Behavioral Health Workforce Minimum Data Set for Mental Health Counselors

April 2020

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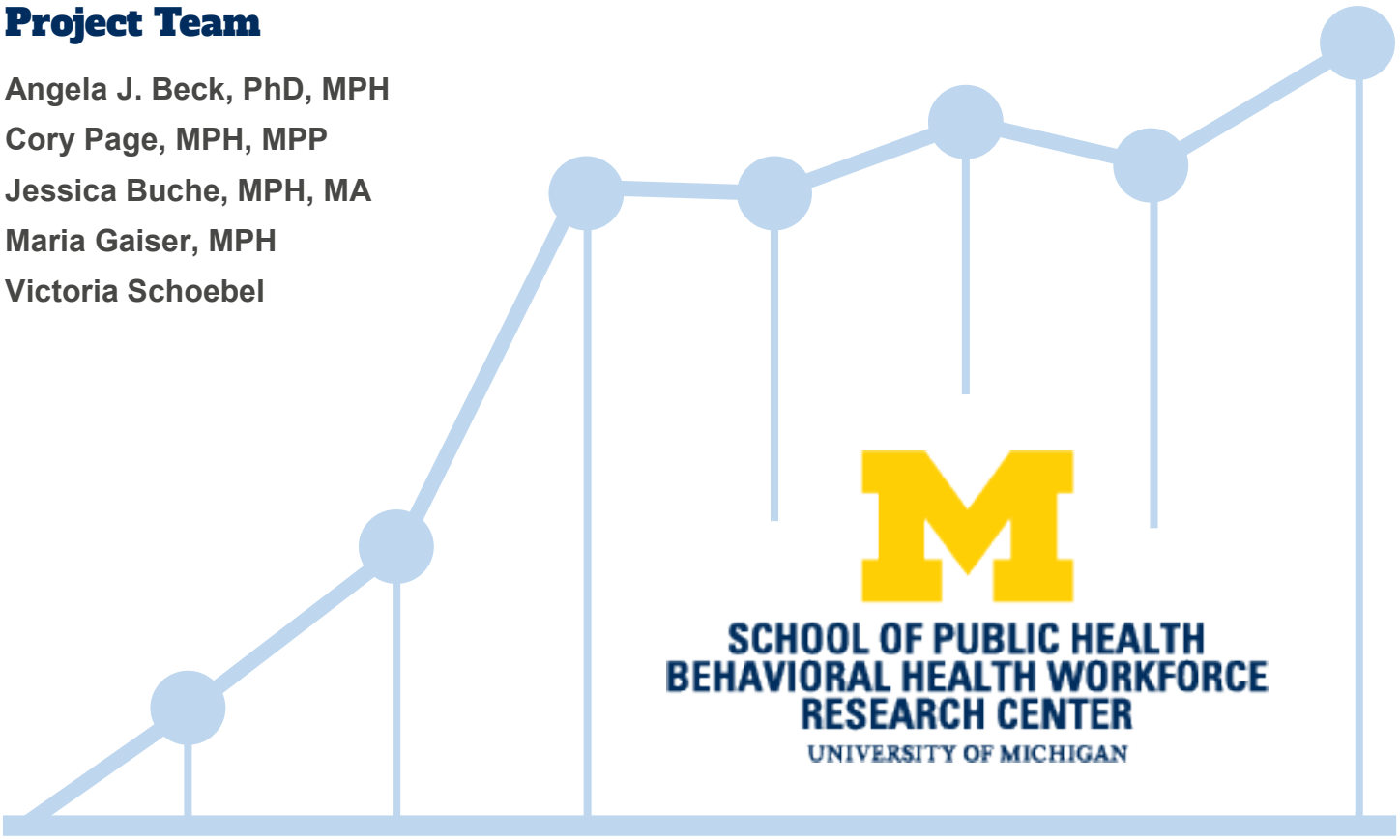

ACKNOWLEDGEMENTS

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1.2 million. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government.

SUGGESTED CITATION

University of Michigan Behavioral Health Workforce Research Center. Behavioral Health Workforce Minimum Data Set for Mental Health Counselors. Ann Arbor, MI: UMSPH; 2020.

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Background

Workforce shortages present a key challenge for meeting the growing demand for mental health services. Approximately 47.6 million adults in 2018 experienced mental illness in the last year, yet only 43.3% received mental health services.1 Understanding key characteristics of the workforce providing mental health care is the first step in identifying strategies to address this gap in treatment.

