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The Mental Health Workforce: A Primer

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The Mental Health Workforce: A Primer

Abstract

[Excerpt] Congress has held hearings and introduced legislation addressing the interrelated topics of the quality of mental health care, access to mental health care, and the cost of mental health care. The mental health workforce is a key component of each of these topics. The quality of mental health care depends partially on the skills of the people providing the care. Access to mental health care relies on, among other things, the number of appropriately skilled providers available to provide care. The cost of mental health care depends in part on the wages of the people providing care. Thus an understanding of the mental health workforce may be helpful in crafting policy and conducting oversight. This report aims to provide such an understanding as a foundation for further discussion of mental health policy.

Keywords

mental health, healthcare, workforce

Comments

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The Mental Health Workforce: A Primer

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Summary

Congress has held hearings and introduced legislation addressing the interrelated topics of the quality of mental health care, access to mental health care, and the cost of mental health care. The mental health workforce is a key component of each of these topics. The quality of mental health care depends partially on the skills of the people providing the care. Access to mental health care relies on, among other things, the number of appropriately skilled providers available to provide care. The cost of mental health care depends in part on the wages of the people providing care. Thus an understanding of the mental health workforce may be helpful in crafting policy and conducting oversight. This report aims to provide such an understanding as a foundation for further discussion of mental health policy.

No consensus exists on which provider types make up the mental health workforce. This report focuses on the five provider types identified by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS) as “core mental health professionals”: clinical social workers, clinical psychologists, marriage and family therapists, psychiatrists, and advanced practice psychiatric nurses. The HRSA definition of the mental health workforce is limited to highly trained (e.g., graduate degree) professionals; however, this workforce may be defined more broadly elsewhere.

An understanding of typical licensure requirements and scopes of practice may help policy makers determine how to focus policy initiatives aimed at increasing the quality of the mental health workforce. Although state licensure requirements vary widely across provider types, the scopes of practice converge into provider types that generally can prescribe medication (psychiatrists and advanced practice psychiatric nurses) and provider types that generally cannot prescribe medication (clinical psychologists, clinical social workers, and marriage and family therapists). The core mental health provider types can all provide psychosocial interventions (e.g., talk therapy). Administration and interpretation of psychological tests is generally the province of clinical psychologists.

Access to mental health care depends in part on the number of mental health providers overall and the number of specific types of providers. Clinical social workers are generally the most plentiful core mental health provider type, followed by clinical psychologists, who substantially outnumber marriage and family therapists. While less abundant than the three aforementioned provider types, psychiatrists outnumber advanced practice psychiatric nurses. Policy makers may influence the size of the mental health workforce through a number of health workforce training programs.

Policy makers may assess the relative wages of different provider types, particularly when addressing policy areas where the federal government employs mental health providers. Psychiatrists are the highest earners, followed by advanced practice psychiatric nurses and clinical psychologists. Marriage and family therapists earn more than clinical social workers. The relative costs of employing different provider types may be a consideration for federal agencies that employ mental health providers.

Contents

Introduction.....	1
Mental Health Workforce Definition: No Consensus	2
Mental Health Workforce Overview.....	3
Licensure Requirements	3
Degree	3
Supervised Practice	4
Exam	4
Scope of Practice	4
Mental Health Workforce Size.....	8
Mental Health Workforce Annual Wages.....	12
Concluding Comments	13

Figures

Figure 1. Workforce Size Estimates, by Mental Health Provider Type	9
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Tables

Table 1. Licensure Requirements and Scope of Practice, by Mental Health Provider Type.....	5
Table 2. Workforce Size Estimates, by Mental Health Provider Type.....	10
Table 3. Mean and Median Annual Wages, by Mental Health Provider Type	12

Appendixes

Appendix A. Mental Health Professional Shortage Areas (MHPSA) Definition	15
Appendix B. Additional Resources.....	19

Contacts

Author Contact Information.....	20
Acknowledgments	20

Introduction

The federal government is involved in mental health care in various ways, including direct provision of services, payment for services, and indirect support for services (e.g., grant funding, dissemination of best practices, and technical assistance).¹ Policy makers have demonstrated interest in the federal government's broad role in mental health care. They have done so primarily by holding hearings² and introducing legislation³ addressing the interrelated topics of quality of mental health care, access to mental health care, and the cost of mental health care.

The mental health workforce is a key component of mental health care quality, access, and cost. The quality of mental health care, for example, is influenced by the skills of the people providing the care. Access to mental health care depends on the number of appropriately skilled providers available to provide care, among other things. The cost of mental health care is affected in part by the wages of the people providing care. Thus an understanding of the mental health workforce may be helpful in crafting legislation and conducting oversight for overall mental health care policy.

It is important to note that, while the federal government has an interest in the mental health workforce, and federal initiatives may affect the training of mental health care providers, for instance, most of the regulation of the mental health workforce occurs at the state level. State boards determine licensing requirements for mental health professionals, and state laws establish their scopes of practice.

This report begins with a working definition of the mental health workforce and a brief discussion of alternative definitions. It then describes three dimensions of the mental health workforce that may influence quality of care, access to care, and costs of care: (1) licensure requirements and scope of practice for each provider type in the mental health workforce, (2) estimated numbers of each provider type in the mental health workforce, and (3) average annual wages for each provider type in the mental health workforce. The report then briefly discusses how these dimensions of the mental health workforce might inform certain policy discussions.

¹ For example, federal agencies such as the Veterans Health Administration (within the Department of Veterans Affairs) provide mental health care directly; federal programs such as Medicare pay for mental health care; and federal agencies such as the Substance Abuse and Mental Health Services Administration (within the Department of Health and Human Services) support mental health care through grant funding, dissemination of best practices, technical assistance, and other means.

