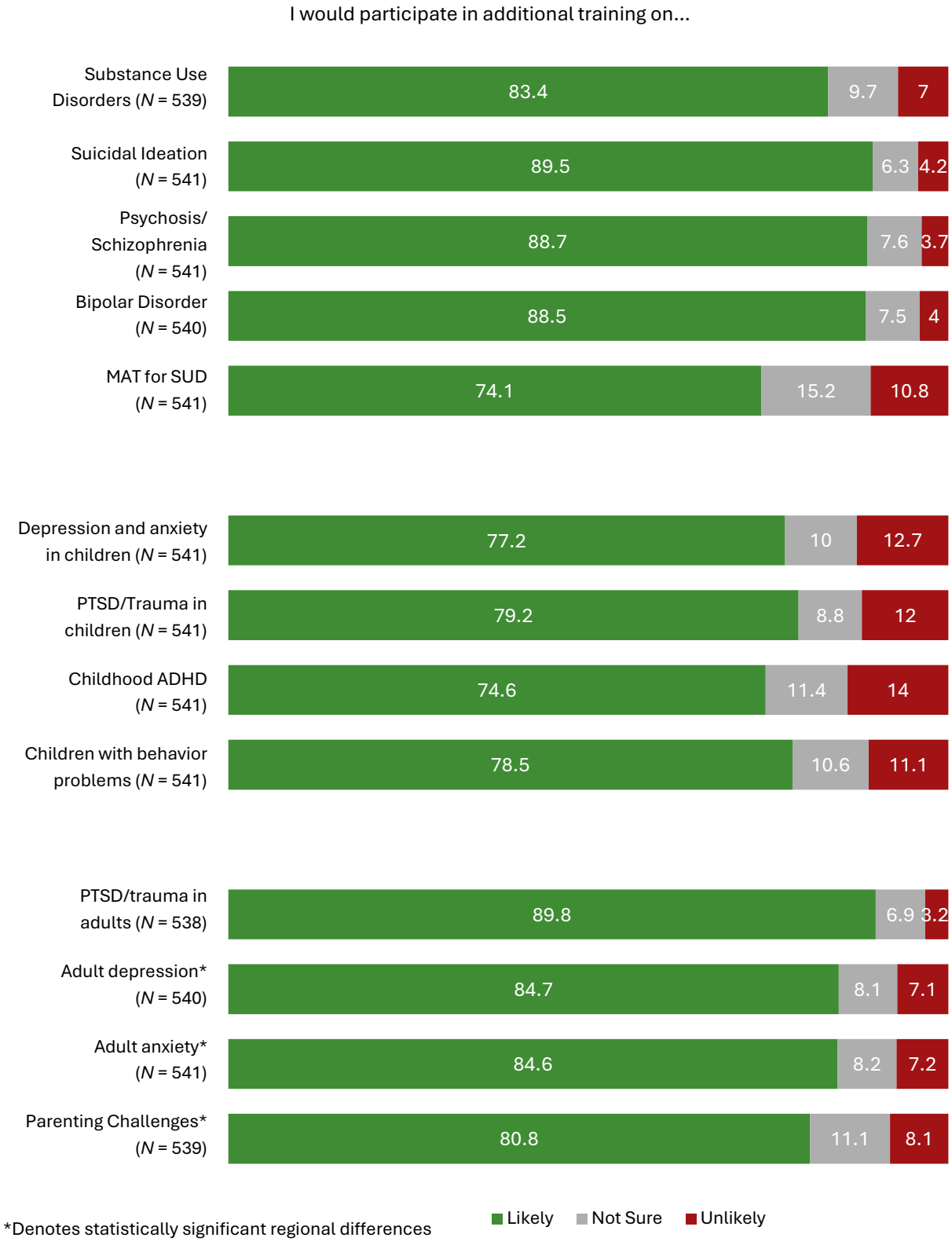
Across all training topics, providers indicated an overall high likelihood of participating in additional training. The likelihood of provider participation in most trainings did not significantly vary across regions, other than for adult depression, adult anxiety, and parenting challenges.

Regions 4 and 5 – region 4 in particular – indicated a significantly higher likelihood of attending training on adult depression, adult anxiety, and parenting challenges. Other regions reported a generally high likelihood of attending training for all three topic areas as well. See Appendix D for more details.

> *"Generally, learning about children with behavioral issues. Most of my area of expertise is adults with chronic illnesses and I would love the opportunity to continue my studies with children."*
>
> Provider Feedback in Open-Ended Question

[9] Level of likelihood variables were condensed from Very Unlikely, Unlikely, Not Sure, Likely, Very Likely to Unlikely, Likely, and Not Sure. Very Unlikely and Unlikely became Unlikely and Likely and Very Likely became Likely. Not Sure remained the same.

Figure 7. Likelihood of Participation in Intervention Training (%)



*Denotes statistically significant regional differences

Additional Training on Evidence-Based Practices

Providers reported that they were generally likely to participate in trainings on evidence-based practice (EBP) interventions such as CBT with adults and children, MI, SFBT, MBSR, ACT, DBT, psychodynamic therapy, and parent skills training. **The likelihood of participation in the presented EBP trainings was consistently high for all interventions across all regions**, with the lowest participation likelihood being 67.9% (MAT).

