SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN
http://www.behavioralhealthworkforce.org

Health Workforce Policy Brief

August 2016

An Assessment of Behavioral Health Workforce Data Sources

Phillip M. Singer, MHSA, Angela J. Beck, PhD, MPH, Jessica Buche, MPH, MA

BACKGROUND

The need for additional behavioral health workers has been well-documented, as over 4000 U.S. counties and territories have been designated as Mental Health Professional Shortage Areas by the Health Resources and Services Administration.[1] Further, nearly one in five U.S. counties reports unmet need for non-prescribing behavioral health professionals, while nearly all counties report unmet need for prescribing behavioral health professionals.[2] Despite this recognized need, behavioral health workforce planning efforts are limited by the lack of systematic monitoring of workforce size and composition across all occupations involved in prevention and treatment of mental health and substance use disorders. Valid and reliable data sources are needed to develop accurate estimates of workforce shortage and maldistribution.

To address some of these challenges, the Behavioral Health Workforce Research Center (BHWRC) conducted a study to assess existing sources of workforce data. The purpose of this project was to: 1) identify national and state-level data sources that provide information on workforce size and/or characteristics; 2) map the variables to the data elements outlined in the behavioral health workforce Minimum Data Set (MDS); 3) assess data quality; and 4) summarize behavioral health workforce data gaps.

METHODS

BHWRC staff conducted a review of all accessible national and state-based behavioral health workforce data sources. National data sources were primarily collected from government agencies (e.g. Office of Personnel Management Federal Employment Statistics), accrediting bodies (e.g. American Nurses Credentialing Center), for-profit entities (e.g. National Center for Analysis of Healthcare Data), and discipline-specific organizations (e.g. American Association for Marriage and Family Therapy). State-based data sources were collected from government agencies, health systems, discipline-specific organizations, accrediting bodies, and non-profit organizations.

To determine whether existing data sources could populate an MDS, national data sources were mapped to the MDS data elements developed by the BHWRC. Data elements are categorized under the themes of enumeration, demographics, licensure, certification, education, training, occupational category, area of practice, and employment setting. Additionally, national data sources were rated as Good, Fair, Poor, or Unknown, on the following criteria:

- Validity - the extent to which the data source accurately enumerates the behavioral health workforce.
- Reliability - the extent to which the data source provides consistent measures of the behavioral health workforce.

CONCLUSIONS AND POLICY IMPLICATIONS

Main conclusions from this study include:

- Existing data sources are inadequate to fully populate a behavioral health MDS.
- Gaps exist in the quality and breadth of existing data sources, many of which are discipline-specific.
- MDS data elements are useful in assessing the comprehensiveness of workforce data sets.
- The Pacific Northwest and New England regions have produced the most state-specific behavioral health workforce data in the U.S.
- Three states, Alabama, Rhode Island, and Tennessee, lacked any accessible state-based behavioral health workforce data.

The findings of this project highlight the need for greater resources, both at the state and national levels, to ensure that valid, reliable data are collected on the behavioral health workforce. National data sources may be useful in providing some information on workforce size and composition but a systematic mechanism for monitoring the workforce is still needed.

[1] Health Resources and Services Administration. "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations." *United States Department of Health and Human Services Health Resources and Services Administration,* 2016. http://www.hrsa.gov/shortage/.

[2] Thomas, K.C., Ellis, A.R., Holzer, C.E., & Morrissey, J.P. (2009). County-level Estimates of Mental Health Professional Shortage in the United States. Psychiatric Services, 60(10), 1323-1328.

- Frequency - how often the data source collects behavioral health workforce information.
- Accessibility - the extent to which data are available for public use.

State-based data sources were not mapped to the Minimum Data Set; rather, the number of existing data sources by state were calculated to assess variation in behavioral health workforce data collection across states.

KEY FINDINGS

National Data Sources

The mapping of data source variables to MDS elements showed that there are substantial behavioral health workforce data gaps.

- This study identified 24 national data sources that included at least one variable that aligned with the MDS data elements (Table 1), although one data source was not publicly accessible. Only two of the remaining 23 data sources collected data from each of the main components of the MDS. (Both were nurse workforce data sources.)
- None of the 24 existing data sources collected information on all behavioral health workforce occupations and several were specific to one discipline, indicating a gap in the breadth of data for the behavioral health workforce.
- There are gaps in the validity, reliability, frequency and accessibility of existing national data sources. None of the existing data sources were rated as "Good" for all four categories.

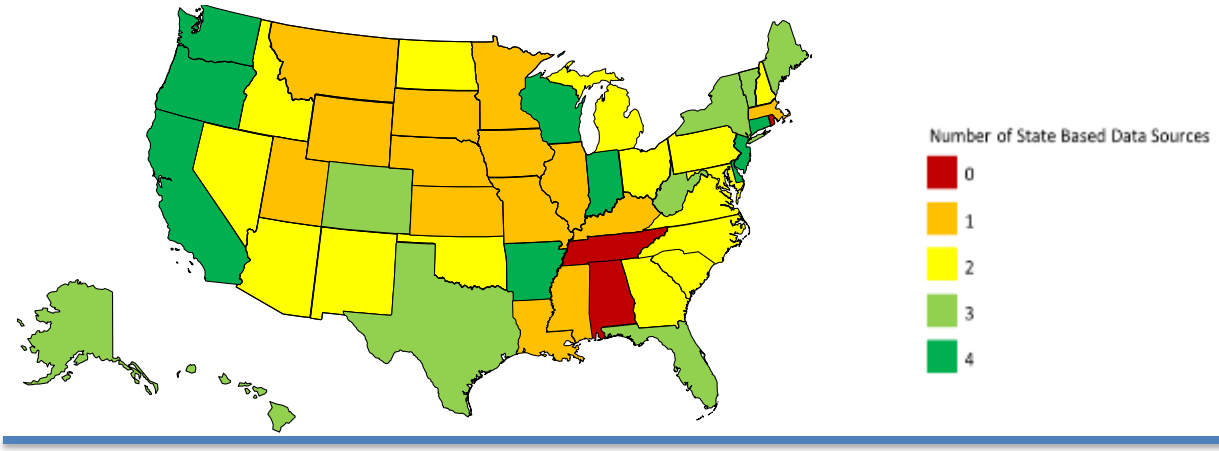
Table 1. Summary of National Data Source Findings

MDS Category	MDS Category Examples	Data Collection Efforts
Enumeration	Total count of provider type	All of the data sources included enumeration
Demographics	Gender, race, ethnicity	16 data sources collect Demographic data
Education	Highest degree attained	15 data sources collect Education data
Training	Residency program	7 data sources collect Training data
Licensure	Type of Nursing degree	9 data sources collect Licensure data
Certification	Peer support certification	7 data sources collect Certification data
Occupational Category	Psychiatrist, Counselor, Therapist, Social Worker, Peer Support Specialist	16 data sources collect Occupational Category data
Area of Practice	Specialty in Social Work	7 data sources collect Area of Practice data,
Employment Setting	Work in clinic, hospital, group practice	15 data sources collect Employment Setting data

State-based Data Sources

A total of 114 state-based behavioral health workforce data sources were identified. The number of data sources varied by state (Figure 1).

Figure 1. Number of Behavioral Health Workforce Data Sources by State.



This work is funded through HRSA Cooperative Agreement U81HP29300: Health Workforce Research Centers Program.