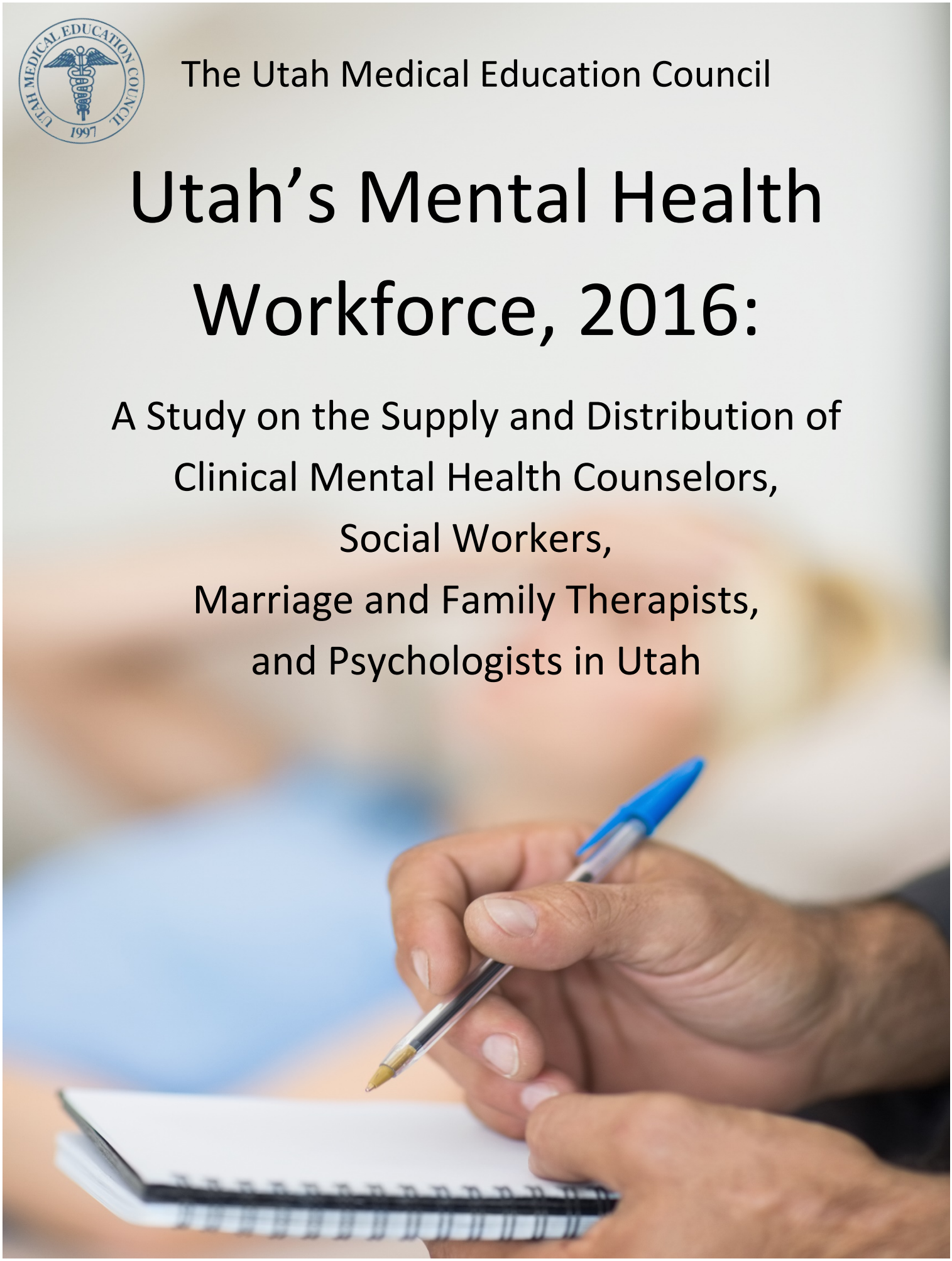
The Utah Medical Education Council

Utah's Mental Health Workforce, 2016:

A Study on the Supply and Distribution of Clinical Mental Health Counselors, Social Workers, Marriage and Family Therapists, and Psychologists in Utah



UTAH'S MENTAL HEALTH WORKFORCE, 2016:

A STUDY IN THE SUPPLY AND DISTRIBUTION OF CLINICAL MENTAL HEALTH COUNSELORS, SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS, AND PSYCHOLOGISTS IN UTAH

The Utah Medical Education Council

State of Utah

www.utahmec.org

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THE UTAH MEDICAL EDUCATION COUNCIL

The Utah Medical Education Council (UMEC) was created in 1997 by H.B.141 out of a need to secure and stabilize the state's supply of healthcare clinicians. This legislation authorized the UMEC to conduct ongoing healthcare workforce analyses and to assess Utah's training capacity and graduate medical education (GME) financing policies. The UMEC is presided over by an eight member board appointed by the Governor to bridge the gap between public/private health care workforce and education interests.

Our Mission

To conduct health care workforce research, to advise on Utah's health care training needs, and to influence graduate medical education (GME) financing policies.

Core Responsibilities – Healthcare Workforce

- Assess supply and demand
- Advise and develop policy
- Seek and disburse Graduate Medical Education (GME) funds
- Facilitate training in rural locations

Current Areas of Focus

- Retention of Utah trained healthcare workforce
- Facilitate rural training opportunities
- Strengthen public/private partnerships

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The UMEC would like to thank its staff and the following members of the Mental Health Workforce Advisory Committee for their time and expertise in developing this report:

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EXECUTIVE SUMMARY

As of March 2015, there were 7,425 mental health professionals licensed in the state of Utah. This includes Clinical Mental Health Counselors (CMHCs), Licensed Clinical Social Workers (LCSWs), Marriage and Family Therapists (MFTs), and Psychologists (PSYCHs). Associate level practitioners (ACMHCs, CSWs, etc.) are also included in this analysis. As a baseline analysis, it is difficult to estimate the growth rate in the state using this data. However, the Bureau of Labor Statistics (BLS) estimates that each of the professions mentioned in this report will grow faster than average, between 12.0% and 19.0% over the next 10 years (BLS, 2016). An estimated 82.9% (6,154) of mental health professionals licensed in Utah work in the state. This number consists of 1,109 (18.0%) CMHCs, 3,512 (57.1%) LCSWs, 582 (9.5%) MFTs, and 950 (15.4%) Psychologists.

The mean age for all mental health professionals is 51. CMHCs are slightly younger with a mean age of 47 and Psychologists tend to be slightly older at 53. Over a quarter (28.5%, 1,755) of the workforce is between the ages of 35 and 44 and 17.5% (1.079) is aged 65 or older. In every profession apart from CMHCs, the age cohort of 65 and older hold more people than any other single age cohort.

The majority of the workforce (62.4%, 3,842) is female. This holds true across all four professions. Psychologists have the lowest percentage of women at 55.2%. Apart from Native Hawaiian/ Pacific Islander, all minority populations are underrepresented in the Utah workforce. The largest gap is among Hispanics with 13.5% of Utah's general population, but only 4.8% of the workforce.

An estimated 44.0% (2,710) of the workforce grew up in Utah. Another 18.8% (1,159) moved here from the western U.S. The vast majority (72.4%, 4,457) obtained their highest mental health degree in the state while 12.2% (750) obtained their degrees in the Western U.S. LCSWs and Psychologists attend state universities a majority of the time, 74.7% and 54.3%, respectively, while CMHCs and MFTs more often attend private universities (63.4% and 57.5%, respectively).

The median income for the entire workforce is $56,000. CMHCs make a median of $49,000, LCSWs make $55,000, MFTs make $57,000, and Psychologists make $86,000. Across the board, this is higher than national estimates from the BLS (BLS, 2016). Patterns were found when looking at income differences between men and women. These patterns were enough to concern the advisory committee; however, the UMEC does not have enough data to make any confident statement on whether or not gender pay disparities are widespread.

The share of the population compared to the share of the workforce is fairly even in most counties. Mental health professionals are underrepresented in Davis, Utah, and Weber counties and overrepresented in Salt Lake County. Daggett and Piute counties had no reporting mental health professionals. The four professions are not evenly represented across counties. Psychologists and LCSWs work in urban settings more often while CMHCs and MFTs work in rural

areas more often. Urban settings fare better when looking at population to provider ratios. Urban areas in Utah have 170 full-time equivalent providers (FTEs) per 100,000 people while rural areas have 141 FTEs per 100,000 people.

Almost a quarter (24.8%, 1,527) of all mental health providers work in either an independent solo or group practice. Independent solo practices are the most common primary setting among all professions apart from CMHCs. Also common among all four professions are mental health clinics with 13.7% (840) of the workforce, although a smaller share of Psychologists work in clinics compared to CMHCs, LCSWs, and MFTs. More Psychologists are found in veterans facilities and college or university counseling centers than the other professions. A third (33.6%) of providers hold more than one mental health position. Independent solo practices are also the most common secondary setting.

On average, mental health providers work 36 hours per week. Part-time providers work 20 hours and full-time providers work 44 hours. Hours worked varies by setting from 27.5 hours at hospice settings to 45.5 hours at child welfare facilities. The workforce sees a mean of 5.4 individual clients per day and 1.7 groups per day. Again, this varies by setting from 2.8 individuals per day at organization/business settings to 8.1 individuals at correctional facilities. The number of groups seen is between 0.8 and 1.9 for all settings save correctional facilities, which sees an average of 2.9 groups per day.