While parent skills training may appear to be most relevant for providers who work with children and adolescents in some capacity, there is also potential for use of this intervention for providers who only serve adults. This is because adult clients may seek parenting support from their primary therapist. **When looking at therapy/counseling providers that exclusively work with adults (*N* = 104), the likelihood of participating in training on parent skills interventions was over half (57.3%)** likely to attend training on this topic.

Participants were also given the opportunity to share comments via open-ended questions. 152 participants responded with feedback to "What other practice areas, if any, do you think you need additional training in?" and/or "What other topics, if any, would you like to receive training in?" Many respondents included more than one suggestion per response. Each distinct suggestion was counted separately to accurately represent the frequency of each topic mentioned.[10] These responses were categorized utilizing Qualtrics' Text iQ, a text analysis feature designed to process and analyze unstructured data using natural language processing (NLP) techniques. See Appendix F for detailed methodology.

> *"Much more training is needed for non - [substance abuse] counselors who work in community-based agencies."*
>
> Provider Feedback in Open-Ended Question

In respondent feedback, **104 comments included interest in training on specific presenting problems**, **most prominently substance use (21) and PTSD/trauma (17).** Additionally, 74 responses noted interest in additional training with specific populations, including those with an intellectual disability, developmental disability, and/or neurodivergence (20) and children/adolescents (13). Therapeutic techniques were mentioned in 56 responses, with suggestions indicating a wide range of interests without a single dominant technique; however, the most frequent being crisis and safety techniques at 10 mentions and Family/Couples Therapy at 9. See Appendix F for full topic frequency.

[10] The sum of individual topic mentions may exceed the total number of respondents, as multiple topics can be mentioned within a single response. Therefore, the total topic mentions are not directly proportional to the number of respondents.

Additional Training on Topics Related to Work Duties and Environment

Training topics unrelated to interventions were presented to providers to identify their likelihood of participation in different trainings. Similarly to intervention training interest, **providers reported a generally high likelihood of attending non-intervention training**. Providers reported the highest likelihood of participating in training regarding strategies to prevent and manage burnout, stress management, and supervision.

Table 3. Likelihood of Participation in Non-Intervention Training

	Documentation *N* = 531	Stress Mgmt. *N* = 533	Strategies for burnout *N* = 533	Time Mgmt. *N* = 532	Effective Supervision *N* = 533
Unlikely	16.5	11	9.9	19.4	12.6
Not Sure	17.8	9.8	8.8	14	12.8
Likely	65.7	79.2	81.3	66.5	74.6

There were no significant differences in the likelihood of participation in effective supervision training based on region, licensure, or years of experience in the field. **Regardless of region, whether providers had a license, and regardless of how long they have been in the field, providers are highly likely to attend training on how to prevent burnout, how to manage stress, and how to engage effectively in supervision.**

Supervision also stood out in the open-ended question "What type of support do you need to stay in your current position?". In respondent feedback, **45 comments mentioned the need for effective supervision, with both supervisors and supervisees identifying this as needed support**. Additionally, there were 9 mentions of effective supervision in response to the open-ended question, "What other topics, if any, would you like to receive training in?" See Appendix H for full topic frequency.

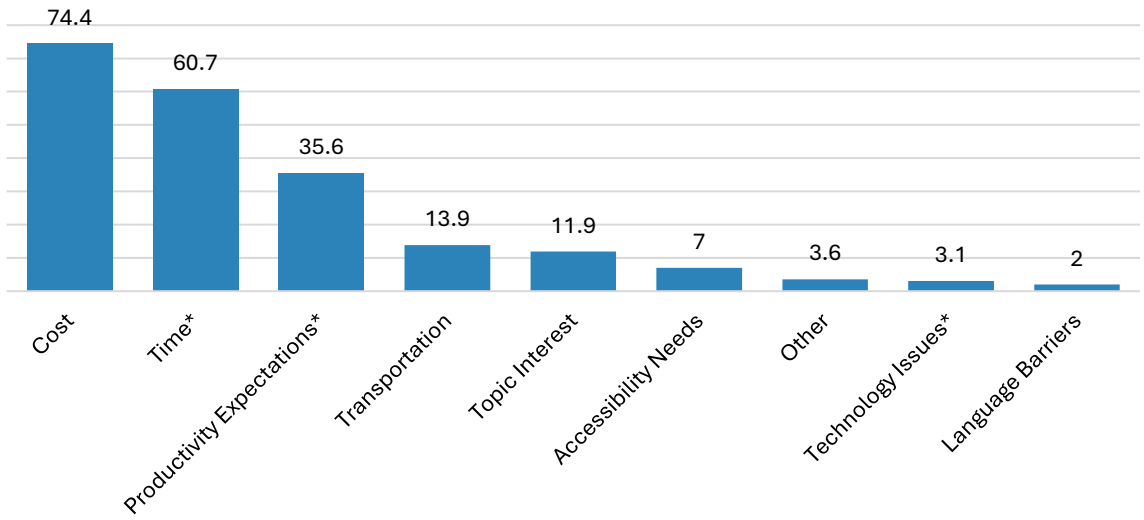
> *"[I need] individual coaching or consultation, training on how to help effectively train new staff and new supervisors…[I] need my agency to make it agency wide - all new supervisors get xyz training…"*
>
> Provider Feedback in Open-Ended Question

Training Barriers

Providers were asked to identify up to 3 barriers that could prevent them from attending training. **The most substantial barrier to attending training was cost, with nearly three-**

quarters of providers highlighting it as a concern. Time constraints, particularly being unable to attend training during work hours, also posed a barrier for over half of the respondents. The third most frequently identified barrier to training attendance was productivity expectations.