The American Mental Health Counselors Association (AMHCA) defines the role of clinical mental health counselors (MHCs) as diagnosing and treating mental illness; addressing life distress; and facilitating wellness in individuals, families, couples, and groups.2 MHCs make up the third-largest segment of the workforce that provides behavioral health treatment, estimated at 267,730 providers in 2018 and projected to grow 22% by 2028.3,4 Accredited education and training requirements for MHCs are well understood, but the following MHC workforce characteristics are unknown: demographic composition, practice characteristics, job functions, and settings in which services are delivered. A lack of comprehensive data accurately describing this population complicates estimates of both current and future MHC supply.

Improving and expanding upon uniform definitions of MHC roles and responsibilities can aid workforce planning efforts hindered by inconsistent occupational definitions. Creation of a minimum data set (MDS) to house basic, consistent, and standardized workforce information would inform supply and demand modeling and estimates.5 The purpose of this study is to create a comprehensive profile of the MHC workforce, including size, composition, function, and location, to build upon the Center's previous scope of practice, MDS, and workforce mapping studies.6

The AMHCA served as a key partner in this study.

Methods

In 2019, the Behavioral Health Workforce Research Center (BHWRC) conducted a literature review to examine state policies regarding and workforce definitions of mental health counseling training and practice. The BHWRC research team developed and implemented a Qualtrics survey for MHCs using findings from the literature review, assistance from the AMHCA, and previously constructed MDS products. Survey themes, consistent with the primary categories of the MDS, included:

- demographics;
- education and training;
- licensure;
- occupation and area of practice;
- function/daily responsibilities; and
- practice setting.

The BHWRC disseminated a link to the survey to 3,360 clinical MHCs with membership at AMHCA. Researchers sent weekly follow-up e-mails to the sample. The first 500 respondents received a $20 incentive. To protect the identities of respondents, survey responses were kept anonymous and required no personally identifying information. The survey remained available for 1 month from October 2019 through November 2019. Following survey closure, BHWRC researchers cleaned and analyzed responses.

Of the 3,360 MHCs invited to take the survey, 592 responded. Skip and display logics prevented some respondents from seeing all sections of the survey, so researchers established a threshold of 75% to identify respondents who had completed the survey. Of the 592 responses, 99 were removed for not meeting this completion threshold. The final sample consisted of 446 responses, for a response rate of 13.3%. Because

respondents were allowed to skip certain questions, the denominator varied by question and will be noted throughout this report.

Results

Demographics

The majority of respondents identified as female (73%, 312/428), white (88%, 389/441), and of non-Hispanic, Latino, or Spanish origin (93%, 401/431). Most respondents were U.S. citizens (99%, 439/444), non-veterans (93%, 415/445), and not currently serving in the military (99%, 445/446). The majority spoke English (89%, 396/446), and of the 50 respondents (11%, 50/446) that spoke more than one language, Spanish (56%, 28/50) and American Sign Language (20%, 10/50) were the primary means of communication used.

Education and Training

All respondents reported having earned a higher education degree, with 86% of respondents (383/446) holding a master's degree in counseling and 23% of respondents (104/446) holding a master's degree in a different field. More than half (56%, 250/446) of respondents completed a post-degree program in counseling, and only 4% (18/446) were currently enrolled in a formal education program. The low number of current students suggests the sample consisted of postgraduate associate providers or full-practice clinical providers.

Licensure

Nearly all respondents were actively licensed, 56% (247/446) of whom were licensed in professional counseling, 47% (211/446) in mental health counseling, and 15% (67/446) in another behavioral health profession. Ninety-one percent (191/210) of respondents with mental health counseling licensure, 86% (212/247) with professional counseling licensure, and 90% (43/48) with other health professional licensure reported practicing in only one state.

Table 1. Mental Health Counselor Areas of Behavioral Health Practice (n=446)

Area of Practice	n (%)*
Addiction/Substance Use Disorder Counseling	149 (33.4)
Child, Adolescent, and Family Counseling	191 (42.8)
Clinical Counseling	290 (65.0)
Criminal Justice	28 (6.3)
Forensic Family Therapy	10 (2.2)
Gerontology	16 (3.6)
Marriage/Couples Counseling	166 (37.2)
Mental Health Counseling	377 (84.5)
Military or Veterans Affairs Counseling	72 (16.1)
Occupational Counseling/Employee Assistance Program	62 (13.9)
Public Health	15 (3.4)
School Counseling	20 (4.5)
Social Work	12 (2.7)
Other	60 (13.5)

*Respondents were allowed to select multiple areas of practice; totals do not sum to 100%

Occupation and Area of Practice

Approximately 92% (410/446) of respondents reported currently providing prevention or treatment services for mental health or substance use disorder. Most respondents identified themselves as MHCs (88%, 391/445), with the remaining respondents primarily identifying as substance use disorder counselors (5%, 21/445), or other forms of counselors (e.g., marriage and family therapists, social workers).