Over 40.0% of the workforce spends some time each week working on clinical supervision or instruction (43.4%), administration or management (42.8%), and practice management (46.6%). Classroom training (21.8%) and consulting or research (35.9%) are also common. The amount of time spent on these activities ranges from 3.1 hours per week to 9.1 hours per week. Apart from CMHCs spending time on consulting or research, median income increases for those in the workforce who spend at least 10 hours per week in these activities.

Primary Care Physicians and Psychiatrists are used by a majority of the workforce as the main point of contact for prescribing medication (70.8%). Access to prescribing partners is good or excellent for a majority of the workforce (54.6%), however 31.4% report having fair or poor access. Urban settings generally see worse access than rural, especially among providers who are mainly using Primary Care Physicians. Inadequate access to prescribing partners varies widely by setting from 7.8% in hospice settings to 58.3% in child welfare facilities.

Almost a quarter (23.5%, 1,444) of all mental health providers switched employers within the last two years and 39.0% (2,403) switched employers within the last five years. Psychologists had the least amount of turnover while CMHCs saw the most. Working two or more jobs (23.5%) and considering leaving mental health (17.4%) are also prominent employment issues. Psychologists report experiencing fewer employment issues. CMHCs report experiencing employment issues

such as involuntary unemployment, working part-time while preferring full-time, and working two or more jobs at once at higher rates than the other professions.

Almost a third (31.6%) of the workforce reports that they do not plan to retire. Half of the workforce plans to reduce their hours either in lieu of or before retirement. Over the next five years, 7.1% of the workforce plans to retire completely and 15.6% plan on reducing their hours. Those who say they will reduce their hours plan on working a mean of 17.6 hours per week after the reduction. This may result in 14.9% of the workforce leaving over the next five years.

Utah has a total of 5,026 mental health FTEs or 171 FTEs and 209 providers per 100,000 people. Nationally, the Bureau of Labor Statistics estimates that there are 311 providers per 100,000 people (BLS, 2016). This shortage equates to every county in Utah being designated a Mental Health Health Provider Shortage Area (HPSA) (United States Department of Health and Human Services, Health Resources and Services Administration, 2016). Exacerbating this shortage is the fact that Utah experiences mental illness at higher rates than the national average (SAMHSA, 2015). In order to meet the national average over the next 15 years, the Utah workforce must grow from the 5,026 FTEs today to 11,186 FTEs by 2030. Some of the factors involved in reaching this target such as retention rates for training programs in the state or class size increases for popular online programs are unknown at this time. Without this data, it is difficult to estimate how many FTEs Utah will need to import from the national pool to meet the need for growth. Future analysis should focus on better addressing this growth question.

POLICY RECOMMENDATIONS

1. **Increase the Number of Providers.** Despite suffering from higher rates of mental illness than the national average, Utah has fewer providers per 100,000 people than the nation (171 FTEs and 209 providers per 100,000 people compared to 311 providers per 100,000 people nationally). In order to keep up with population growth and move closer to national ratios over the next 15 years, Utah must more than double the current workforce.
    a. Encourage employers and insurance providers to hire and reimburse all mental health professionals more transparently and equally according to training, scope of practice, and the type of services provided, thereby attracting more providers to either stay in or move to Utah.
    b. Support state and federally funded student loan repayment programs for mental health practitioners in Utah.
    c. Support increases in state funding for mental and behavioral health services.
2. **Promote a More Diverse Workforce.** Only 9.7% of the mental health workforce in Utah identifies as a racial or ethnic minority, compared to 19.7% of the population in the state. Increasing diversity can help ensure that the mental health needs of an increasingly diverse state are being met.
    a. Encourage collaboration with organizations such as United Way, Healthinsight and the Utah Department of Health, local high schools, etc. to encourage minority youth to consider a career in the mental health field.
3. **Strengthen the Rural Workforce.** Utah is facing a mental health provider shortage across all 29 counties, but rural areas are experiencing higher shortfalls than urban areas. While urban Utah has 171 FTEs per 100,000, rural Utah has 141 FTEs per 100,000.
    a. Support state funding for loan repayment programs for mental health providers who practice in rural areas.
    b. Encourage graduate programs to target applicants who come from rural backgrounds as they tend to practice in rural settings more often than their urban counterparts.
    c. Encourage graduate programs to build and maintain rural practicum placements.
4. **Enhance Data Collection.** With this baseline analysis, the UMEC has begun the vital task of tracking the mental health workforce, however additional data is needed in order to make an accurate prediction of the demand for mental health providers.
    a. Continue to conduct regular surveys of the mental health workforce.
    b. Conduct employer surveys and track the workforce that moves into independent practice settings in order to better understand demand and workforce movement.
    c. Support efforts to request legislative change in order to incorporate the UMEC survey into the DOPL licensing process.

d. Partner with graduate schools in the state in order to obtain accurate information on class size and student demographics.
e. Encourage efforts to track retention rates of mental health providers trained in Utah as well as those from Utah who are training out of state.

5. **Support Health Care Integration.** Integrating mental and physical health has so far shown to cut down on repeat ER visits, decrease health care costs, and improve overall health outcomes. Health care integration may increase both the number of mental health providers in the state and the percentage of the population accessing mental health services.
6. **Encourage Further Analysis of Gender Pay Disparities.** The UMEC cannot presently make any firm conclusions regarding the gender pay gap within mental health. The advisory committee recommends further analysis into the subject.

METHODOLOGY

License Data

The Utah Division of Occupational and Professional Licensing (DOPL) provided the UMEC with information for every mental health practitioner in the state. This included those licensed as Associate Clinical Mental Health Counselors, Clinical Mental Health Counselors, Certified Social Workers, Licensed Clinical Social Workers, Associate Marriage and Family Therapists, Marriage and Family Therapists, Certified Psychology Residents, and Psychologists. As of March 2015, there were 7,425 mental health providers holding one of these licenses in Utah.

Design of Survey Instrument

A variety of sources were used in order to design the first Mental Health workforce survey. Several questions included in the instrument are standard with any workforce study the UMEC conducts, however specific wording was changed in order to more accurately apply to the mental health workforce. For example, changing "patient" to "client" in standard questions. Other survey instruments were referred to as well including the Health Resources and Services Administration's Minimum Data Sets for Licensed Professional Counselors and Psychologists (HRSA, 2013), the National Association of Social Workers Workforce Survey (National Association of Social Workers, 2004), and the Substance Abuse & Mental Health Data Archive National Mental Health Services Survey (SAMHSA, 2010). The advisory committee was consulted on each question and additional questions were added at the request of the committee.

Data Collection

The first mailing was done in August of 2015. Respondents were tracked and a second mailing was sent to those who had not returned the survey in October 2015. A third mailing was sent in January 2016 to those who had not responded. Data collection was completed at the end of February 2016. A total of 2,704 surveys were returned for a 36.4% response rate. With a high response rate, the analysis has a confidence interval of 95% +/- 1.1%. Survey responses were given a weight of 2.746 to account for non-respondents.

Data Entry and Analysis

The 2016 Mental Health Workforce Survey was processed using forms and databases created in Microsoft Access. Data entry was completed by All West Communications and data cleaning was conducted in house by UMEC staff. Once the data entry was complete, the information was imported into SPSS for statistical analysis. Analysis began in April 2016.

Survey Limitations

While data entry allowed for respondents to report multiple license type, data analysis did not. An unweighted total of 25 respondents reported having two license types. This did not include those who reported having different license levels of the same type. For example, a respondent reporting that they had both an LCSW and a CSW was analyzed as only having an LCSW. Those who reported having different license types, such as an MFT and an LCSW, were analyzed as only having one license based on their highest mental health degree.

Respondents were asked what populations they generally serve. This question was asked in order to ascertain whether or not any specific populations were being underserved. While the results do not point to any immediate shortfalls, asking what populations providers are currently serving may provide better data.

When asked what health care provider was their main point of contact for prescribing medication, there were some respondents who marked more than one answer. However, only one response was possible in the data entry process. It is probable that in these cases, only the first response in the list was recorded. Because Primary Care Provider was listed first, it may be overrepresented.

The survey offered income brackets with the highest being $110,000 or more. It was not expected that many mental health providers would have income in this range, but 20.2% of Psychologists and 10.8% of Marriage and Family Therapists did. When estimating random income based on income bracket, those on the high end of the spectrum may not have accurate figures as it is not known how much more than $110,000 they are making. Reporting on median income does rectify this issue, however it is recommended that the next survey increase the income brackets.

INTRODUCTION AND BACKGROUND

The Utah Medical Education Council has been charged with conducting periodic analyses of the medical professions in the state of Utah in order to assess workforce supply and demand. Until now, the mental health workforce has been excluded from such analysis. With this report, the UMEC has conducted the first state-wide analysis of the mental health workforce including Clinical Mental Health Counselors (CMHCs), Licensed Clinical Social Workers (LCSWs), Marriage and Family Therapists (MFTs), and Psychologists (PSYCHs), as well as their respective associate level licensed professionals. The mental health workforce is not tracked as closely as other health professions at this time. Only two other states (Virginia and Nebraska) were found that regularly survey and report on this workforce. Because of this, very few comparisons can be made with the national workforce.

Although the population of Utah self-reports as having the third lowest rate of fair or poor physical health, the population also reports as having the fourth highest rate of poor mental health (Kaiser Family Foundation, 2014). Indeed, Utah has higher rates of mental illness and serious thoughts of suicide than the national average (SAMHSA, 2015) and the fifth highest per capita suicide rate in the country (Centers for Disease Control and Prevention, 2014). Despite these facts, Utah has far fewer mental health professionals than the national average.