² See, for example, U.S. Congress, Senate Committee on Health, Education, Labor, and Pensions, *Assessing the State of America's Mental Health System*, 113th Cong., 1st sess., January 24, 2013; U.S. Congress, House Committee on Veterans' Affairs, *Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans*, 113th Cong., 1st sess., February 13, 2013; U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Ensuring Timely Access to High-Quality Care*, 113th Cong., 1st sess., March 20, 2013; and U.S. Congress, House Energy & Commerce Committee, Oversight and Investigations Subcommittee, *Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill*, 113th Cong., 1st sess., May 22, 2013. (SAMHSA is the abbreviation for the Substance Abuse and Mental Health Services Administration.)

³ For example, in the 113th Congress, bills have been introduced intended to improve mental health care overall (e.g., H.R. 1263, H.R. 3717, S. 264, and S. 689), and for specific populations such as veterans (e.g., H.R. 1725 and H.R. 2540), school children (e.g., H.R. 320 and H.R. 628), and Medicare beneficiaries (e.g., H.R. 794 and S. 562), among others.

Mental Health Workforce Definition: No Consensus

No consensus exists on which provider types make up the mental health workforce. While some define the workforce as a broad range of provider types, others take a more narrow approach. For example, the Institute of Medicine (IOM)—a private, nonprofit organization that aims to provide evidence-based health policy advice to decision makers, often through congressionally mandated studies—has conceptualized the mental health workforce broadly, including primary care physicians, nurses, physician assistants, peer support specialists, and family caregivers, among others.⁴ The Substance Abuse and Mental Health Services Administration (SAMHSA)—the public health agency within the Department of Health and Human Services (HHS) that leads efforts to improve the nation’s mental health—has in recent years defined the mental health workforce to include psychiatry, clinical psychology, clinical social work, advanced practice psychiatric nursing, marriage and family therapy, substance abuse counseling, and counseling.⁵ Previously, SAMSHA’s definition also included psychosocial rehabilitation, school psychology, and pastoral counseling and excluded substance abuse counseling.⁶

The Health Resources and Services Administration (HRSA)—the public health agency within HHS with primary responsibility for increasing access to health care (including mental health care) for vulnerable populations⁷—provides a more narrow definition of the mental health workforce that is tied to existing federal programs aimed at alleviating provider shortages (e.g., Medicare bonus payments and health workforce recruitment programs). Eligibility for such programs is determined in part by the designation of a Mental Health Professional Shortage Area (MHPSA).⁸ The MHPSA designation is based on a limited number of core provider types because it is intended to identify the most extreme workforce shortages in order to target federal investments. For purposes of designating MHPSAs, HRSA identifies “[c]ore mental health professionals [as] psychiatrists, clinical psychologists, clinical social workers, [advanced practice psychiatric nurses],⁹ and marriage and family therapists” who meet specified training and licensing criteria (as detailed in **Appendix A**). Notably, this definition is limited to highly trained mental health professionals.

⁴ IOM (Institute of Medicine). 2012. *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Washington, DC: The National Academies Press. Hereinafter, *IOM Workforce Report*. The IOM definition also includes all fields in the SAMHSA definitions.

⁵ SAMHSA. (2013). *Behavioral Health, United States, 2012*. HHS Publication No. (SMA) 13-4797. Rockville, MD: SAMHSA.

⁶ SAMHSA. (2006) *Mental Health, United States, 2004*. HHS Publication No. (SMA) 06-4195. Rockville, MD: SAMHSA. The IOM definition includes all fields in the SAMHSA definitions.

⁷ HRSA, *About HRSA*, <http://www.hrsa.gov/about/>.

⁸ Health professional shortage areas (HPSAs) are defined in 42 U.S.C. §254e. HRSA developed operational definitions of HPSAs and of MHPSAs specifically, available at <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html> and <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html>. HRSA designates MHPSAs based on the ratio of mental health providers to population. As of June 2013, HRSA had designated 3,744 MHPSAs. See U.S. Department of Health and Human Services, Health Resources and Services Administration, “Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P),” <http://datawarehouse.hrsa.gov/hpsadetail.aspx>. For a larger discussion of HPSAs, of which MHPSAs are a specific type, see CRS Report R42029, *Physician Supply and the Affordable Care Act*, by Elayne J. Heisler.

⁹ This report uses the term “advanced practice psychiatric nurse,” which is more common than the term “psychiatric nurse specialists” used in HRSA’s MHPSA designation criteria. See U.S. Department of Health and Human Services, Health Resources and Services Administration, “Mental Health HPSA Designation Overview,” <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html>.

Mental Health Workforce Overview

In conceptualizing and outlining the mental health workforce, this report relies on the HRSA definition of “core mental health professionals,” including clinical social workers, clinical psychologists, marriage and family therapists, psychiatrists, and advanced practice psychiatric nurses.¹⁰ For each of the five core mental health professions, **Table 1** summarizes licensure requirements (including degree, supervised practice, and exam) and scope of practice; each of these terms is explained briefly below. Although the licensure requirements vary widely across provider types, the scopes of practice converge into provider types that generally can prescribe medication (psychiatrists and advanced practice psychiatric nurses) and provider types that generally cannot prescribe medication (clinical psychologists, clinical social workers, and marriage and family therapists). All provider types in this report can provide psychosocial interventions (e.g., talk therapy). Administration and interpretation of psychological tests is generally the province of clinical psychologists.

Licensure Requirements

Licensure requirements are the minimum qualifications needed to obtain and maintain a license in a specific health profession. These requirements are generally defined by state licensing boards— independent entities to which state governments have delegated the authority to set licensure requirements for specified professions. State licensing boards generally have responsibility for verifying that requirements to obtain (and maintain) a license have been met, issuing initial and renewed licenses, and tracking licensure violations, among other activities.¹¹

Table 1 focuses on licensure requirements that are common across many states; it generally does not address state variation. Across all provider types, the table addresses licensure for independent clinical practice,¹² although some disciplines offer licensing at lower practice levels or provisional licensing. The table describes requirements to *obtain* a license and does not include requirements to *maintain* a license (e.g., continuing education).¹³

Degree

The degree noted in **Table 1** indicates the minimum level of education generally required to be licensed for independent practice.¹⁴ For the core mental health professionals outlined in this report, licensure for independent practice requires the completion of graduate education.¹⁵ **Table**

¹⁰ The HRSA definition is used because of its relevance to federal workforce programs.