Respondents were able to select multiple practice areas, with most indicating practice in mental health counseling (85%,

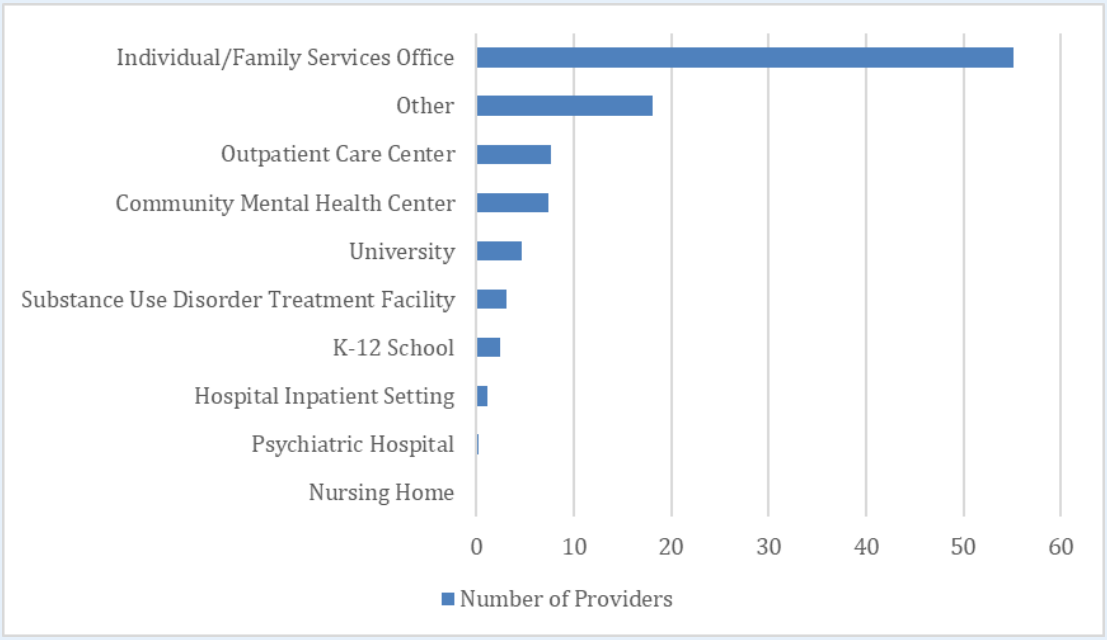
377/446) or clinical counseling (65%, 290/446) (Table 1). Few respondents practiced as social workers or school counselors, suggesting the survey sample accurately captured MHCs instead of other behavioral health providers.

Employment Characteristics and Job Responsibilities

Respondents employed as MHCs reported having practiced counseling for an average of 30 years. Almost all (94%, 420/446) reported that they were actively working in a position that requires a mental health counseling license, and 80% (348/433) worked in only one position. Thirty-five percent (154/444) of respondents reported serving as clinical supervisors at their primary place of employment. Regarding employment arrangements, 62% (277/446) were self-employed in consulting or private practice, 25% (111/446) were permanent salaried staff by their place of employment, and 7% (32/446) were permanent hourly staff by their place of employment.

Employment settings varied across respondents: A majority (55%, 246/446) described their primary practice setting as an individual or family services office, 8% (34/446) were employed in an outpatient care center, and 7% (33/446) in a community mental health center (Figure 1). The geographic regions in which MHCs practice varied as well: 28% (93/332) of respondents reported providing more behavioral health services at the rural site at which they practice than at their non-rural practice site(s), and 33% (111/332) reported providing the same number of behavioral health services at both their rural and non-rural practice sites. The majority (72%, 322/446) also reported utilizing telehealth/telemedicine at their primary place of employment.