As a baseline analysis, it is difficult to determine how quickly the workforce has grown. Looking at national trends as well as licensing data allows us to infer that the mental health field has been growing quickly and will continue a steady upward trend. If the Utah workforce is to grow to parity with national provider levels, existing graduate programs will need to utilize maximum training capacities, state funding will have to remain steady or increase, and the state will have to take advantage of graduates of online training programs as well as import out of state graduates.

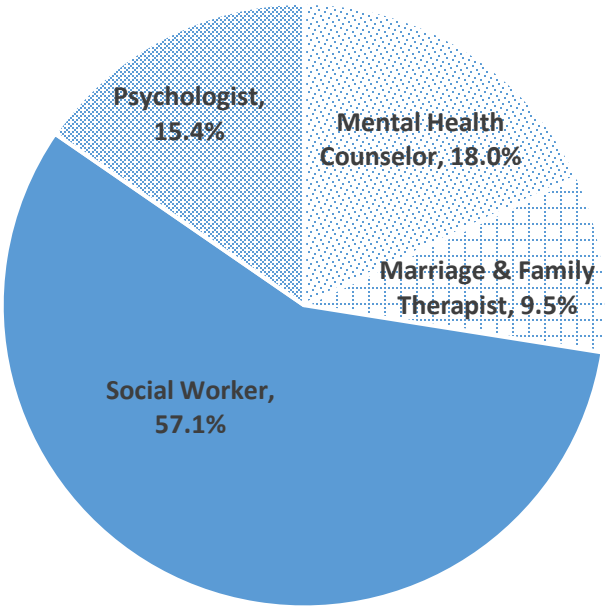
LICENSED IN UTAH

As of March 2015, there were 7,425 mental health professionals licensed in the state of Utah, including 1,282 (17.3%) Clinical Mental Health Counselors, 4,336 (58.4%) Social Workers, 711 (9.6%) Marriage and Family Therapists, and 1,096 (14.8%) Psychologists. The mental health field has seen considerable growth nationally in recent years and is likely to continue growing at a rate faster than average (BLS, 2016).

An estimated 16.7% of mental health providers licensed in Utah report not working in the state. Of those, reasons for maintaining a license in Utah are varied. Prominent reasons include not currently working in mental health due to retirement, family, health, or other reasons but may work in the future (30.1%) and a possibility of moving back to Utah (14.8%), while 9.3% said they are letting their license expire. When asked what factors motivated them to work outside of Utah, family reasons rank number one among Mental Health Counselors, Social Workers, and Marriage and Family Therapists.

In 2015, 82.9% (6,154) of mental health providers licensed in Utah reported working in the state, including 86.5% (1,109) of Clinical Mental Health Counselors, 81.0% (3,512) of Social Workers, 81.9% (582) of Marriage and Family Therapists, and 86.7% (950) of Psychologists. All statistics in the following report refer to the 6,154 mental health providers working in the state unless otherwise noted.

Figure 1: Profession Breakdown of the Mental Health Workforce in Utah



Decision to Practice in Utah

When asked what factors contributed to their deciding to practice in Utah, 70.4% (4,330) of all providers working in Utah cited family reasons. Lifestyle and graduating in Utah were cited by 42.0% (2,584) and 32.0% (1,969) of respondents, respectively.

Table 1: Factors Influencing Decision to Practice in Utah

Rank	Factor
1	Family
2	Lifestyle
3	Utah Graduate
4	Practice Opportunities
5	Practice Environment
6	Other
7	Military

DEMOGRAPHIC CHARACTERISTICS

Age

The average age for all mental health providers is 51. Mental Health Counselors tend to be slightly younger with an average age of 47 and Psychologists tend to be slightly older with an average age of 53. However, in three out of the four professions, more providers are aged 65 or over than all other age cohorts.

Table 2: Average Age by Profession

Profession	Mean Age
CMHC	47
LCSW	51
MFT	51
PSYCH	53
ALL	51

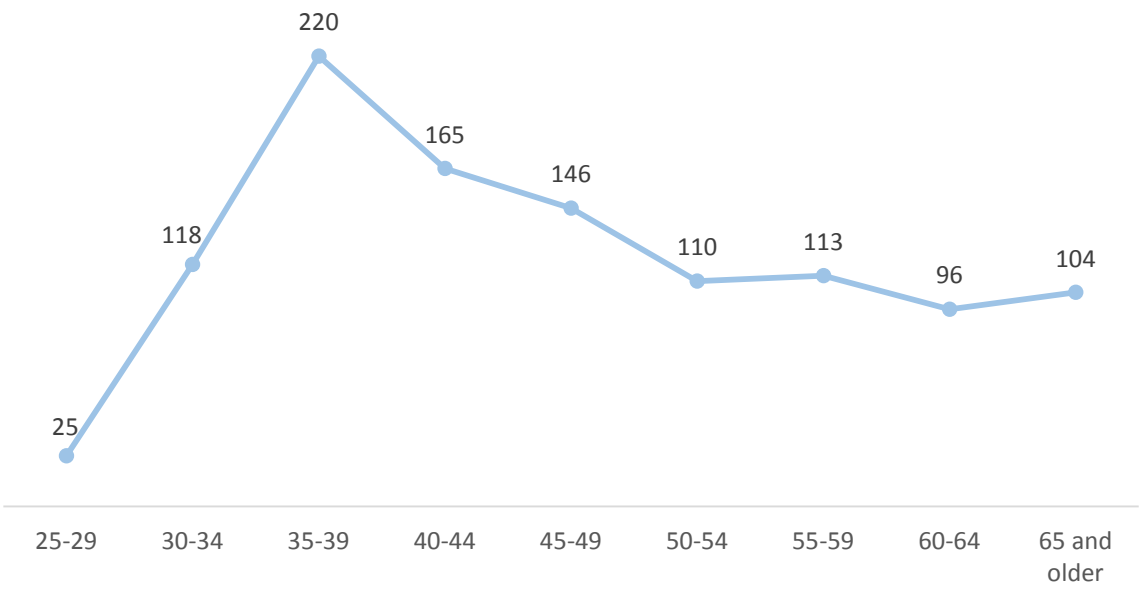
While national data can be difficult to find for these occupations, the Bureau of Labor Statistics (BLS) does provide a source for some comparisons. Although Utah tends to have a younger population and workforce than the nation, the mental health field in Utah is slightly older. Nationally, the median age for Counselors (which includes both Mental Health Counselors and Marriage and Family Therapists) is 43, for Social Workers it is 41, and for Psychologists it is 50 (BLS, 2015).

Table 3: Age Cohort by Profession

	CMHC	LCSW	MFT	PSYCH	ALL
<29	2.2%	1.0%	1.4%	1.4%	1.3%
30-34	10.6%	8.1%	6.1%	5.2%	7.9%
35-39	19.8%	13.1%	15.1%	10.4%	14.1%
40-44	14.9%	14.4%	12.3%	15.3%	14.4%
45-49	13.1%	10.8%	13.2%	10.7%	11.4%
50-54	9.9%	9.1%	11.3%	7.8%	9.2%
55-59	10.1%	12.1%	10.8%	11.3%	11.5%
60-64	8.7%	12.5%	11.3%	12.7%	11.7%
65+	9.4%	18.4%	17.0%	24.3%	17.5%

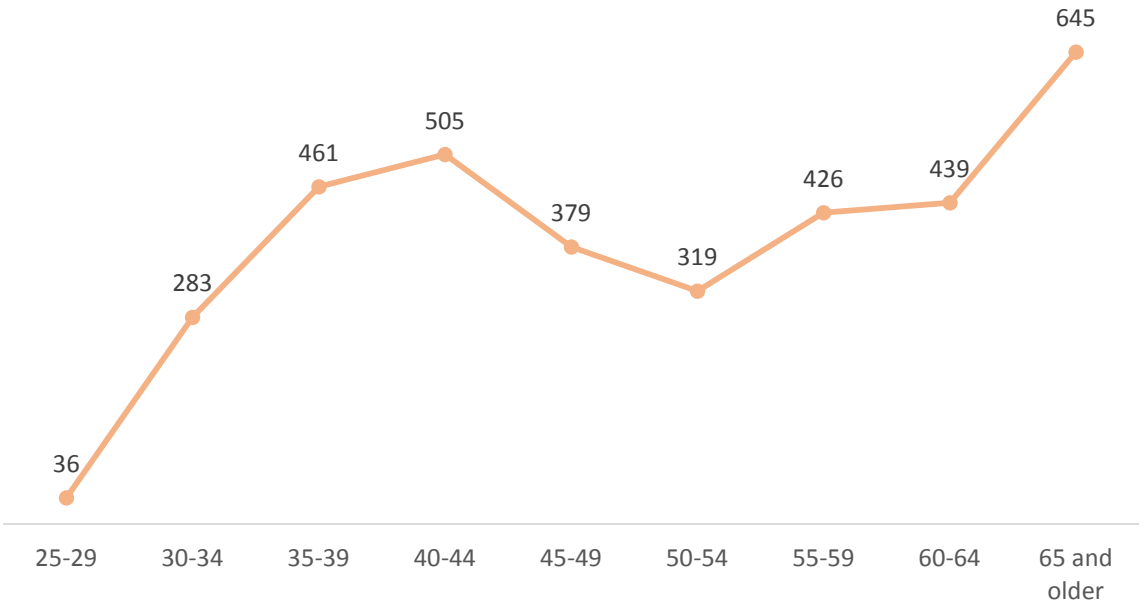
Breaking down age cohort by profession shows a more detailed view of the mental health field. While three of the other mental health professions have their highest percentage of providers aged 65 and over, Clinical Mental Health Counselors are primarily concentrated between the ages of 35-39 (19.8%). Also unique to CMHCs is the fact that a majority of providers are under the age of 50 (60.6%).