¹¹ See, for example, “FSMB Mission and Goals,” Federation of State Medical Boards at <http://www.fsmb.org/mission.html>.

¹² In order for a health professional to “count” for MHPSA designation purposes, the health professional must be licensed to practice independently.

¹³ As licensure requirements change over time, previously licensed providers may not be subject to new requirements.

¹⁴ Some disciplines offer degrees with the same title in both clinical and non-clinical tracks—for example, a Doctor of Philosophy (PhD) in clinical psychology and a PhD in experimental psychology or a Masters of Social Work (MSW) in clinical social work and an MSW social work administration—where graduates of the non-clinical track are not qualified for clinical licensure.

¹⁵ Licensure generally requires a degree from a school or program that has been accredited; however, a discussion of accreditation of educational institutions and programs is beyond the scope of this report.

1 generally does not include degrees that are prerequisites for graduate education (e.g., a bachelor's degree) or degrees beyond those required for licensure (e.g., a doctoral degree available in a discipline where a master's degree is qualifying for licensure for independent practice). Notably, in order to enroll in a graduate program to become an advanced practice psychiatric nurse, an individual must first be a *registered nurse* with a bachelor's degree in nursing. The other provider types in this report do not have equivalent requirements for specific undergraduate degrees or for prior licensing.

Table 1 provides a brief description of each graduate degree, including requirements such as a field experience or a dissertation. The table also indicates the amount of time typically required to complete the degree. In some cases, individuals may complete the degree in less time (e.g., by participating in an accelerated program) or more time (e.g., by attending school part-time or taking longer to complete a dissertation).

Supervised Practice

For most provider types discussed in this report, licensure for independent practice requires a period of post-graduate supervised practice. This period of supervised practice is distinct from the practicum or internship experiences required to obtain a degree. An example of such supervised practice is the residency required for physicians to become psychiatrists.

Exam

State licensing boards generally require a passing score on an exam offered by a national body (e.g., the American Board of Psychiatry and Neurology), although some state licensing boards may offer their own exams in addition to or in lieu of the national exam. In some cases, individuals applying for licensure may have a choice of exams that meet the licensure requirement. The timing of the exam may vary by state; that is, some states may allow individuals to take the exam immediately upon completing the degree requirements, while other states may require individuals to have completed a portion (or all) of the supervised practice requirement prior to taking the exam.

Scope of Practice

The scope of practice for each provider type is established at the state level by state statute, regulation, or guidance. **Table 1** highlights elements within scope of practice that involve *diagnosing* and *treating* mental illness. The scope of practice for most provider types includes other activities, such as preventive care, case management, and consultation with other providers. The scope of practice described in the table reflects what is generally true in most states. For example, prescribing medication is included in the scope of practice for advanced practice psychiatric nurses, a provider type that comprises both nurse practitioners (allowed to prescribe medication in all states) and clinical nurse specialists (allowed to prescribe medication in only some states).

Table 1. Licensure Requirements and Scope of Practice, by Mental Health Provider Type

Provider Type ^a	Licensure Requirements			Scope of Practice ^b
	Degree ^c	Supervised Practice	Exam	
Clinical Social Worker	Master of Social Work (MSW), which typically requires 2 years. Coursework emphasizes human and community well-being. Requires a supervised field practicum (internship).	Generally requires 3,200–3,400 post-degree supervised clinical hours, which take approximately 2 years.	Generally requires a passing score on the Clinical Exam of the Association of Social Work Boards.	<ul style="list-style-type: none"> • Diagnose mental disorders. • Provide psychosocial treatment for individuals, families, and groups. • Cannot prescribe medication.
Clinical Psychologist	Doctoral degree in psychology or a related field, which generally takes between 5 and 7 years to complete and requires academic coursework, clinical training, a dissertation, and an exam.	Generally requires 3,000 hours of supervised clinical training, which take approximately 2 years. ^d	Generally requires a passing score on the Examination for Professional Practice in Psychology (EPPP). ^e	<ul style="list-style-type: none"> • Diagnose mental disorders. • Provide psychosocial treatment for individuals, families, and groups. • Administer and interpret psychological tests. • Generally cannot prescribe medication.^f
Marriage and Family Therapist (MFT)	Master's degree (2-3 years), doctoral degree (3-5 years), or postgraduate clinical training (3-4 years) in marriage and family therapy or a related field. ^g Coursework emphasizes the individual's mental health in the context of interpersonal relationships (e.g., family and peers). Generally requires a field practicum or internship.	Generally requires 2 years of post-degree supervised clinical training.	Generally requires a passing score on the Association of Marital and Family Therapy Regulatory Board's Examination in Marriage and Family or the equivalent California Exam. ^h	<ul style="list-style-type: none"> • Diagnose mental disorders. • Provide psychosocial treatment for individuals, families, and groups. • Cannot prescribe medication.

Provider Type ^a	Licensure Requirements			Scope of Practice ^b
	Degree ^c	Supervised Practice	Exam	
Psychiatrist	Medical Doctorate (MD) or Doctorate of Osteopathic Medicine (DO), both of which typically require 4 years to complete (including 2 years of clinical rotations). Coursework emphasizes physical medicine.	Generally requires 3 or 4 years of post-degree supervised clinical training (residency) in the specialty of psychiatry.	Generally requires a passing score on the United States Medical Licensing Examination (USMLE) for MDs or DOs. ⁱ DOs can also elect to take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). <i>To become board certified, an exam administered by the American Board of Psychiatry and Neurology.^j</i>	<ul style="list-style-type: none"> • Diagnose mental disorders. • Provide psychosocial treatment for individuals, families, and groups. • Can prescribe medication. • Can diagnose and treat physical conditions as well.
Advanced Practice Psychiatric Nurse (APPN) ^k	Master of Science (MS) in nursing, which generally requires 2 years of coursework and clinical hours (generally 500 or more). ^l Coursework and clinical experience focus on psychiatric mental health nursing.	No separate post-graduate clinical training is required.	Generally requires a passing score on an exam offered by the American Nurses Credentialing Center. ^m	<ul style="list-style-type: none"> • Diagnose mental disorders. • Provide psychosocial treatment for individuals, families, and groups. • Generally can prescribe medication. • Can diagnose and treat physical conditions as well.ⁿ

Source: U.S. Department of Labor, Bureau of Labor Statistics; U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA); and various professional associations. For more information on the professional organizations for each of five health professions, see **Appendix B**.