Figure 8. Barriers to Attending Trainings (%) (*N* = 552)



*Denotes statistically significant regional differences

Time constraints, productivity expectations, and technology issues were barriers that showed significant differences between regions. Time was notably less of an issue in region 4, with under half reporting it as a barrier (39.7%). In contrast, **in Chicago, time constraints posed a barrier for over two-thirds of providers** (68.4%). Productivity expectations were another significant barrier for providers, with region 2 exhibiting the highest percentage and Chicago reporting the lowest. Technology issues, although a relatively low barrier overall, were most problematic in region 4 (11.1%). See Appendix E for significance and other details.

Regarding the formatting in which providers would be most interested in receiving training (selecting up to 2), **providers showed a strong preference for instructor-led webinars** (68.7%). However, instructor-led, in-person training also had notable interest (42.9%), followed by self-paced training options such as recorded webinars or interactive courses (37.8%).

> *"Access to in person trainings are not feasible to me because I work another job and scheduling is difficult. Webinar options are better for me to attend and help me feel prepared when handling clients."*
>
> Provider Feedback in Open-Ended Question

Summary of Findings

Confidence in Providing Services

- **Age ranges:** Providers had the lowest levels of confidence in providing services to children, especially ages 0-3 (*M* = 1.9). Providers had the highest levels of confidence in service provision to young and middle-aged adults (*M* = 3.7).
- **Special populations:** Providers were overall confident in providing services to diverse racial/ethnic groups. Confidence was generally high when serving unhoused individuals, individuals with substance use disorders, criminal justice system-involved individuals, and DCFS-involved youth, with some regional differences.
    - Suburban Cook County had the lowest confidence levels for these populations compared to other regions.

Perceived Adequacy of Training

- **Adult services:** Most providers felt their training was adequate for dealing with many mental health challenges in adults, with depression (88.6%) and anxiety (89.1%) being the highest areas of adequacy in training.
    - Psychosis/schizophrenia had the highest rate of inadequate training (59.8%).
- **Child services:** Providers reported lower adequacy of training to work with children than with adults. Childhood ADHD had the lowest rate of adequate training (62.3%).
- **Regional differences** were seen in:
    - **Chicago:** Providers reported the lowest rates of adequate training for addressing psychosis/schizophrenia (46.3%) and bipolar disorder (57.9%).
    - **Suburban Cook County:** Providers had the lowest rates of adequate training for addressing SUD (41.6%) and suicidal ideation (72.0%).

Use of Interventions in Therapy/Counseling

- **Motivational Interviewing (MI):** 65.5% of providers often or always use MI, making it the most frequently used intervention.
- **Cognitive Behavioral Therapy (CBT) with adults:** 62.4% of providers use this often or always.
- **Child/adolescent providers**
    - CBT with children: 62.2% of providers often or always use it.
    - Parent skills training: 20.2% often or always use it, indicating a significant gap in optimal usage.
- Intervention use remained consistent regardless of providers' years of experience, except for the use of **Solution-Focused Brief Therapy** (SFBT), in which providers with more years of experience reported more frequent use.

Openness to Additional Training

- **Presenting problem-specific training:** Providers reported an overall high likelihood to engage in further training across a range of areas, particularly to address substance use disorders (83.4%), bipolar disorder (88.5%), schizophrenia (88.7%), and suicidal ideation (89.5%).
- **Job support training:** Providers reported being likely to attend training on how to prevent burnout, how to manage stress, and how to engage effectively in supervision
    - **No significant differences** in region, whether they have a license/certificate, or how long they have been in the field.

Barriers to Training

- **Cost** was the primary barrier to attending training. This was followed by time constraints and productivity expectations, with significant regional variations.
- **Regional differences in barriers**
    - **Chicago** had the highest reports of time constraints (68.4%).
    - **Region 2** had the highest rates of productivity expectations (46.9%).
    - **Region 4** had significantly higher issues related to technology (11.1%).

Discussion and Implications

The Community Mental Health Provider Survey, which included 555 mental health service providers, provides insight into the confidence and training needs of the community mental health workforce across Illinois.

Key Topic Areas for Training

Providers report a strong interest in receiving more training, irrespective of region, licensure, or years of experience, indicating **a statewide acknowledgment of the need for continuous professional development and potential skills gaps**.

Areas of greatest need to prioritize include the following:

- **Psychosis and Severe Mental Illness**: Over half of the providers in Chicago highlighted inadequate training in working with individuals experiencing psychosis. Given the critical nature of this gap, training in interventions for severe mental illness, such as schizophrenia and bipolar disorder, should be a top priority statewide.