Figure 2: CMHC Age Distribution



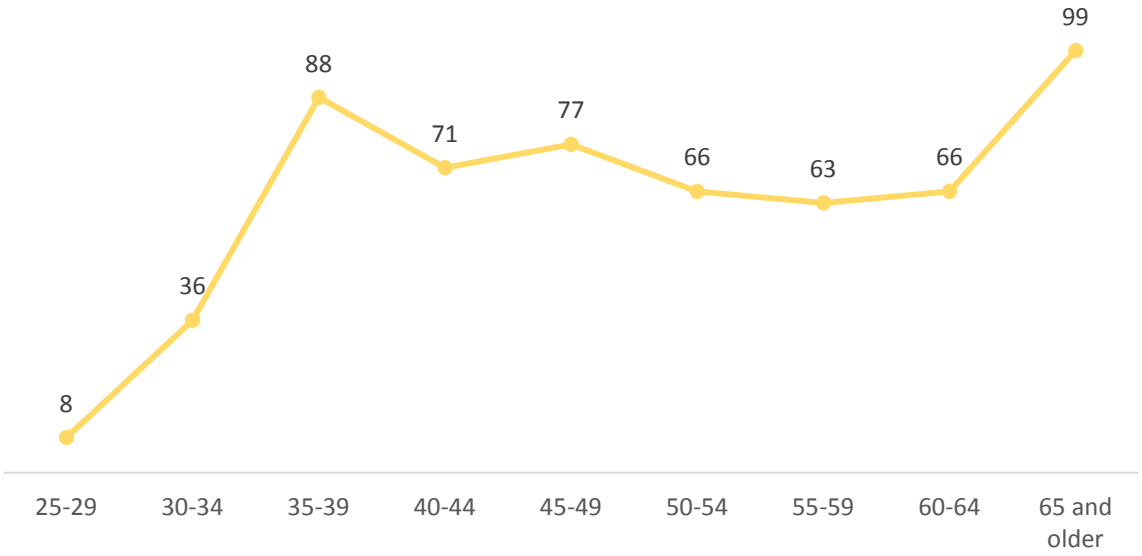
A small majority of Social Workers are 50 years or older (52.1%). This is due in large part to the fact that 18.4% of the workforce is over the age of 65.

Figure 3: LCSW Age Distribution



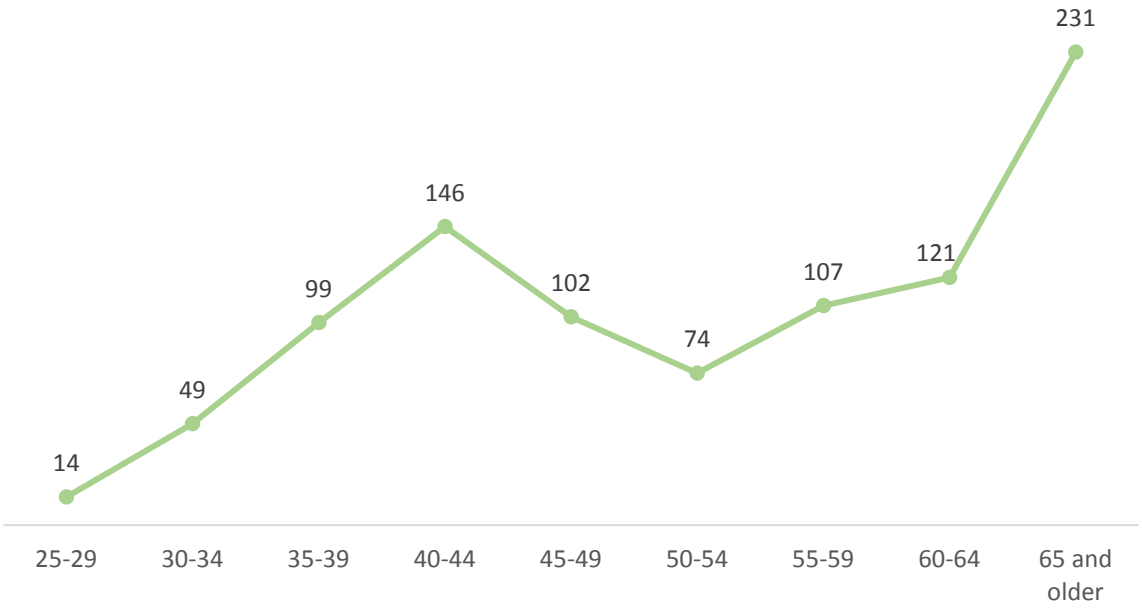
Marriage and Family Therapists are more evenly distributed among age cohorts than the other three professions. Just over half of all MFTs are 50 years or older (50.2%)

Figure 4: MFT Age Distribution



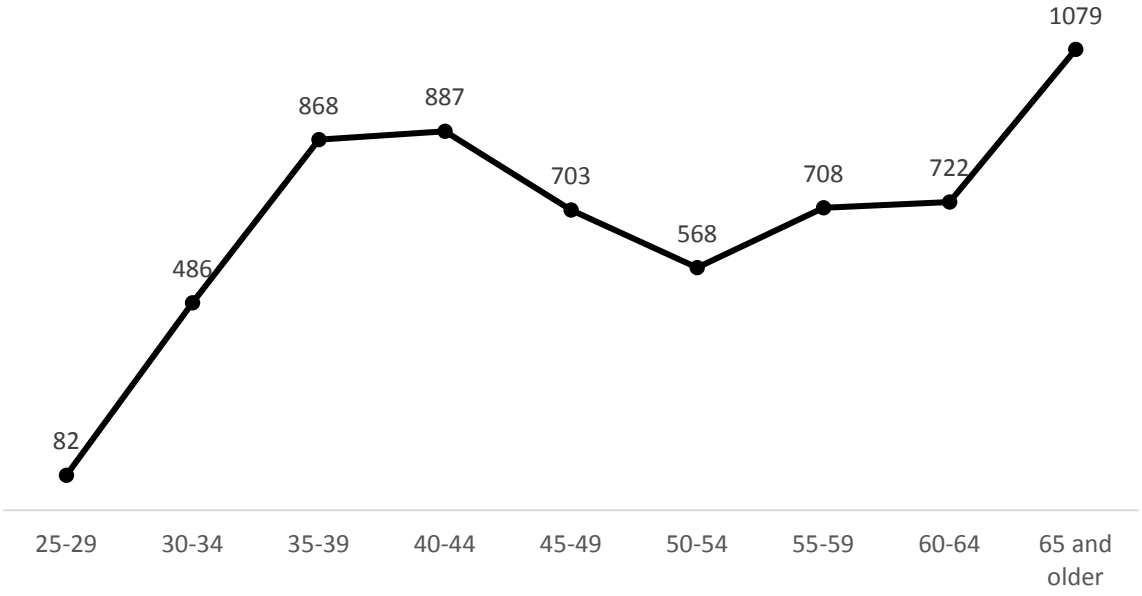
Psychologists tend to be older than the other three professions. Almost a quarter of all Psychologists are 65 or older (24.3%) and over half are 50 years or older (56.1%).

Figure 5: PSYCH Age Distribution



Taken together, there are more providers aged 65 and older than any other single cohort. Although many mental health professionals plan on simply reducing their hours as opposed to retiring completely (discussed later in this report), it may be difficult to replace such a large cohort as they age out of the profession.

Figure 6: Total Mental Health Provider Age Distribution

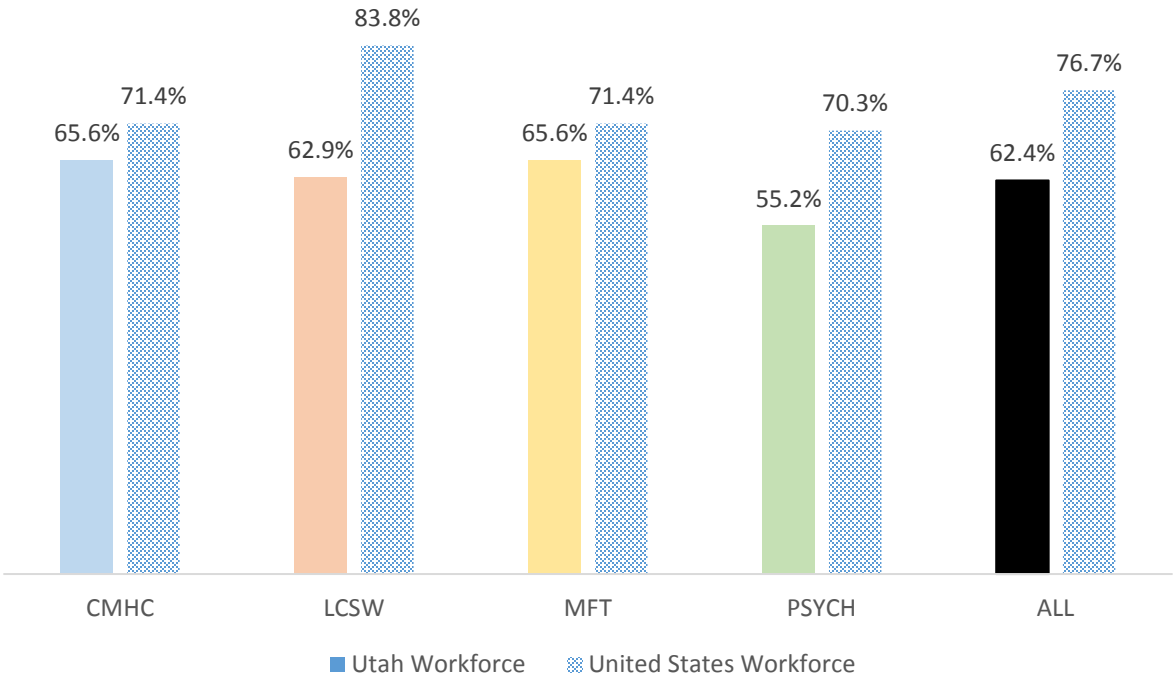


Gender

The mental health field has long been female dominated. Currently 62.4% (3,842) of the workforce in Utah is female. However, Utah has a slightly lower percentage of women in the workforce compared to national data (BLS, 2015). The biggest gap can be seen in Social Workers, with women making up 62.9% of the Utah workforce and 83.8% of the national workforce. Meanwhile, Mental Health Counselors and Marriage and Family Therapists see the lowest gap with women making up 65.6% of the workforce in Utah[1] and 71.4% of the workforce nationally.