Notes: The degree, supervised practice, and exam indicated in the table are those generally required to obtain a license for independent practice. Licensure requirements (defined by state boards) and scope of practice (defined by state laws) vary by state. Degree requirements may vary by program. In all cases, the information provided in the table reflects what is generally true in most states and programs. Elaborating the exceptions is beyond the scope of this report.

- The provider type may not correspond to the name of the license (which may vary by state for some provider types). The provider types correspond to HRSA’s “core mental health professionals” (with the exception of advanced practice psychiatric nurses, which HRSA calls “psychiatric nurse specialists”).
- The table focuses on the elements within scope of practice that involve diagnosing and treating mental illness. The scope of practice for most provider types includes other activities, such as preventive care, case management, and consultation with other providers.
- The table focuses on graduate degree requirements (i.e., post-baccalaureate training requirements).
- Generally, states require that at least 1,500 hours (of the 3,000 hours required) be a post-doctoral experience. See Association of State and Provincial Psychology Boards, “Entry Requirements for the Professional Practice of Psychology, 2008,” http://www.asppb.net/files/public/09_Entry_Requirements.pdf.

- e. A board certified psychologist is one who has completed training in a specific specialty and has passed an examination that assesses the basic knowledge and skills in that particular area. As in psychiatry, board certification is not required, but some employers may require it. Board certification is conducted by the American Board of Professional Psychology, see <http://www.abpp.org/>.
- f. In New Mexico, Louisiana, Guam, the U.S. Department of Defense (DOD) system, the Indian Health Service, and the U.S. Public Health Service, licensed psychologists who obtain additional training can apply to have prescription writing privileges as part of their scope of practice. See Robert E. McGrath, "Prescriptive Authority for Psychologists," *Annual Review of Clinical Psychology*, vol. 6 (April 27, 2010), pp. 21-47.
- g. Related fields may include psychology, social work, nursing, education, or pastoral counseling. See American Association for Marriage and Family Therapy, *About AAMFT, Qualifications and FAQs*, http://www.aamft.org/imis15/content/about_aamft/Qualifications.aspx.
- h. Marriage and Family Therapists (MFTs) who practice in California (representing more than half of all MFTs), must pass a separate California licensing exam.
- i. Graduates of certain foreign medical schools may also be eligible to take the USMLE.
- j. The term "board certified physician" means one who has completed the required training in a specific specialty and has passed an examination that assesses the basic knowledge and skills in a particular area (in this case psychiatry or neurology). Board certification is not required to practice as a psychiatrist but may be a condition of employment for some employers.
- k. This includes mental health/psychiatric nurse practitioners and clinical nurse specialists. This report uses the term "advanced practice psychiatric nurse," which is more common than the term "psychiatric nurse specialists" used by HRSA. The American Psychiatric Nurses Association (APNA) aims to bring uniformity to the requirements for advanced practice psychiatric nurses by 2015, in accordance with the "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education;" see American Psychiatric Nurses Association, *APRN Consensus Model*, <http://www.apna.org/i4a/pages/index.cfm?pageID=4387>.
- l. The nursing profession is moving towards requiring doctoral degrees in these fields, which requires an additional two years of training. See American Psychiatric Nurses Association, "What is an Advanced Practice Psychiatric Nurse?" <http://www.apna.org/i4a/pages/index.cfm?pageID=3866>.
- m. Prior to January 1, 2014, the American Nurses Credentialing Center offered four different exams: two for Nurse Practitioners (in Adult or Family Psychiatry) and two for Clinical Nurse Specialists (in Adult or Child/Adolescent Psychiatric Nursing). In order to become an advanced practice psychiatric nurse, an individual must first be a registered nurse, which generally requires a passing score on the National Council Licensure Examination-RN (NCLEX-RN). See National Council of State Boards of Nursing, *NCLEX Examinations*, <https://www.ncsbn.org/nclex.htm>.
- n. Some states may require that advanced practice psychiatric nurses be supervised by physicians.

Mental Health Workforce Size

Access to mental health care depends in part on the overall number of practicing mental health providers and the number of specific types of providers.¹⁶ As of June 2013, HRSA had designated 3,744 Mental Health Professional Shortage Areas (MHPSAs), including one or more in each state, the District of Columbia, and each of the territories.¹⁷ Although HRSA designates MHPSAs, it does not collect parallel data on the size of the mental health workforce nationally.¹⁸ **Figure 1** and **Table 2** both present workforce size estimates for each core mental health provider type from

- *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* by IOM;¹⁹
- *Behavioral Health, United States, 2012* by the SAMHSA;²⁰ and
- other sources, including professional associations and licensing boards.

Although the number of mental health providers in each profession varies across the three sources,²¹ each source yields the same order of provider types from most plentiful to least plentiful, as illustrated in **Figure 1**. According to each data source, clinical social workers are estimated to be the most plentiful, followed by clinical psychologists, who substantially outnumber marriage and family therapists. While less abundant than the three aforementioned provider types, psychiatrists outnumber advanced practice psychiatric nurses.

¹⁶ One of the primary challenges in assessing the overall size of the mental health workforce is that there is no uniform definition; see “Mental Health Workforce Definition.” Using the HRSA definition of “core mental health professionals,” a relatively narrow definition, yields a smaller estimate than would be found using a somewhat broader definition such as the one used by SAMSHA or a much broader definition such as the one used by the IOM.