- **Substance Use Disorders**: Substance use training emerged as a significant need across regions. Targeted training in evidence-based interventions for substance use should focus on both adults and adolescents, as providers identified this as a key area where their preparation was lacking.
- **Child and Adolescent Interventions**: Providers consistently reported lower confidence in working with younger populations, with confidence levels increasing as client age increased. Training programs should emphasize evidence-based practices for children and adolescents by:
    - Providing training in evidence-based interventions for children and families using a modular platform such as PracticeWise/ MATCH to support optimal effectiveness.
    - Providing enhanced training in evidence-based behavioral parenting interventions across most areas of the state, but especially in Chicago.
    - Supporting the adoption of these interventions through targeted training initiatives that include effective support for implementation, such as supervision, coaching, and learning collaboratives.
- **Stress Management and Burnout Prevention**: High demand for training in stress management and burnout prevention reflects the pressures providers face in their roles. Offering these trainings can directly improve provider retention and reduce workforce turnover.
- **Supervision and Support:** Supervision training was highlighted as an area of interest for providers, with effective supervision recognized as key to provider satisfaction and retention. Supervisors should be equipped with training to provide constructive feedback, guide professional growth, coach providers in the use of effective practices, and support providers dealing with complex cases.

Currently, the BHWC provides training in an evidence-based parenting group model, MATCH (modular intervention for children), skills to work with individuals with SMI, and supervision skills, consistent with these findings. In some areas, such as MATCH training, however, attendance is lower than anticipated given the high interest in additional training. This discrepancy points to the relevance of the barriers that providers reported in attending training.

Addressing Barriers to Training

Participation in training requires eliminating the barriers that inhibit provider attendance. **Cost** was reported as the primary barrier to attending training, followed by **time constraints** and **productivity expectations**. These barriers were particularly pronounced in certain regions, such as Chicago, where time constraints affected over two-thirds of providers, and region 2, where productivity expectations were a significant concern.

Strategies to address these barriers may include:

- Offering low-cost or free training options during work hours
- Incorporating ongoing consultation and coaching through supervision or learning collaboratives to support uptake of effective interventions
- Adapting billing and workplace policies to support training attendance
- Exploration of skill-based training requirements for licensing renewal

Appendices

Appendix A

Confidence in Providing Services to Populations

Confidence in serving various age groups is reported in Table A1. In an analysis of service providers' confidence across different child age groups, significant variability in confidence levels was identified ($F(4, 2728) = 212.358$, $p < .001$), suggesting meaningful differences in perceived capability dependent on the age of children. Descriptive analysis showed a progressive increase in mean confidence from 1.94 for providers working with children aged 0-3 years up to 3.69 for those working with children aged 18-59 years. Descriptives and Tests of Homogeneity are reported in Tables A2 and A3.

Table A1. Confidence Percentage in Providing Mental Health Services to Various Age Groups Overall

	Children (age 0-3) *N* = 547	Children (age 4-12) *N* = 544	Adolescents (age 12-18) *N* = 547	Young to mid-aged adults (age 18-59) *N* = 548	Older adults (age 60+) *N* = 547
Not a t All Confident	45.7	14.6	7.1	1.9	7.6
Somewhat Confident	28.5	32.2	23.3	7.5	16.5
Confident	15.7	30.8	30.9	29.9	32.5
Very Confident	6.2	17.3	28.3	40.7	30.2
Extremely Confident	3.9	5.1	10.6	20.0	13.2

Table A2. Descriptives

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
Children (age 0-3)	547	1.94	1.100	.047	1.85	2.03

Children (age 4-12)	544	2.66	1.082	.046	2.57	2.75
Adolescents (age 12-18)	547	3.12	1.099	.047	3.03	3.21
Young to mid-aged adults	548	3.69	.938	.040	3.62	3.77
Older adults (age 60+)	547	3.25	1.113	.048	3.16	3.34

Table A3. Tests of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Based on Mean	5.082	4	2729	<.001
Based on Median	6.476	4	2729	<.001
Based on Median and with adjusted df	6.476	4	2724.931	<.001
Based on trimmed mean	5.978	4	2729	<.001

Table A4. Confidence Percentage in Providing Mental Health Services to Diverse Populations Overall

	Diverse racial/ ethnic groups *N* = 549	LGBTQIA+ individuals *N* = 548
Not At All Confident	0.9	4.3
Somewhat Confident	13.7	21.6
Confident	41.5	36.8
Very Confident	29.8	25.7
Extremely Confident	14.2	11.7
Not Significant by Region		

Table A5. Confidence Percentage in Providing Mental Health Services to Unhoused/Underhoused Individuals by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Not At All	12.4	14.3	2.0	5.8	3.2	5.3
Somewhat	21.6	32.5	28.6	15.4	27.0	25.7
Confident	40.2	23.8	42.9	42.3	46.0	36.3
Very	14.4	20.6	18.4	25.0	22.2	22.1
Extremely	11.3	8.7	8.2	11.5	1.6	10.6
Likelihood Ratio X^2 (20, N = 549) = 42.3, p = 0.003						

Table A6. Confidence Percentage in Providing Mental Health Services to Criminal Justice System-Involved Individuals & Families by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Not At All	16.3	17.5	7.1	3.8	1.6	8.0
Somewhat	33.7	31.0	25.5	25.0	24.2	15.0
Confident	25.5	31.7	40.8	26.9	43.5	38.1
Very	11.2	14.3	15.3	26.9	29.0	23.0
Extremely	13.3	5.6	11.2	17.3	1.6	15.9
Likelihood Ratio X^2 (20, N = 549) = 63.0, p < 0.001						