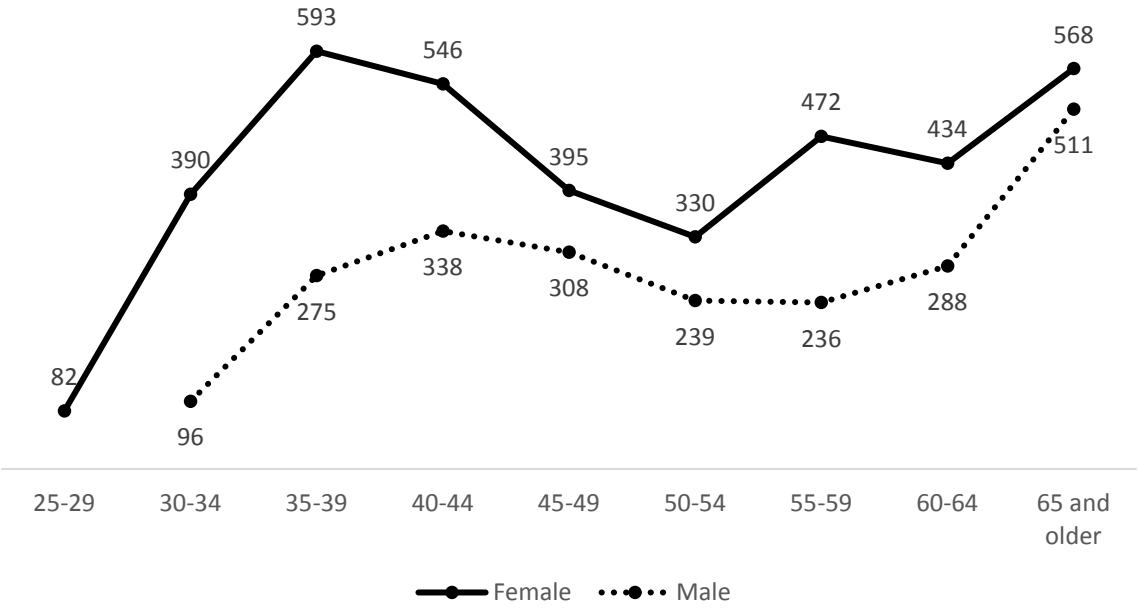
[1] The BLS combines CMHCs and MFTs into the same group while the UMEC separates the two. Each profession has 65.6% of the workforce identifying as female in Utah. When combined, that number increases slightly to 65.7% of all CMHCs and MFTs.

Figure 7: Percentage of Female Workforce in Utah and United States



Broken down by age cohort, women outnumber men at every level overall. However, the gap is more pronounced in the younger cohorts, with no men under the age of 30 currently in the workforce.

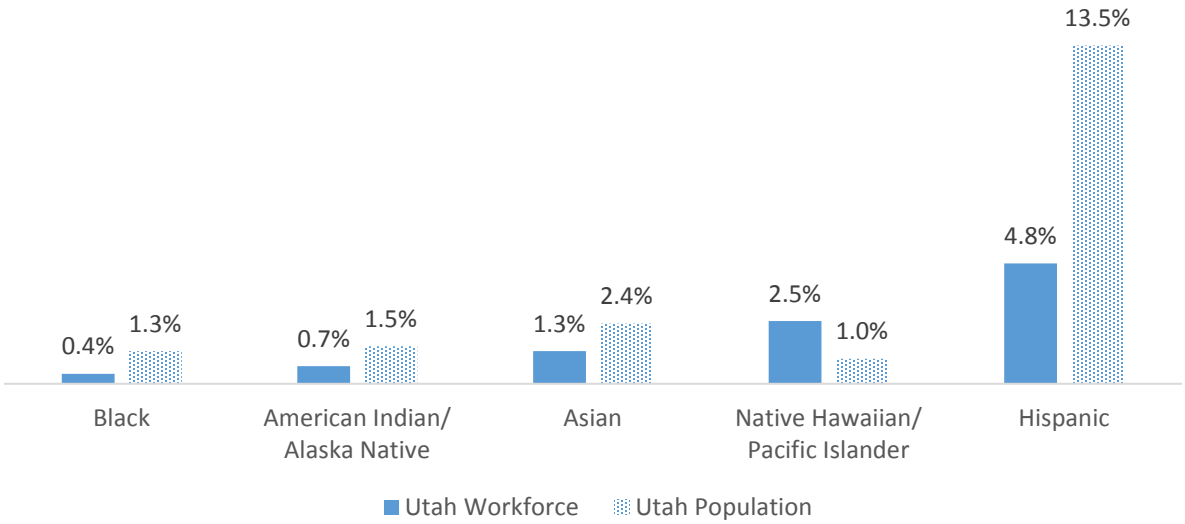
Figure 8: Total Mental Health Provider Age Cohort by Gender



Race/Ethnicity

The mental health workforce in Utah is predominantly White/Caucasian with a total of 92.5% of the Utah workforce identifying as such. Other than Native Hawaiian/Pacific Islander, every major minority group is underrepresented in the mental health field when compared to the general population in the state. In Utah, Native Hawaiian/Pacific Islanders make up 1.0% of the population but are slightly overrepresented among Mental Health Counselors (3.2%), Social Workers (2.2%), Marriage and Family Therapists (2.8%), and Psychologists (2.3%). The only other minority group to come close to proportional representation are Asians, but only among Psychologists, with 2.3% of the Psychologist workforce and 2.4% of the general population. Hispanics, the minority group with the biggest representation gap, see similar employment numbers in each profession, ranging from 4.5% to 4.9% of each mental health profession.

Figure 9: Racial Composition of Mental Health Workforce vs. Utah Population



Upbringing

A total of 44.0% (2,710) of all mental health providers in Utah spent the majority of their upbringing in the state.[2] Other states include California (7.6%, 470), Idaho (2.5%, 157), Arizona (1.8%, 110), Colorado (1.7%, 102), and New York (1.5%, 91). A total of 18.8% (1,159) of Utah's mental health workforce were brought up in one of the ten states in the western region of the U.S.[3] However, differences do arise when breaking these numbers down by profession, as shown in the tables below.

[2] This question had a non-response rate of 21.9%. The numbers reported include non-responses.
[3] Arizona (1.8%), California (7.6%), Colorado (1.7%), Idaho (2.5%), Montana (0.7%), Nevada (0.7%), New Mexico (0.5%), Oregon (1.4%), Washington (1.0%), and Wyoming (0.8%).

Table 4: State/Region of Origin by Profession

ALL		
State/Region	**Percent**	**Count**
Utah	44.0%	2,710
California	7.6%	470
Idaho	2.5%	157
Arizona	1.8%	110
Colorado	1.7%	102
New York	1.5%	91
Western Region	18.8%	1,159

CMHC		
State/Region	**Percent**	**Count**
Utah	50.5%	560
California	5.2%	58
Arizona	2.2%	25
Idaho	2.0%	22
Colorado	1.5%	16
Missouri; International*	1.2%	14
Western Region	15.6%	173

LCSW		
State/Region	**Percent**	**Count**
Utah	47.0%	1,650
California	6.5%	228
Idaho	2.6%	91
Colorado	1.8%	63
Arizona; New York; Oregon*	1.6%	58
Illinois	1.2%	41
Western Region	17.4%	612

MFT		
State/Region	**Percent**	**Count**
Utah	38.7%	225
California	13.7%	80
Idaho	3.3%	19
Washington	2.8%	16
Texas	1.9%	11
Colorado, Connecticut, Texas*	1.4%	8
Western Region	25.9%	151

*Each state listed has equal numbers

PSYCH		
State/Region	**Percent**	**Count**
Utah	28.9%	275
California	11.0%	104
Idaho; Missouri*	2.6%	25
Arizona	2.3%	22
Connecticut; New York	1.7%	16
Colorado; Minnesota; Montana; Oklahoma; Pennsylvania*	1.4%	14
Western Region	23.4%	222