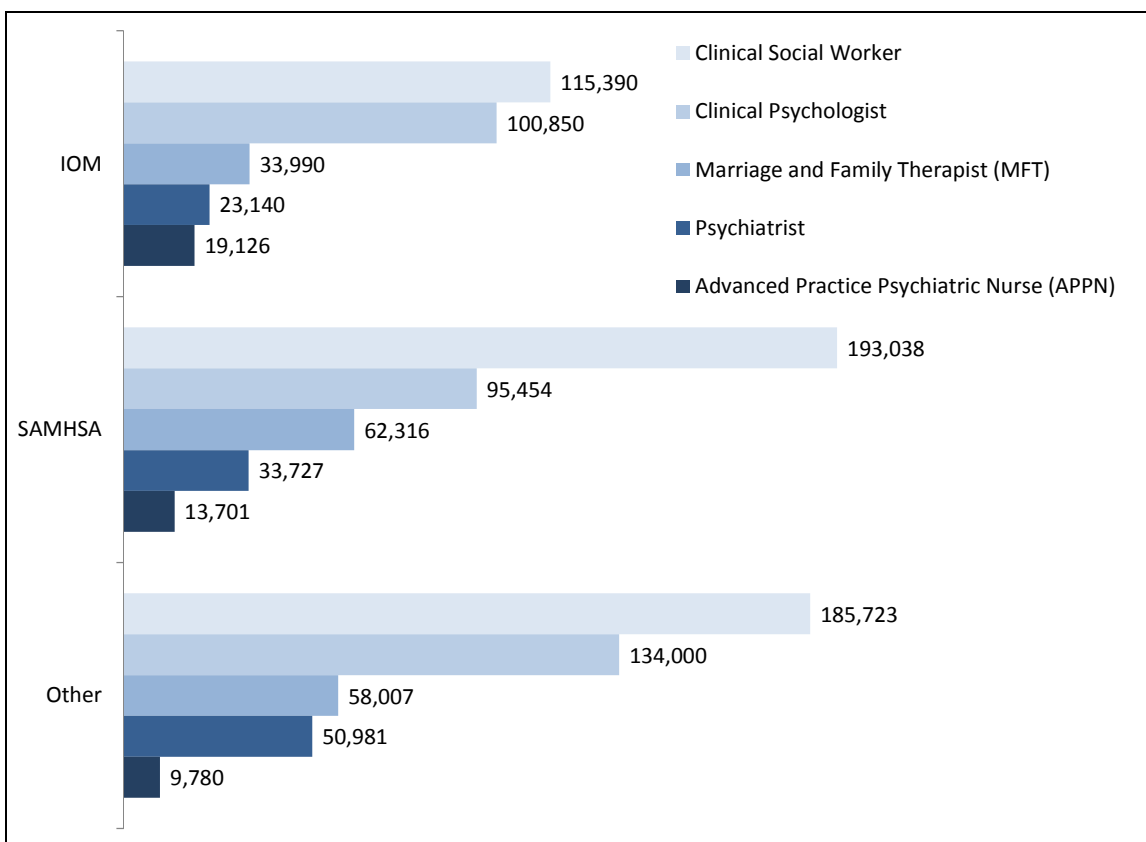
¹⁷ Health Resources and Services Administration, Data Warehouse, *Health Professional Shortage Areas (HPSA) and Medically Underserved Areas / Populations (MUA/P)*, <http://datawarehouse.hrsa.gov/hpsadetail.aspx>.

¹⁸ HRSA uses a variety of data sources when designating MHPSAs. Individual states apply to HRSA for MHPSA designations. When doing so states must provide data on the ratio of health practitioners to population. States use a variety of sources when providing these data including professional association data, state licensing data, and state specific survey data. Source: E-mail from HHS Office of the Assistant Secretary for Legislation, August 1, 2013. In November 2013, HRSA released a chartbook that included counts of certain behavioral health professions (e.g., psychologists and counselors); these data are not used in this CRS report because they do not include all professions included in the MHPSA definition nor do they restrict counts to clinical practitioners. For more information, see U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, *The U.S. Health Workforce Chartbook*, Part IV: Behavioral and Allied Health, Rockville, MD, November 2013.

¹⁹ Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Washington, DC: The National Academies Press. IOM is a private, nonprofit institution established in 1970 under the congressional charter of the National Academy of Sciences to provide health policy advice. See National Academies, Institute of Medicine, *About the IOM*, <http://www.iom.edu/About-IOM.aspx>. For information about the health professions included in the IOM’s definition of the mental health workforce, see “Mental Health Workforce Definition.”

²⁰ Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Behavioral Health, United States, 2012*. HHS Publication No. (SMA) 13-4797. Rockville, MD: SAMHSA. SAMHSA is a public health agency established within HHS by Congress in 1992 to advance mental health in the United States. See SAMHSA, *About Us*, <http://beta.samhsa.gov/about-us>. For information about the health professions included in the SAMSHA’s definition of the mental health workforce, see “Mental Health Workforce Definition: No Consensus.”

²¹ The numbers obtained vary in part because these data sources rely on different methodologies including surveys, state licensure data, and membership in professional associations.

Figure I. Workforce Size Estimates, by Mental Health Provider Type

Source: CRS analysis of data from Institute of Medicine, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* (Washington, DC: National Academies Press, 2012); Substance Abuse and Mental Health Services Administration, *Behavioral Health, United States, 2012*, Rockville, MD, 2013; and other sources (i.e., professional associations and licensing boards).

Variation in the numbers from different sources reflects some of the difficulty in determining the size of the workforce—and therefore also in determining the adequacy of the workforce to provide access to mental health care. Along with workforce size estimates for each provider type, **Table 2** presents the *original* data sources (e.g., the IOM report relies primarily on data from the Bureau of Labor Statistics within the U.S. Department of Labor). Limitations of each original data source may lead to overstating or understating the number of providers (e.g., the Bureau of Labor Statistics data excludes self-employed workers). Major limitations are noted in **Table 2**.