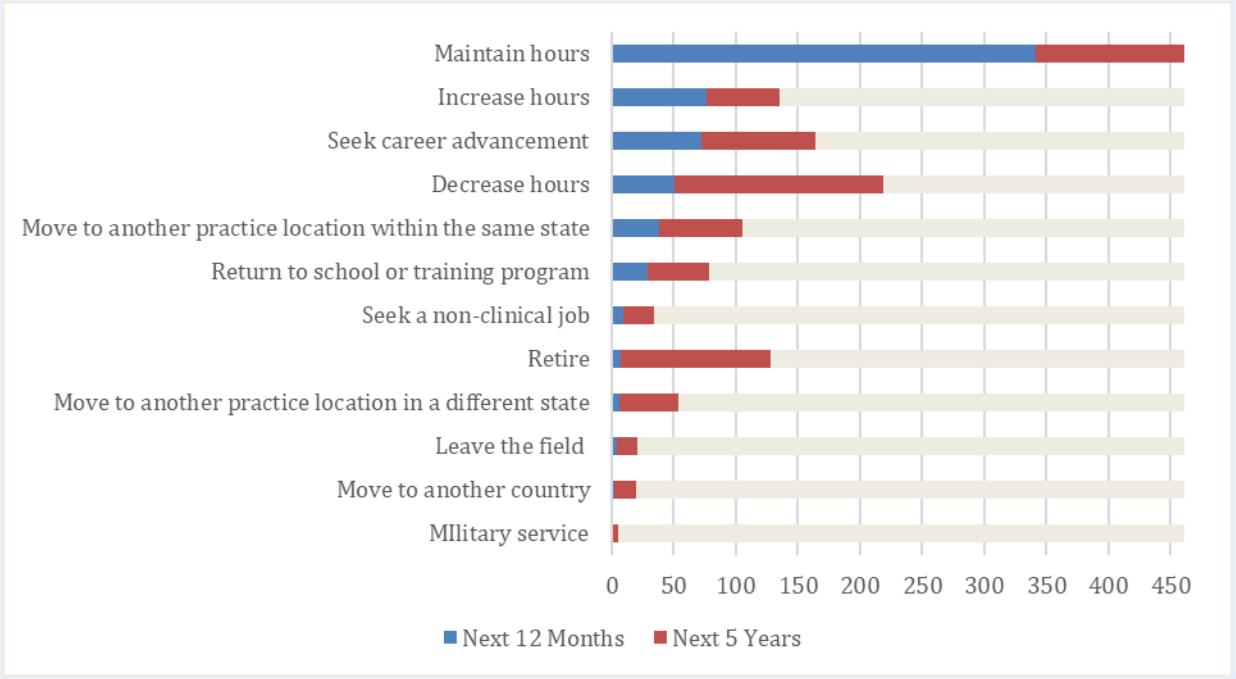
Figure 1. Primary Employment and Practice Settings of Mental Health Counselors (n=446)



Respondents indicated that, on average, 62% of their clients receive individual adult therapy in a typical week, 18% receive child or adolescent therapy, and the rest of their clients receive some form of group therapy or geriatric therapy. On average, respondents worked 33 hours per week over 48 weeks of the year at their primary place of employment. Regarding employment plans for the next 12 months, 77% (342/445) of respondents reported plans to maintain their hours, 17% (77/445) to increase their hours, and 16% (72/445) to seek career advancement. Only 0.9% (4/445) reported plans to leave the field, 2% (8/445) to retire, and 2% (10/445) to seek a non-clinical job in this time period. Respondents' most common 5-year employment plans included maintaining their current hours (41% of respondents, 183/445), retirement (27%, 120/445), seeking career advancement (21%, 92/445), and returning

to a school or training program (11%, 50/445) (Figure 2). Given that 26% (130/495) of the total sample reported starting to provide MHC services prior to 1990, the high proportion of respondents who indicated plans to retire in the next 5 years is in alignment with those providers approaching the average age of retirement.

Figure 2. Respondent 12-Month and 5-Year Employment Plans



Respondents accepted various methods of payment for their direct provision of behavioral health services, including but not limited to: private insurance/ fee-for-service (71%, 315/443), consumer's own funds (57%, 253/443), a preferred provider private insurance plan other than Medicare or Medicaid HMO (42%, 184/443), TriCare (27%, 121/443), Medicaid HMO (23%, 102/443), Medicaid PPO (20%, 87/443), another Medicaid managed care arrangement (23%, 101/443), and state, county, or city funding (19%, 84/443). To compensate for behavioral health services provided at the respondents' primary place of employment, respondents reported being most likely to use fee-for-service (62%, 275/442), consumer self-pay (43%, 190/442), and salary (20%, 90/442) payment arrangements.

Conclusions

To better understand the demographics, training, and practices of the mental health counselor workforce, an MDS was administered to more than 3,000 members of the AMHCA. The surveyed MHCs were predominately white, female, and self-employed. The number of MHCs planning to decrease their hours in the next 5 years outnumbered the number planning to increase their hours. The average respondent also had 30 years of experiencing providing counseling services, suggesting the workforce is aging. And though only 2% of MHCs planned to retire in the next year, 27% planned to retire sometime in the next 5 years. These measurements could indicate an upcoming decrease in the MHC workforce in the next decade.

Respondents typically had master's degrees and more than half were self-employed. They were most likely to accept private insurance or a client's personal funds, rather than TriCare or Medicaid. This reliance on

private payment as opposed to public payment could be due in part to the relatively lower reimbursement rates Medicaid offers compared with private insurance. MHCs are not covered by Medicare, which narrows the patient pools MHCs can feasibly treat and could also restrict these patients' access to care.

This project successfully addressed its aim of collecting workforce data from practicing MHCs to aid in the creation of an MDS. This MDS will ultimately inform MHC workforce planning and improvement efforts.

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