Table A7. Confidence Percentage in Providing Mental Health Services to DCFS-Involved Youth/Families – Youth in Care by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Not At All	15.3	14.3	18.4	3.8	3.2	6.2
Somewhat	31.6	31.7	26.5	26.9	20.6	23.0
Confident	24.5	31.0	39.8	36.5	42.9	33.6
Very	16.3	15.1	12.2	19.2	25.4	23.0
Extremely	12.2	7.9	3.1	13.5	7.9	14.2
Likelihood Ratio X^2 (20, N = 550) = 42.6, p = 0.002						

Table A8. Confidence Percentage in Providing Mental Health Services to Individuals with Substance Use Disorders by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Not At All	13.4	11.9	7.1	1.9	7.9	6.2
Somewhat	26.8	36.5	37.8	26.9	22.2	20.4
Confident	32.0	28.6	31.6	34.6	39.7	37.2
Very	15.5	13.5	12.2	23.1	28.6	21.2
Extremely	12.4	9.5	11.2	13.5	1.6	15.0
Likelihood Ratio X^2 (20, N = 549) = 38.9, p = 0.007						

Confidence in providing services to young-middle aged adults (age 18-59) and older adults (age 60+) by whether or not providers have a license/certificate

Table A9. Confidence (%) In Services to Adults (Ages 18-59) by License/Certificate

	Yes (N=271)	No (N=278)
Never	2.2	1.8
Rarely	8.1	6.8
Sometimes	21.8	37.8
Often	44.3	37.1
Always	23.6	16.5
Likelihood Ratio X^2 (4, N = 549) = 17.4, p = 0.002		

Table A10. Confidence (%) in Services to Older Adults (Age 60+) by License/Certificate

	Yes (N=270)	No (N=278)
Never	8.5	6.5
Rarely	15.6	17.6
Sometimes	25.9	38.8
Often	34.8	25.5
Always	15.2	11.5
Likelihood Ratio X^2 (4, N = 548) = 13.5, p = 0.009		

Appendix B

Adequacy of Training

Table B1. Received Adequate Training Percentage Overall

	Disagree	Agree
Adult Depression	11.4	88.6
Adult Anxiety	10.7	89.1
PTSD/Trauma in Adults	21.7	78.3
Parenting Challenges	35.2	64.8
Depression and Anxiety in Children	27.9	72.1
PTSD/Trauma in Children	34.8	65.2
Childhood ADHD	37.8	62.3
Children with Behavior Problems	31.7	68.4
Substance Use Disorders	37	63
Suicidal Ideation	12.8	87.3
Psychosis/Schizophrenia	40.2	59.8
Bipolar Disorder	29.4	70.6

Table B2. Received Adequate Training on Psychosis/Schizophrenia Percentage by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Disagree	53.7	43.6	31.9	36.5	39.4	31.5
Agree	46.3	56.5	68	63.5	60.6	68.5

Likelihood Ratio X^2 (20, N = 540) = 25.5, p = 0.043

Table B3. Received Adequate Training on Substance Use Disorders Percentage by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Disagree	36.5	58.4	37.1	23	38.7	29.4
Agree	63.6	41.6	62.9	75	61.3	70.6

Likelihood Ratio X^2 (20, N = 544) = 34.3, p = 0.003

Table B4. Received Adequate Training on Suicidal Ideation Percentage by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Disagree	13.8	28	9.3	9.6	9.7	7.1
Agree	86.2	72	90.7	90.4	90.3	92.9

Likelihood Ratio X^2 (20, N = 542) = 34.6, p = 0.003

Table B5. Received Adequate Training on Bipolar Disorder Percentage by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Disagree	42.1	32.8	22.7	19.2	33.8	24.1
Agree	57.9	67.2	77.3	80.8	66.1	75.9

Likelihood Ratio X^2 (20, N = 543) = 27.5, p = 0.025

Significant differences in providers reported adequacy of training to address adult depression, substance use disorders, and PTSD/Trauma in adults by having a licensure and/or certificate.

Table B6. Adequate Training to Address Adult Depression (%) by License/Certificate

	Yes (N=266)	No (N=265)
Strongly Disagree	2.3	2.6
Disagree	7.5	10.2
Agree	42.9	52.1
Strongly Agree	47.4	35.1

Likelihood Ratio X^2 (3, N = 531) = 8.38, p = 0.039

Table B7. Adequate Training to Address Substance Use Disorders (%) by License/Certificate

	Yes (N=270)	No (N=274)
Strongly Disagree	6.7	9.5
Disagree	30.7	27.0
Agree	42.6	53.6
Strongly Agree	20.0	9.9

Likelihood Ratio X^2 (3, N = 544) = 14.9, p = 0.002

Table B8. Adequate Training to Address PTSD/Trauma In Adults (%) by License/Certificate

	Yes (*N*=266)	No (*N*=267)
Strongly Disagree	0.8	4.1
Disagree	17.3	21.3
Agree	45.1	49.1
Strongly Agree	36.8	25.5
Likelihood Ratio X^2 (3, N = 533) = 13.3, p = 0.004		