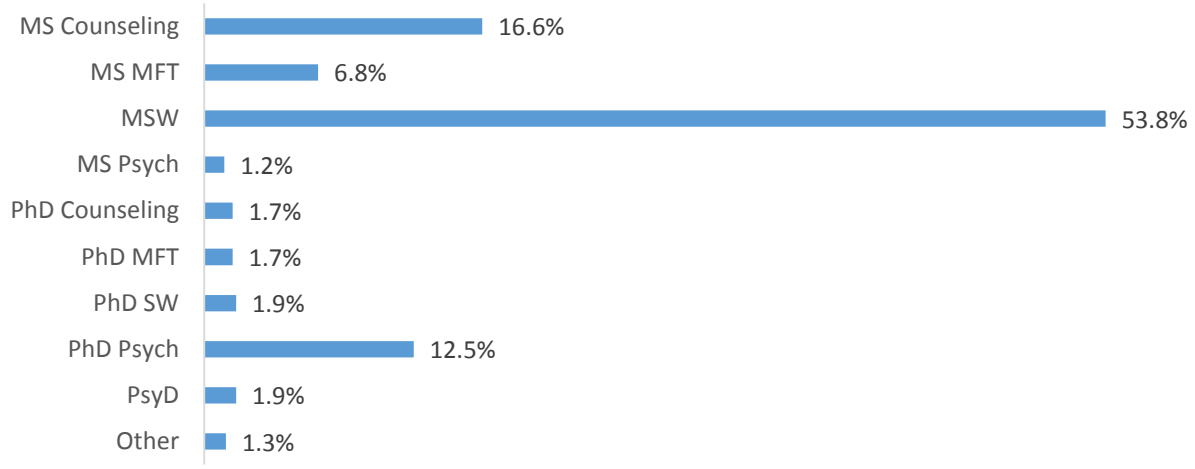
Respondents were also asked whether they spent the majority of their upbringing in a rural, suburban, or urban setting. Overall, 24.6% (1,516) grew up in a rural setting, 52.3% (3,216) grew up in a suburban setting, and 18.2% (1,118) grew up in an urban setting. Marriage and Family Therapists saw the highest rate of rural backgrounds (25.0%, 146) while Social Workers had the highest rate of urban backgrounds (10.5%, 684). Conversely, Psychologists had the lowest rate of rural backgrounds (23.4%, 222) and Marriage and Family Therapists had the lowest rate of urban backgrounds (13.7%, 80).

Education Background

Among the mental health workforce, 72.4% (4,457) obtained their highest mental health degree in Utah while 26.6% (1,634) obtained their degree out of state. Other states that fed into the Utah workforce include California (4.1%, 250), Arizona (1.8%, 113), Texas (1.7%, 107), Colorado (1.7%, 104), and Washington (1.6%, 99). The Western Region accounts for 12.2% (750) of the mental health workforce.

A total of 8.3% of the workforce grew up in Utah but trained out of state. Only 13.3% of the state's mental health workforce has no ties to Utah, that is, they neither grew up nor were educated in the state. On the other hand, 64.8% of the workforce grew up or received their professional mental health training here. Even with a high non-response rate,[4] it is clear that Utah is not relying on bringing in employees from other states. While there are high school- and bachelor's-level mental health professionals, only those with a master's degree or above can obtain a license to practice therapy, therefore, none of the providers we surveyed had obtained a degree below a master's. For Psychologists, the requirement is a doctoral level degree.

Figure 10: Mental Health Workforce Highest Degree Obtained



[4] Non-response rate for which state providers grew up in was 21.9%.

By profession, a vast majority of Mental Health Counselors, Social Workers, and Marriage and Family Therapists obtained a master's degree in their respective disciplines. For Psychologists, the same is true at the doctoral level. Other than Psychologists, more Marriage and Family Therapists have obtained a PhD (22.7%) than the other two professions, while Mental Health Counselors have the smallest proportion of PhD's (3.7%). Marriage and Family Therapists have the highest proportion of providers with degrees in something other than Marriage and Family Therapy (13.3%), followed by Psychologists (8.7%), Mental Health Counselors (8.6%), and Social Workers (2.5%).

Table 5: Highest Degree Obtained by Profession

Mental Health Counselors			
MS Counseling	**PhD Counseling**	**Other MS**	**Other PhD**
89.6%	1.5%	6.4%	2.2%
Social Workers			
MSW	**PhD Social Work**	**Other MS**	**Other PhD**
94.0%	3.1%	1.2%	1.3%
Marriage and Family Therapists			
MS MFT	**PhD MFT**	**Other MS**	**Other PhD**
69.8%	15.6%	7.1%	6.2%
Psychologists			
PhD Psych	**PsyD**	**PhD Counseling**	**PhD Social Work**
77.7%	10.4%	8.4%	0.3%

A total of 21.0% (1,293) of the mental health workforce graduated since 2010 and 59.8% (3,682) graduated since 2000. Conversely, 37.5% (2,307) graduated before 2000. Similar numbers are seen with Social Workers and Marriage and Family Therapists, however, Mental Health Counselors and Psychologists are more varied. Mental Health Counselors have the highest numbers graduated since 2000 at 80.4% (892). Half of all CMHCs (50.0%, 555) graduated between 2000 and 2009 and 30.4% (338) have graduated since 2010, suggesting faster growth in that profession over the last 15 years. On the other hand, a majority of Psychologists (58.1%, 552) graduated before 2000 with 11.6% (110) graduating since 2010. Psychology graduates are much more evenly dispersed across time.

Table 6: Graduation Decade by Profession

	1960-1969	1970-1979	1980-1989	1990-1999	2000-2009	2010+
CMHC	0.2%	1.2%	3.2%	9.9%	50.0%	30.4%
LCSW	0.7%	5.2%	11.6%	20.7%	39.3%	19.9%
MFT	0.9%	6.1%	10.8%	24.5%	29.7%	25.5%
PSYCH	1.7%	9.2%	20.2%	26.9%	29.5%	11.6%
ALL	0.8%	5.2%	11.4%	20.1%	38.8%	21.0%

A majority of mental health providers (59.5%, 3,660) attended a state university for their mental health training while 33.7% (2,076) attended a private university. There are some stark differences when breaking these numbers down by profession. While a majority of Social Workers and Psychologists attended a state university (74.7% and 54.3%, respectively), the proportion is flipped when looking at Mental Health Counselors and Marriage and Family Therapists.

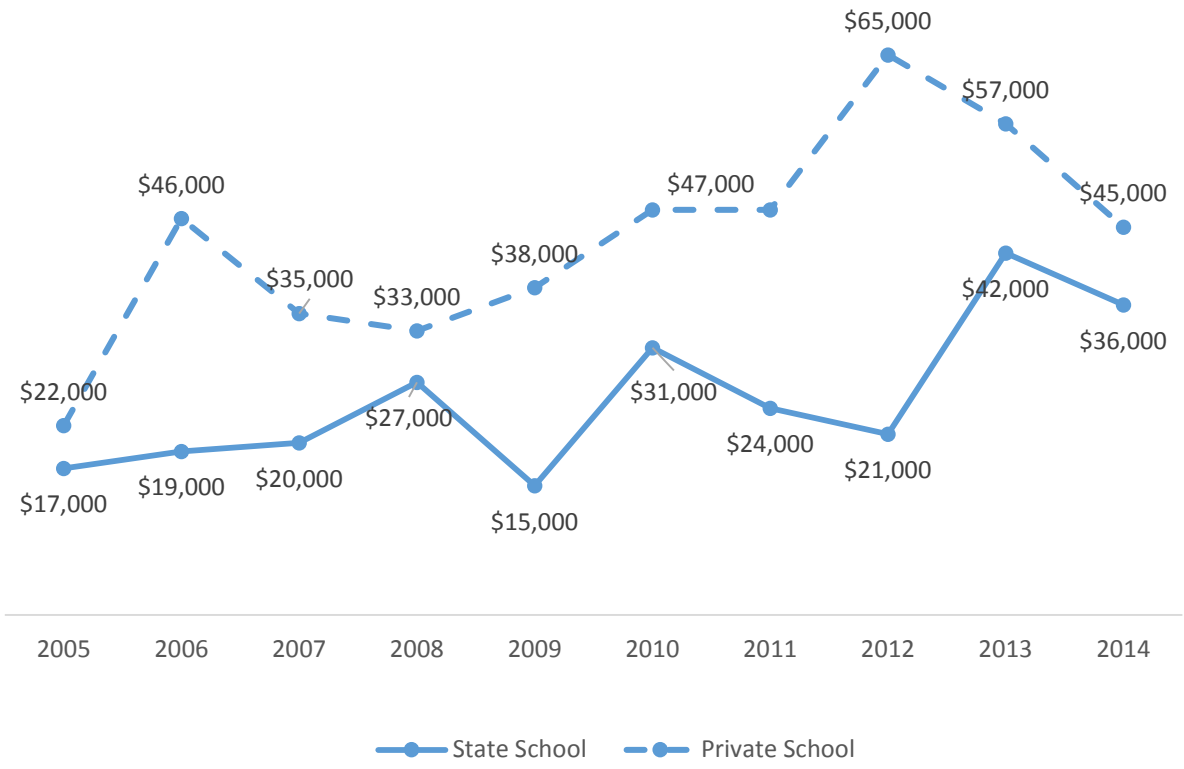
Table 7: University Type by Profession

	State University	Private University
CMHC	27.2%	63.4%
LCSW	74.7%	18.8%
MFT	37.3%	57.5%
PSYCH	54.3%	39.6%
ALL	59.5%	33.7%

The high proportion of private university graduates among CMHCs and MFTs could have far reaching implications, such as educational debt, which, in turn, may affect job satisfaction (discussed later in this report). While the survey did not ask what specific school providers had attended, DOPL does offer an opportunity for providers to list their school when applying for or renewing a license. Of the Mental Health Counselors who are licensed in Utah, 89.7% listed a school with DOPL, 37.3% listed University of Phoenix, a for-profit university. Marriage and Family Therapists listed schools with DOPL only 48.0% of the time, but for-profit universities were less common.

