POLICY BRIEF

Behavioral Health Workforce Minimum Data Set for Mental Health Counselors

Project Team

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Background

Mental health counselors (MHCs) make up the third-largest segment of the workforce that provides mental health treatment, with a workforce currently estimated at 267,730 providers that is projected to grow 22% by 2028.[1,2] The American Mental Health Counselors Association (AMHCA) defines clinical MHCs as providers who diagnose and treat mental illness, address life distress, and facilitate wellness in individuals, families, couples, and groups.[3] Few characteristics beyond standardized education and training requirements are currently known about the national MHC workforce. Creation of a minimum data set (MDS) to track standardized workforce information would inform supply and demand modeling and estimates.[4] This quantitative study aimed to create a comprehensive profile of the MHC workforce.

Methods

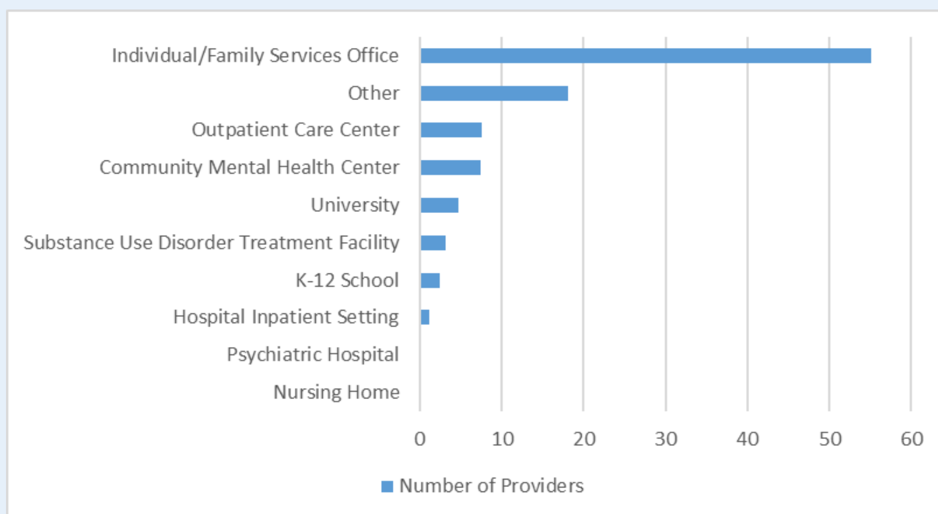
The Behavioral Health Workforce Research Center fielded a Qualtrics survey for MHCs developed from a literature review and assistance from AMHCA. Survey themes included: demographics, education and training, licensure, area of practice, function/daily responsibilities, and practice setting. The Behavioral Health Workforce Research Center disseminated a link to the survey in October 2019 to 3,360 clinical MHCs with membership at AMHCA. To protect the identities of respondents, survey responses were kept anonymous and required no personally identifying information. A total of 446 respondents completed ≥75% of the survey for a response rate of 13.3%.

Key Findings

Ninety-two percent of the total respondents reported currently providing prevention or treatment services for mental health or substance use disorder. Respondents were primarily female (73%, 312/428), white (88%, 389/441), and non-Hispanic, Latino, or of Spanish origin (93%, 401/431). Most MHCs were U.S. citizens (99%, 439/444), non-veterans (93%, 415/445), and not currently serving in the military (99%, 445/446).

Respondents predominately identified their profession as MHCs (88%, 391/445) with a practice area of mental health counseling (85%), clinical counseling (65%), or child, adolescent, and family counseling (43%). Nearly all respondents held licensure to practice, 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 practiced in only one state. Employment settings varied across respondents, with 55% (246/446) describing their primary practice setting as an individual or family services office (Figure 1). Twenty-eight percent (93/332) of

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



respondents reported providing more behavioral health services at the rural site at which they practice than at any non-rural practice site(s). The majority (72%) also utilized telehealth/ telemedicine at their primary place of employment.

Respondents worked an average of 33 hours per week at their primary place of employment. Regarding their employment plans over the next 12 months, 77% of respondents planned to maintain their hours, 17% to increase their hours, and 16% to seek career advancement. Only 0.9% planned to leave the field, 2% to retire, and 2% to seek a non-clinical job in the next 12 months. Most common 5-year plans included maintaining current employment hours (41% of respondents), retirement (27%), seeking career advancement (21%), and returning to a school or training program (11%).

Respondents accepted varying payment methods for their services, including private insurance/fee-for-service (71% of respondents), consumer's own funds/out-of-pocket (57%), and a preferred provider private insurance plan other than Medicare or Medicaid HMO (42%), which were the most commonly cited. Additionally, fee-for-service (62%), consumer self-pay (43%), and salary (20%) payment arrangements were the most common ways in which MHCs made up their income.

Conclusions & Policy Implications

Understanding key characteristics of the MHC workforce is vital for addressing gaps in mental health care provision. The extended, 5-year plans of surveyed MHCs showed more MHCs decreasing hours than increasing them, and more than a quarter of respondents planning to retire. This could lead to an upcoming decrease in the MHC workforce. MHCs were also less likely to accept public insurance (e.g., Medicaid, TriCare) than to accept private insurance. This could be due to Medicaid reimbursing at lower rates than private insurance. By not accepting public insurance, potentially because the payments are too low, MHCs are reducing the pool of patients they could be treating, potentially resulting in lack of care access for these patients.

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