Appendix C

Use of Interventions

Table C1. Overall Percentage of Intervention Use

	CBT with adults *N* = 297	MI *N* = 299	SFBT *N* = 299	MBSR *N* = 299	ACT *N* = 299	DBT *N* = 299
Never	8.7	2.6	8.8	5.5	25.2	13.4
Rarely	6.5	7.3	10.2	10.0	23.0	24.5
Sometimes	22.4	24.5	36.4	34.4	33.2	25.6
Often	45.0	40.1	36.3	39.0	15.1	21.9
Always	17.4	25.5	8.3	11.6	3.5	4.5

Table C2. Overall Percentage of Intervention Use

	Psychodynamic Therapy* *N* = 297	Play Therapy *N* = 153
Never	13.7	9.7
Rarely	24.6	6.7
Sometimes	35.3	27.9
Often	19.7	38.8
Always	6.7	16.9

Table C3. Child/Adolescent Providers' Intervention Use (%)

	Parent skills training* *N* = 154	CBT with children* *N* = 154
Never	32.7	4.4
Rarely	24.0	7.0
Sometimes	23.1	26.4
Often	17.2	41.2
Always	3.0	21.0

*Indicates significant difference by region

Table C4. Child/Adolescent Providers' Use of CBT With Children by Region (%)

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Never	12.1	2.7	0.0	0.0	0.0	3.4
Rarely	15.2	10.8	0.0	0.0	4.0	3.4
Sometimes	36.4	10.8	8.3	50.0	36.0	17.2
Often	24.2	54.1	45.8	40.0	44.0	58.6

Always	12.1	21.6	45.8	10.0	16.0	17.2
Likelihood Ratio X^2 (20, N = 158) =43.3, p = 0.002						

Use of Psychodynamic Therapy

Psychodynamic therapy had a wide range of usage across regions. However, this intervention was used least frequently in region 2. with only 14.5% using it often or always.

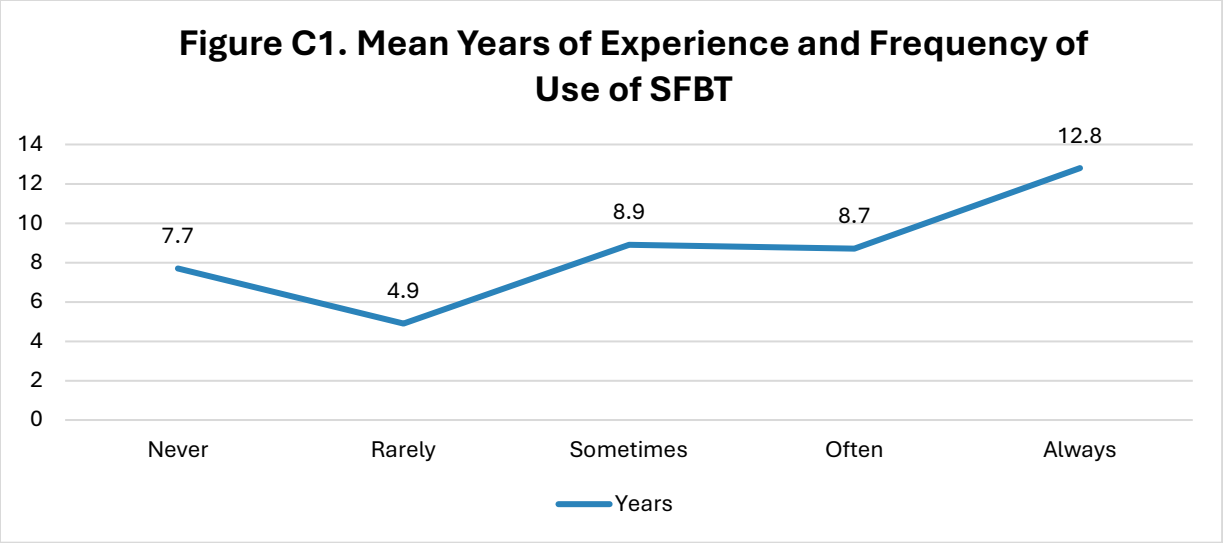
Table C5. Providers' Percentage Use of Psychodynamic Therapy by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Never	10.0	15.2	14.5	10.7	15.8	20.0
Rarely	16.0	22.7	38.2	10.7	36.8	26.7
Sometimes	46.0	24.2	32.7	46.4	18.4	30.0
Often	20.0	22.7	10.9	25.0	23.7	21.7
Always	8.0	15.2	3.6	7.1	5.3	1.7
Likelihood Ratio X^2 (20, N = 297) = 33.7, p = 0.028						

Use of Psychodynamic Therapy by whether or not providers have a license or certificate

Table C6. Use of Psychodynamic Therapy (%) by License/Certificate

	Yes (N=179)	No (N=118)
Never	10.6	18.6
Rarely	21.8	28.8
Sometimes	36.3	33.9
Often	22.9	15.3
Always	8.4	3.4
Likelihood Ratio X^2 (4, N = 297) = 9.73, p = 0.045		



One-way ANOVA test [F(4, 292) = 2.716, p = 0.030]

This was consistent when looking at categorical years of experience and use of SFBT as well.