The median amount of educational debt for all mental health providers is $13,000 at the time of graduation and $0 currently, although current debt changes drastically when just looking at providers who still have outstanding student loans (discussed below). These numbers also vary when looking at the time of graduation and the type of school attended. For those who have graduated since 2005, the median debt at time of graduation is $24,000 from state universities and $46,000 from private universities. The educational debt at time of graduation has gone up since 2005 both at state and private universities.

Figure 11: Median Debt at Graduation, 2005-2014 by School Type



The median debt that all mental health providers held as of 2015 is $700 from state universities and $24,000 from private universities. However, when removing respondents with no outstanding student loans, who are often further removed from their graduation date, median current debt jumps up to $42,000 for graduates of state universities and $61,000 for graduates of private universities. Of the three master's level providers (CMHCs, LCSWs, and MFTs), Clinical Mental Health Counselors have higher debt across school type and time.

Table 8: Median Debt at Time of Graduation and at Time of Survey by Profession and School Type Among Respondents with Outstanding Student Loans

	State University		Private University	
	Original Debt	Current Debt	Original Debt	Current Debt
CMHC	$49,000	$32,000	$58,000	$46,000
LCSW	$31,000	$23,000	$70,000	$64,000
MFT	$40,000	$29,000	$44,000	$29,000
PSYCH	$65,000	$42,000	$87,000	$63,000
ALL	$42,000	$30,000	$61,000	$53,000

Only 11.6% (711) of mental health providers participate in a loan repayment program (LRP). This includes 13.1% (146) of Clinical Mental Health Counselors, 12.6% (442) of Social Workers, 6.1% (36) of Marriage and Family Therapists, and 9.2% (88) of Psychologists. Participation varies across different LRP's, but the Public Service LRP was the most common with 4.7% (288) of providers.

Income

The median income for all mental health providers is $56,000. Broken down by profession, Clinical Mental Health Counselors have a median income of $49,000, Social Workers $55,000, Marriage and Family Therapists $57,000, and Psychologists $86,000. This is higher than national averages taken from the Bureau of Labor Statistics (United States Department of Labor, Bureau of Labor Statistics, 2016).

Table 9: Median Income Utah vs. National by Profession

	Utah Median	National BLS
CMHC	$49,000	$42,000[5]
MFT	$57,000	
LCSW	$55,000	$46,000
PSYCH	$86,000	$71,000

Income for Clinical Mental Health Counselors, Social Workers, and Marriage and Family Therapists tends to be concentrated between $40,000 and $69,999, while Psychologists are concentrated at the higher end of the spectrum at $86,000.

[5] BLS Combines Mental Health Counselors and Marriage and Family Therapists into one profession.