Even looking at the numbers in relative terms, the limitations of the original sources complicate comparisons across professions. For example, the Bureau of Labor Statistics figures in the IOM report *include* school psychologists and *exclude* school social workers, limiting their comparability.

Table 2. Workforce Size Estimates, by Mental Health Provider Type

Provider Type	Institute of Medicine Report^a		Behavioral Health, United States, 2012^b		Other Sources (Membership and Licensing)	
Clinical Social Worker	115,390	BLS, May 2011, estimate of mental health and substance abuse social workers (SOC 21-1023). Excludes the self-employed.	193,038	Psychlist Marketing, Inc. 2011. Based on state licensure data with duplicate addresses removed.	185,723	Association of Social Work Boards, Inc., 2011, sum of state-level numbers of MSWs with experience. May double-count those licensed in multiple states. Excludes those from states that did not report.
Clinical Psychologist	100,850	BLS, May 2011, estimate of clinical, counseling, and school psychologists (SOC 19-3031). Excludes the self-employed.	95,545	Psychlist Marketing, Inc. 2011. Based on state licensure data with duplicate addresses removed.	134,000	American Psychological Association, 2013, members. Includes members who are not mental health providers (e.g., experimental psychologists). Excludes non-members.
Marriage and Family Therapist (MFT)	33,990	BLS, May 2011, estimate of marriage and family therapists (SOC 21-1013). Excludes the self-employed.	62,316	Psychlist Marketing, Inc. 2011. Based on state licensure data with duplicate addresses removed.	58,007	American Association for Marriage and Family Therapy, 2013, sum of state-level numbers of fully licensed MFTs from state boards. May double-count those licensed in multiple states. Excludes those with provisional licenses.
Psychiatrist	23,140	BLS, May 2011, estimate of psychiatrists (SOC 29-1066). Excludes the self-employed.	33,727	American Medical Association 2011. Includes providers engaged in patient care; excludes those in training (e.g., residents and fellows).	50,981	American Medical Association, 2012, Board Certified Psychiatrists. Includes psychiatrists who are not practicing (e.g., researchers or retired).
Advanced Practice Psychiatric Nurse (APPN) ^c	19,126	National Sample Survey of Registered Nurses, 2008, estimates of psychiatric advanced practice registered nurses.	13,701	National Sample Survey of Registered Nurses, 2008.	9,780	American Nurses Credentialing Center, 2008, sum of state-level numbers of APPNs. ^d May double-count those licensed in multiple states.

Notes: BLS = Bureau of Labor Statistics; SOC = Standard Occupational Classification (codes used by the Bureau of Labor Statistics).

- a. Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Washington, DC: The National Academies Press. See Table 3-2 “Estimated Number of Mental Health/Substance Use (MH/SU) Specialists, 2011.” For all provider types other than advanced practice psychiatric nurses, IOM used data from the Bureau of Labor Statistics (BLS), Occupational Employment Statistics, Occupational Employment and Wages, May 2011. BLS estimates are based on a survey that excludes self-employed workers.
- b. SAMHSA. (2013). *Behavioral Health, United States, 2013*. HHS Publication No. (SMA) 13-4797. Rockville, MD: SAMSHA. See Table 93 “Mental Health and Substance Abuse Treatment Providers, by discipline and state: number, United States, 2008, 2009, and 2011.”
- c. The IOM and SAMHSA present different numbers, both attributed to the same source. The information provided was not sufficient to explain how this occurred.
- d. Cited in Hanrahan et al. (2010), “Health Care Reform and the Federal Transformation Initiatives: Capitalizing on the Potential of Advanced Practice Psychiatric Nurses,” *Policy, Politics, & Nursing Practice* 11(3): 235-244.

Mental Health Workforce Annual Wages

Just as access to mental health care providers depends partially on the size of the mental health workforce, the cost of mental health care depends partly on the wages paid to mental health providers. **Table 3** presents mean and median annual wages from the Bureau of Labor Statistics (BLS). These wage data are widely used because of their large sample size, broad geographic reach, and the comparable methodology used to collect data across occupations.²² Information from BLS is likely to either over- or under-state wages for some mental health providers; the data are based on a survey that excludes self-employed workers (i.e., those in private practice), who may have different incomes. For example, for both clinical psychologists and clinical social workers, the categories used by the BLS include individuals who may earn substantially less than those who meet the HRSA definition of the provider type. The wage estimates for clinical psychologists are based on a category that includes school psychologists, who do not have to meet the same licensure requirements as HRSA-defined clinical psychologists and thus might receive lower wages. Similarly, the wage estimates for clinical social workers are based on a category that includes individuals who are not licensed for independent practice and who also might earn less.

Despite their limitations, the BLS data are able to illuminate the relative wages of each provider type as outlined in **Table 3**. Psychiatrists are the relative highest earners, followed by advanced practice psychiatric nurses and clinical psychologists. Marriage and family therapists generally earn more than clinical social workers.

Table 3. Mean and Median Annual Wages, by Mental Health Provider Type

Provider Type	Annual Wage		BLS Category Used ^a
	Mean	Median	
Clinical Social Worker	\$43,340	\$39,980	Mental Health and Substance Abuse Social Workers (SOC 21-1023). No distinction is made between levels of education or licensure.
Clinical Psychologist	\$72,220	\$67,650	Clinical, Counseling, and School Psychologists (SOC 19-3031).
Marriage and Family Therapist (MFT)	\$49,270	\$46,670	Marriage and Family Therapists (SOC 21-1013).
Psychiatrist	\$177,520	\$173,330	Psychiatrists (SOC 29-1066).
Advanced Practice Psychiatric Nurse (APPN)	\$91,450	\$89,960	Nurse Practitioners (SOC 29-1171). No estimate is provided for the psychiatric/mental health specialty.

Source: CRS summary of data from U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, May 2012 Occupation Profiles, http://www.bls.gov/oes/current/oes_stru.htm.

a. BLS wage estimates do not include self-employed workers. SOC = Standard Occupational Classification (codes used by the Bureau of Labor Statistics).