Table C7. Providers' Frequency of Use (%) By Categorical Years Experience

	0-2 yrs *N*=59	2-5 yrs *N*=91	5-9 yrs *N*=54	10+ yrs *N*=91	Total *N*=295
Never	11.9	7.7	9.3	7.7	8.8
Rarely	8.5	17.6	9.3	4.4	10.2
Sometimes	49.2	35.2	31.5	33.0	36.6
Often	28.8	35.2	35.2	42.9	36.3
Always	1.7	4.4	14.8	12.1	8.1
Likelihood Ratio X^2 (12, N = 295) = 24.3, p = 0.019					

Appendix D

Likelihood of Participation in Training

Table D1. Likelihood of Participation in Intervention Training (%)

	Substance Use Disorders *N* = 539	Suicidal Ideation *N* = 541	Psychosis/ Schizophrenia *N* = 541	Bipolar Disorder *N* = 540	MAT for SUD *N* = 541
Unlikely	7	4.2	3.7	4	10.8
Not Sure	9.7	6.3	7.6	7.5	15.2
Likely	83.4	89.5	88.7	88.5	74.1

Table D2. Likelihood Of Participation In Intervention Training

	Depression and anxiety in children *N* = 541	PTSD/Trauma in children *N* = 541	Childhood ADHD *N* = 541	Children with behavior problems *N* = 541
Unlikely	12.7	12	14	11.1
Not Sure	10	8.8	11.4	10.6
Likely	77.2	79.2	74.6	78.5

However, significant regional differences were observed for likelihood of participating in training for adult depression, adult anxiety, and parenting challenges.

Table D3. Likelihood Of Participation In Intervention Training

	Adult depression* *N* = 540	Adult anxiety* *N* = 541	PTSD/trauma in adults *N* = 538	Parenting Challenges* *N* = 539
Unlikely	7.1	7.2	3.2	8.1
Not Sure	8.1	8.2	6.9	11.1
Likely	84.7	84.6	89.8	80.8

Table D4. Percent Likely to Participate in Training on Adult Depression by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Unlikely	9.6	8	9.3	3.8	8.2	1.8
Not Sure	6.4	8.0	7.2	13.5	1.6	9.9
Likely	84.1	84	83.5	82.7	90.2	88.2

Likelihood Ratio X^2 (20, N = 540) = 34.0, p = 0.026

Table D5. Percent Likely to Participate in Training on Adult Anxiety by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Unlikely	8.5	8.8	10.3	3.8	8.1	1.8
Not Sure	6.4	8.8	7.2	13.5	1.6	9.8
Likely	85.1	82.4	82.5	82.7	90.3	88.4

Likelihood Ratio X^2 (20, N = 542) = 35.9, p = 0.016

Table D6. Percent Likely to Participate in Training on Parenting Challenges by Region

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Unlikely	5.4	13.6	13.4	5.8	3.3	4.5
Not Sure	11.8	10.4	10.3	17.3	3.3	9.0
Likely	82.8	76	76.3	76.9	93.5	86.4

Likelihood Ratio X^2 (20, N = 539) = 38.9, p = 0.007

Table D7. Likelihood of Participation in Intervention Training

	MI N = 533	SFBT N = 297	MBSR N = 297	ACT N = 295	DBT N = 297	MAT N = 297
Unlikely	9.7	9.9	4.7	7.6	6.3	15.7
Not Sure	11	13.3	5.4	13.2	6.4	16.4
Likely	79.3	75.0	87.8	79.2	87.4	67.9

Table D8. Likelihood of Participation in Therapy/Counseling EBP Intervention Training

	CBT with adults N = 297	CBT with children N = 154	Parent skills training N = 154
Unlikely	11.6	9.4	5.3

Not Sure	7.3	8.2	10.6
Likely	79.1	82.4	84.2

Appendix E

Barriers to Attending Training

Thinking about how likely you are to attend a training, what barriers could prevent you from attending (Select up to 3).

Table E1. Barriers to Attend Training (%)

Barriers	Percent Selected
Accessibility needs	7.0
Cost*	74.4
Language barriers	2.0
Productivity expectations*	35.6
Technology issues*	3.1
Time (unable to attend during work hours)*	60.7
Topics are not interesting enough to me	11.9
Transportation issues for in-person opportunities	13.9
Other	3.6
*Indicates significant differences by region	

Table E2. Barriers Preventing Training Attendance by Region (%)

	1 (Chi.)	1 (Sub. Cook)	2	3	4	5
Time Constraints	68.4	65.9	52.0	65.4	39.7	63.7
Likelihood Ratio X^2 (5, N = 552) = 19.362, p = 0.002						
Productivity Expectations	23.5	32.5	46.9	44.2	38.1	29.2
Likelihood Ratio X^2 (5, N = 552) = 15.906, p = 0.007						
Technology Issues	4.1	3.2	2.0	0.0	11.1	1.8

Likelihood Ratio X^2 (5, N = 552) = 12.812, p = 0.025

Appendix F

Additional Training for Practice Areas – Open-Ended Feedback

A qualitative thematic analysis was conducted to understand patterns among training and support needs reported in the open-response portion of the survey. Following a close reading of all responses, the team discussed and developed codes in alignment with themes from both the qualitative and quantitative survey data. To organize and analyze the data, the team utilized Qualtrics' Text iQ software, a text analysis feature designed to process and analyze unstructured data using natural language processing (NLP) techniques. All responses were manually assigned codes and subcodes using Text iQ topic functionality, and any uncertain responses were discussed and addressed between team members. Once coded, categorical data were extracted for inclusion in the final report.

In the analysis of responses to the questions "What other practice areas, if any, do you think you need additional training?" and "What other topics, if any, would you like to receive training in?" (Appendix E) instances in which the content of a response was more applicable to the alternate question were reassigned to better reflect the intent of the respondent. Sub-categories that contain at least one response from another question are marked with an asterisk (*).

What other practice areas, if any, do you think you need additional training?

Table F1. Provider Feedback on Practice Area Training, Categories and Sub-categories Overview

Category	Sub-Category	Frequency
Specific Presenting Problems		**104**
	Substance use*	21
	PTSD/trauma (age not specified)*	17
	Personality Disorders*	11
	Psychosis/schizophrenia*	11
	Grief & Loss*	6
	Dissociative Disorders*	5
	Food disorder*	5
	Co-occurring Disorders*	4

	Chronic pain*	3
	Parenting challenges	3
	Adult ADHD	2
	Bipolar disorder	2
	Childhood ADHD	2
	Dementia	2
	Depression (age unspecified)	2
	PTSD/trauma in children	2
	Adjustment Disorders	1
	Anxiety (no age specified)	1
	Diagnoses - Unspecified	1
	Mood disorder	1
	OCD	1
	Suicidal ideation	1
Specific Populations		**74**
	Intellectual disability, developmental disability, neurodivergence*	20
	Children/Adolescents	13
	LGBTQIA+ individuals*	9
	Older adults (60+)	7
	Grief & Loss	5
	Violence exposure	5
	Criminal justice system-involved individuals and families	4

	Diverse racial/ethnic groups*	4
	DCFS-involved youth/families - youth in care*	3
	Unhoused/under-housed	2
	Caregivers	1
	Challenging Clients*	1
Interventions (EBP and non-EBP)		**56**
	Crisis & Safety*	10
	Family/Couples Therapy*	9
	Medication-Assisted Treatment (MAT)*	6
	CBT (age unspecified) *	5
	DBT*	5
	Mindfulness/MBSR*	3
	Play therapy*	3
	Group therapy*	2
	Somatics	2
	Diagnoses - Unspecified*	2
	Polyvagal*	2
	Community outreach	1
	Macro practice	1
	Measurement-Based Care	1
	Moral Recognition Therapy (MRT)	1
	EMDR*	1

	Ethical decision making*	1
	Teletherapy*	1

Appendix G

Additional Training on Topics Related to Work Duties and Environment – Open-Ended Feedback

A qualitative thematic analysis was conducted to understand patterns among training and support needs reported in the open-response portion of the survey. Following a close reading of all responses, the team discussed and developed codes in alignment with themes from both the qualitative and quantitative survey data. To organize and analyze the data, the team utilized Qualtrics' Text iQ software, a text analysis feature designed to process and analyze unstructured data using natural language processing (NLP) techniques. All responses were manually assigned codes and subcodes using Text iQ topic functionality, and any uncertain responses were discussed and addressed between team members. Once coded, categorical data were extracted for inclusion in the final report.

In the analysis of responses to the questions "What other practice areas, if any, do you think you need additional training?" (Appendix D) and "What other topics, if any, would you like to receive training in?" instances in which the content of a response was more applicable to the alternate question were reassigned to better reflect the intent of the respondent. Sub-categories that contain at least one response from another question are marked with an asterisk (*).

What other topics, if any, would you like to receive training in?

Table G1. Provider Feedback on Other Training, Categories and Sub-categories Overview

Category	Sub-Category	Frequency
Agency Support		**30**
	Effective supervision*	9
	Documentation requirements*	6
	Strategies to prevent burnout	3
	Systemic	3
	Team communication	3
	Administrative	2
	Discharging clients	1

	Unsupportive agency culture	1
	Interdisciplinary Teams	1
	Boundary Setting	1

Appendix H

Additional Support – Open-Ended Feedback

A qualitative thematic analysis was conducted to understand patterns among training and support needs reported in the open-response portion of the survey. Following a close reading of all responses, the team discussed and developed codes in alignment with themes from both the qualitative and quantitative survey data. To organize and analyze the data, the team utilized Qualtrics' Text iQ software, a text analysis feature designed to process and analyze unstructured data using natural language processing (NLP) techniques. All responses were manually assigned codes and subcodes using Text iQ topic functionality, and any uncertain responses were discussed and addressed between team members. Once coded, categorical data were extracted for inclusion in the final report.

What types of support do you need to stay in your current position?

Table H1. Provider Feedback on Additional Support, Categories and Sub-Categories Overview

Category	Sub-Category	Frequency
Financial		**128**
	Low Pay	101
	Financial Resources – Not salary specific	27
Agency Culture		**68**
	Not feeling appreciated	24
	Team communication	14
	Cultural Connection	2
	Agency Culture - unspecified	28
Productivity Requirements		**62**
	Productivity Requirements - unspecified	30
	Documentation Requirements	13
	Scheduling & Flexibility	11

	Caseload	8
Professional Development		**59**
	Professional Development - unspecified	45
	Strategies to Prevent Burnout	10
	Therapeutic Techniques	4
Effective Supervision		**45**
	Supervision - unspecified	26
	Per Supervisee	14
	Per Supervisor	4
	Technical Support	1
Understaffing		**8**