²² For example, the BLS Handbook of Methods, Chapter 3: Occupational Employment Statistics discusses the uses of the OES data that include federal programs, state workforce agencies, and the Department of Labor Foreign Labor Certification Program, see <http://www.bls.gov/opus/hom/homch3.htm#uses>.

Concluding Comments

Understanding the mental health workforce may help policy makers address a range of potential policy issues related to mental health care, including its quality, access, and cost.

An understanding of typical licensure requirements and scopes of practice may help policy makers determine how to direct federal policy initiatives focused on enhancing the quality of mental health care such as those related to training mental health providers. If, for example, training new providers quickly is a priority, initiatives may focus on training additional providers who can be licensed with a master's degree, rather than a doctoral degree. Initiatives may focus on training providers who can prescribe medication if the need is greater for medication than for psychosocial interventions. Going beyond the provider types discussed in this report, if a priority is to expand the breadth of the mental health workforce, policy makers might also consider federal training directed toward initiatives that focus on paraprofessionals who do not require extensive training or toward primary care professionals who do not specialize in mental health but may provide care for individuals with mental illness. Increasing the breadth of the mental health workforce may also increase its overall size.

Another way policy makers may influence the size of the mental health workforce (and thus access to mental health services) is through the provision or expansion of federal programs.²³ For example, the federal government may provide grants to establish or expand training programs for mental health providers. The federal government may also provide incentives such as loan repayment or loan forgiveness to encourage individuals to enter mental health occupations, which are projected to grow faster than the overall workforce.²⁴ Policy makers may consider strategies to direct people into these high growth fields as part of larger labor force policy considerations. Initiatives may be targeted to certain provider types or to certain locations (e.g., MHPSAs).

Policy makers may also wish to consider the relative wages of different provider types, particularly when addressing domains within which the federal government employs mental health providers. For instance, agencies which employ these mental health professionals include the Department of Defense, the Veterans Health Administration (within the Department of Veterans Affairs), the Bureau of Prisons (within the Department of Justice), and the Indian Health Service (within HHS), among other agencies. The federal government is the largest employer of some provider types, such as clinical psychologists and social workers.²⁵ As such, the cost of

²³ CRS Report R42029, *Physician Supply and the Affordable Care Act*, by Elayne J. Heisler, discusses the interplay between the demand for health services and the supply of a specific type of providers: physicians. Some of the discussion and some of the policy levers used to affect physician supply could also be used to affect the mental health workforce. For a description of health workforce programs, see CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Elayne J. Heisler; CRS Report R42029, *Physician Supply and the Affordable Care Act*, by Elayne J. Heisler; and U.S. Government Accountability Office (GAO), *Health Care Workforce: Federally Funded Training Programs in Fiscal Year 2012*, 13-709R, August 15, 2013, <http://www.gao.gov/products/GAO-13-709R>.

²⁴ BLS projects the growth rate between 2010 and 2020 to be 14% among all occupations, 26% among health care practitioners, and higher within some of the mental health professions (e.g., 41% among marriage and family therapists and 31% among mental health and substance abuse social workers). Department of Labor, Bureau of Labor Statistics, "Employment Projections, Employment by Occupation," February 1, 2012, http://www.bls.gov/emp/ep_table_102.htm.

²⁵ See, for example, U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Human Resources Challenges with the Veterans Health Administration*, committee print, prepared by Randy Phelps, Deputy Executive Director for Professional Practice of the American Psychological Association, 110th Cong., May 22, 2008, <http://veterans.house.gov/witness-testimony/randy-phelps-phd>; psychologist recruiting information from the Federal (continued...)

employing different provider types—as well as their scopes of practice—may be a consideration not only in determining staffing priorities, but also in attempts to recruit and retain mental health providers (e.g., by offering competitive compensation).

(...continued)

Bureau of Prisons at http://www.bop.gov/jobs/hsd/psychology_services.jspl; and social work recruiting information from the Department of Veterans Affairs at http://www.vacareers.va.gov/resources/downloads/MHEI_Brochure.pdf.

Appendix A. Mental Health Professional Shortage Areas (MHPSA) Definition

This appendix excerpts the specific criteria that the Health Resources and Services Administration (HRSA) uses to designate mental health professional shortage areas (MHPSAs). MHPSAs can be geographic areas, population groups, or facilities. This designation is used to determine eligibility for federal programs such as Medicare bonus payments and health professions recruitment programs.²⁶ HRSA bases the MHPSA designation on the availability (relative to population size) of “core mental health professionals,” which include “psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.” The criteria for designating a MHPSA are as follows:²⁷

1. Geographic Areas must:

- *Be a rational area for the delivery of mental health services*
- *Meet one of the following conditions:*
 - *A population-to-core-mental-health-professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1 or*
 - *A population-to-core professional ratio greater than or equal to 9,000:1 or*
 - *A population-to-psychiatrist ratio greater than or equal to 30,000:1*
- *Have unusually high needs for mental health services, and*
 - *A population-to-core-mental-health-professional ratio greater than or equal to 4,500:1 and a population-to-psychiatrist ratio greater than or equal to 15,000:1, or*
 - *A population-to-core-professional ratio greater than or equal to 6,000:1, or*
 - *A population-to-psychiatrist ratio greater than or equal to 20,000:1*
- *Mental health professionals in contiguous areas are overutilized, excessively distant or inaccessible to residents of the area under consideration.*

2. Population Groups must:

- *Face access barriers that prevent the population group from use of the area’s mental health providers*
- *Meet one of the following criteria:*

²⁶ For more information on the general Health Professional Shortage Area (HPSA) designation, see CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

²⁷ See U.S. Department of Health and Human Services, Health Resources and Services Administration, “Mental Health HPSA Designation Overview,” <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html>.

- *Have a ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group greater than or equal to 4,500:1 and the ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group greater than or equal to 15,000:1; or*
- *Have a ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group greater than or equal to 6,000:1; or*
- *Have a ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group are greater than or equal to 20,000:1*

3. *Facilities must:*

- *Be maximum or medium security facilities*
- *Be either Federal and/or State correctional institutions, State/County mental hospitals or public and/or non-profit mental health facilities*
- *Federal or State Correctional facilities must:*
 - *Have at least 250 inmates and*
 - *Have a ratio of the number of internees per year to the number of FTE [full-time equivalent] psychiatrists serving the institution of at least 2,000:1*
- *State and county mental health hospitals must:*
 - *Have an average daily inpatient amount of at least 100; and*
 - *The number of workload units per FTE psychiatrists available at the hospital exceeds 300, where workload units are calculated using the following formula: Total workload units = average daily inpatient census + 2 x (number of inpatient admissions per year) + 0.5 x (number of admissions to day care and outpatient services per year).*
- *Community mental health centers and other public and non-profit facilities must:*
 - *Be providing (or responsible for providing) mental health services to an area or population group designated as having a shortage of mental health professionals and*
 - *Have insufficient capacity to meet the psychiatric needs of the area or population group*

B. *Methodology.*²⁸

In determining whether an area meets the criteria... the following methodology will be used:

²⁸ U.S. Department of Health and Human Services, Health Resources and Services Administration, "Mental Health HPSA Designation Criteria," <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html>.

1. Rational Areas for the Delivery of Mental Health Services.

(a) The following areas will be considered rational areas for the delivery of mental health services:

(i) An established mental health catchment area, as designated in the State Mental Health Plan under the general criteria set forth in section 238 of the Community Mental Health Centers Act.

(ii) A portion of an established mental health catchment area whose population, because of topography, market and/or transportation patterns or other factors, has limited access to mental health resources in the rest of the catchment area, as measured generally by a travel time of greater than 40 minutes to these resources.

(iii) A county or metropolitan area which contains more than one mental health catchment area, where data are unavailable by individual catchment area.

(b) The following distances will be used as guidelines in determining distances corresponding to 40 minutes travel time:

(i) Under normal conditions with primary roads available: 25 miles.

(ii) In mountainous terrain or in areas with only secondary roads available: 20 miles.

(iii) In flat terrain or in areas connected by interstate highways: 30 miles.

Within inner portions of metropolitan areas, information on the public transportation system will be used to determine the distance corresponding to 40 minutes travel time.

2. Population Count.

The population count used will be the total permanent resident civilian population of the area, excluding inmates of institutions.

3. Counting of mental health professionals.

(a) All non-Federal core mental health professionals (as defined below) providing mental health patient care (direct or other, including consultation and supervision) in ambulatory or other short-term care settings to residents of the area will be counted. Data on each type of core professional should be presented separately, in terms of the number of full-time-equivalent (FTE) practitioners of each type represented.

(b) Definitions:

(i) Core mental health professionals or core professionals includes those psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet the definitions below.

(ii) Psychiatrist means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who

(A) Is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, or, if not certified, is “board-eligible” (i.e., has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry); and

(B) Practices patient care psychiatry or child psychiatry, and is licensed to do so, if required by the State of practice.

(iii) Clinical psychologist means an individual (normally with a doctorate in psychology) who is practicing as a clinical or counseling psychologist and is licensed or certified to do so by the State of practice; or, if licensure or certification is not required in the State of practice, an individual with a doctorate in psychology and two years of supervised clinical or counseling experience. (School psychologists are not included.)

Clinical social worker means an individual who—

(A) Is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work, or is listed on the National Association of Social Workers’ Clinical Register, or has a master’s degree in social work and two years of supervised clinical experience; and

(B) Is licensed to practice as a social worker, if required by the State of practice.

(v) Psychiatric nurse specialist means a registered nurse (R.N.) who—

(A) Is certified by the American Nurses Association as a psychiatric and mental health clinical nurse specialist, or has a master’s degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience; and

(B) Is licensed to practice as a psychiatric or mental health nurse specialist, if required by the State of practice.

(vi) Marriage and family therapist means an individual (normally with a master’s or doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or certified to do so by the State of practice; or, if licensure or certification is not required by the State of practice, is eligible for clinical membership in the American Association for Marriage and Family Therapy.

Appendix B. Additional Resources

Below are resources for additional information about each mental health provider type, including national associations of state boards, professional associations, accrediting organizations for educational programs, and other relevant organizations. In some cases, a single organization may serve multiple roles (e.g., a professional association may also accredit educational programs).

Psychiatrists

American Academy of Addiction Psychiatry (AAAP): <http://www2.aaap.org>

American Academy of Child & Adolescent Psychiatry (AACAP): <http://www.aacap.org>

American Academy of Clinical Psychiatrists (AACP): <https://www.aacp.com>

American Board of Medical Specialties (ABMS): <http://www.abms.org>

American Board of Psychiatry and Neurology (ABPN): <http://www.abpn.com>

American Psychiatric Association (APA): <http://www.psych.org>

National Board of Osteopathic Examiners: <http://www.nbome.org>

Psychologists

American Psychological Association (APA): <http://www.apa.org>

Association of State and Provincial Psychology Boards (ASPPB): <http://www.asppb.net>

Social Workers

Association of Social Work Boards (ASWB): <http://www.aswb.org>

Council on Social Work Education (CSWE): <http://www.cswe.org>

National Association of Social Workers (NASW): <http://www.socialworkers.org>

Social Work Policy Institute (SWPI): <http://www.socialworkpolicy.org>

Advanced Practice Psychiatric Nurses

American Academy of Nurse Practitioners (AANP): <http://www.aanp.org>

American Nurses Credentialing Center (ANCC): <http://www.nursecredentialing.org>

American Psychiatric Nurses Association (APNA): <http://www.apna.org>

National Association of Clinical Nurse Specialists (NACNS): <http://www.nacns.org>

National Council of State Boards of Nursing (NCSBN): <https://www.ncsbn.org>

Marriage and Family Therapists

American Association for Marriage and Family Therapy (AAMFT): <http://www.aamft.org>

Association of Marital and Family Therapy Regulatory Boards (AMFTRB):
<http://www.amftrb.org>

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