Figure 12: Yearly Gross Income of Utah Clinical Mental Health Counselors

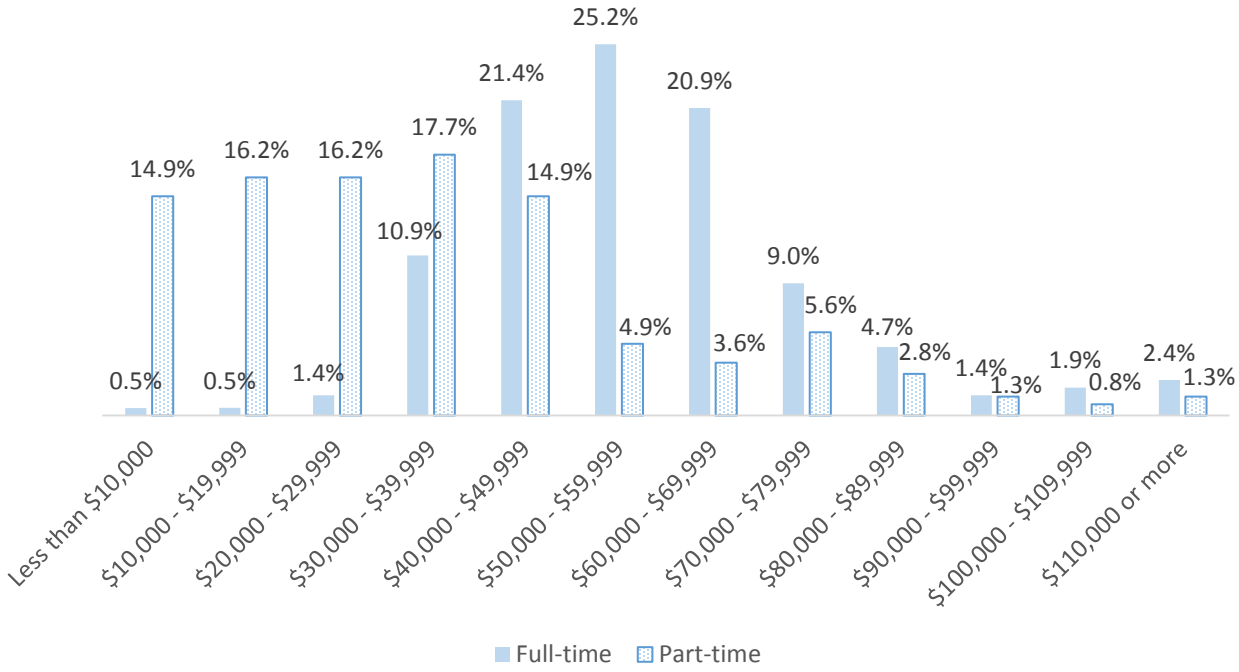


Figure 13: Yearly Gross Income of Utah Social Workers

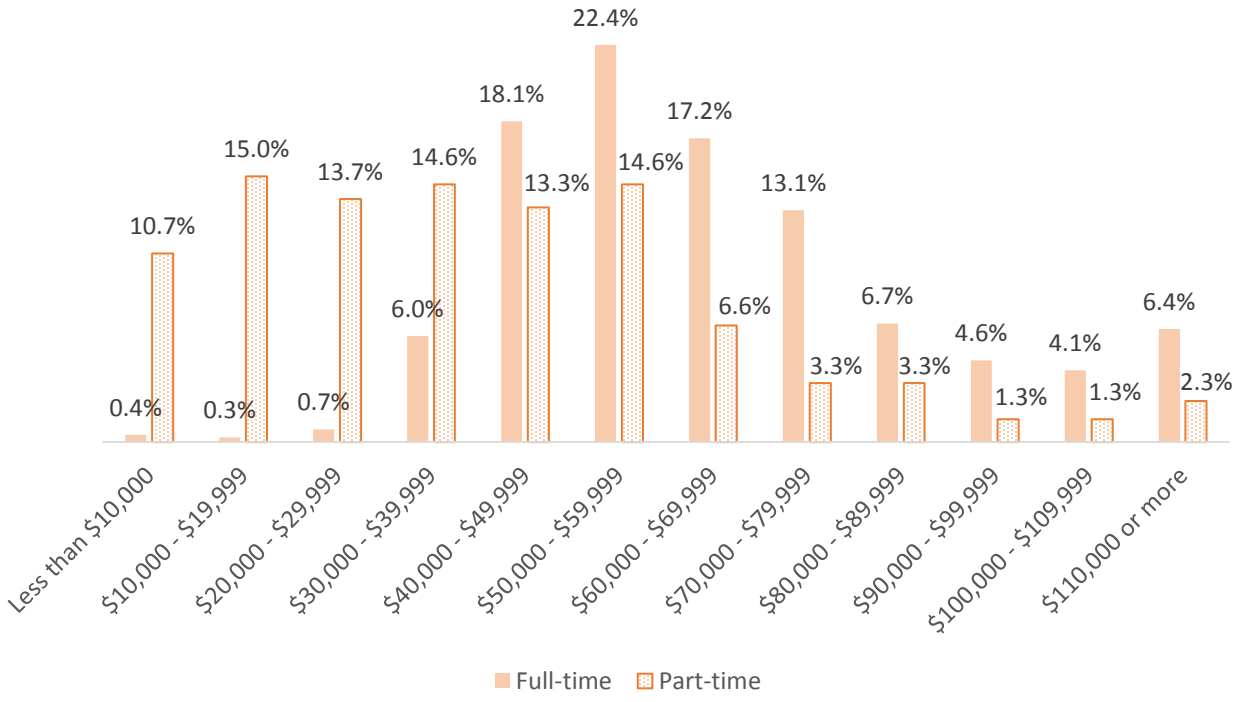


Figure 14: Yearly Gross Income of Utah Marriage and Family Therapists

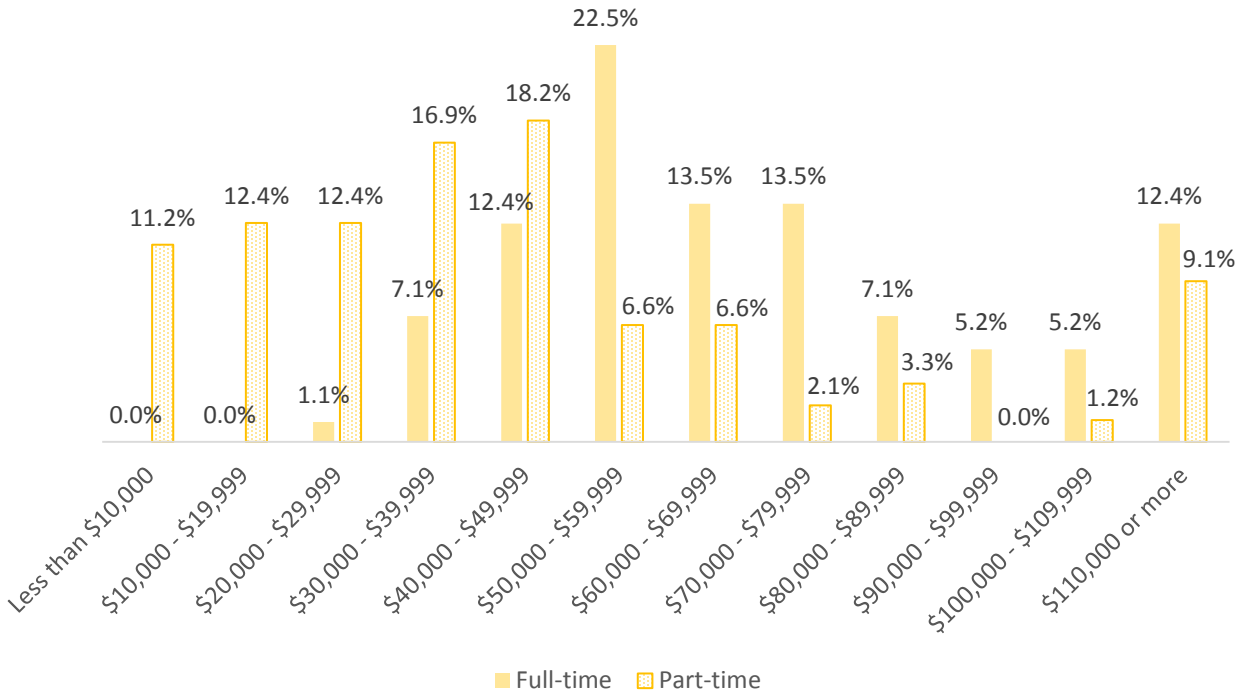
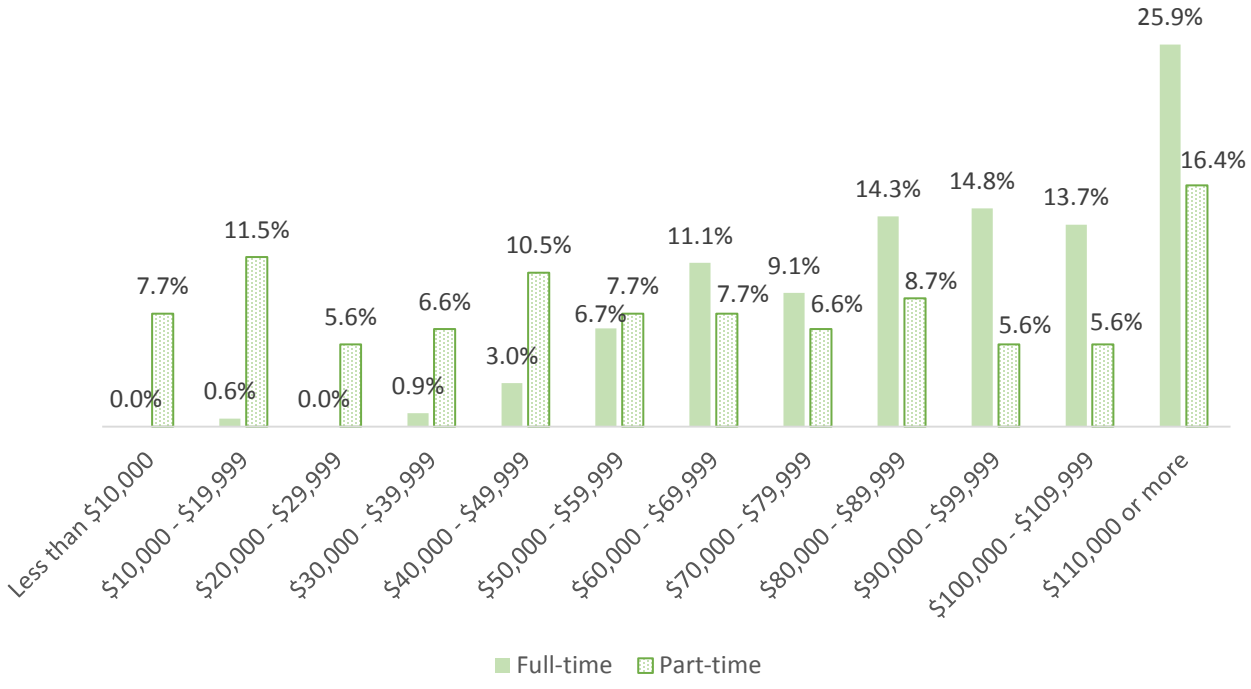


Figure 15: Yearly Gross Income of Utah Psychologists



Median income for full-time vs. part-time work varies by profession, especially when comparing Psychologists to the master's level professions. For example, the median income for a part-time Psychologist is roughly equal to the median income for a full-time Social Worker.

Table 10: Median Income by Profession and Full-time Status

	Part-time	Full-time
CMHC	$31,000	$56,000
LCSW	$38,000	$61,000
MFT	$38,000	$67,000
PSYCH	$62,000	$93,000
ALL	$38,000	$64,000

When breaking median income down by race and ethnicity, there are some variances that are not statistically significant. However, differences in income broken down by gender are statistically significant,[6] with male providers making an average of $3,000 more than female providers when controlling for no other variables. This difference increases when looking at part-time vs. full-time providers.

Table 11: Median Income of Male and Female Providers by Full-time Status

	Male	Female
Part-time	$41,000	$37,000
Full-time	$68,000	$62,000
ALL	$58,000	$55,000

When controlling for variables such as profession, years of experience, and practice setting, the pay gap between genders is not universal, however patterns appear, particularly with Psychologists, that could potentially still be problematic. Further analysis is needed in order to make any definite claims on the subject.

[6] p=.007

Table 12: Median Income by Gender and Graduation Decade

CMHC		
Graduation Decade	**Male Median Income**	**Female Median Income**
1980-1989	$32,000	$53,000
1990-1999	$54,000	$57,000
2000-2009	$52,000	$51,000
2010+	$42,000	$43,000
LCSW		
Graduation Decade	**Male Median Income**	**Female Median Income**
1980-1989	$72,000	$71,000
1990-1999	$67,000	$63,000
2000-2009	$54,000	$55,000
2010+	$44,000	$44,000
MFT		
Graduation Decade	**Male Median Income**	**Female Median Income**
1980-1989	$62,000	$82,000
1990-1999	$77,000	$68,000
2000-2009	$43,000	$58,000
2010+	$41,000	$41,000
PSYCH		
Graduation Decade	**Male Median Income**	**Female Median Income**
1980-1989	$104,000	$98,000
1990-1999	$98,000	$93,000
2000-2009	$91,000	$77,000
2010+	$64,000	$69,000

Table 13: Median Income by Gender and Most Common Practice Settings

CMHC		
Primary Setting	**Male Median Income**	**Female Median Income**
Mental Health Clinic	$48,000	$44,000
Independent Solo Practice	$46,000	$41,000
Substance Abuse Treatment	$50,000	$49,000
Residential Facility	$57,000	$68,000
Independent Group Practice	$41,000	$41,000
LCSW		
Primary Setting	**Male Median Income**	**Female Median Income**
Independent Solo Practice	$54,000	$55,000
Mental Health Clinic	$54,000	$49,000
Public Hospital	$57,000	$55,000
Other Private Non-profit	$57,000	$43,000
Residential Facility	$72,000	$59,000
MFT		
Primary Setting	**Male Median Income**	**Female Median Income**
Independent Solo Practice	$55,000	$57,000
Mental Health Clinic	$46,000	$46,000
Independent Group Practice	$36,000	$38,000
Residential Facility	$74,000	$69,000
Other Private Non-profit	$52,000	$35,000
PSYCH		
Primary Setting	**Male Median Income**	**Female Median Income**
Independent Solo Practice	$86,000	$75,000
College/University Counseling	$81,000	$79,000
Independent Group Practice	$93,000	$73,000
Mental Health Clinic	$74,000	$73,000
Veterans Facility	$99,000	$92,000

Median income also varies by location and setting. Rural providers make an average of $4,000 less than their urban and suburban counterparts. This difference increases drastically with Psychologists. However, both Mental Health Therapists and Marriage and Family Therapists make more in rural settings than in urban settings.

Table 14: Median Income by Geographic Location and Profession

	CMHC	LCSW	MFT	PSYCH
Rural	$51,000	$53,000	$64,000	$63,000
Urban	$48,000	$55,000	$57,000	$86,000

The lowest paid setting pays roughly $42,000 less than the highest paid setting. However, this is due in part because of the fact that Psychologists are found in Academic and Veterans settings at a higher rate than the master's level professions.

Table 15: Five Highest Paying Settings

Setting	Median Income
Academic Institution (teaching)	$82,000
Veterans Facility	$79,000
College/University Counseling Center	$71,000
Primary or Specialist Medical Facility	$65,000
Residential Facility	$64,000

Table 16: Five Lowest Paying Settings

Setting	Median Income
Hospice Setting	$40,000
Methadone Clinic	$45,000
Other Private Non-profit	$48,000
Rehabilitation Facility	$50,000
Mental Health Clinic	$51,000

PRACTICE CHARACTERISTICS

Geographic Distribution

There are mental health providers in 27 of Utah's 29 counties, with Daggett and Piute being the only counties with no reporting providers. LCSWs are found in 26 counties, followed by CMHCs in 20 counties, MFTs in 18, and Psychologists in 16. Among many counties, the ratio of mental health providers to general population is fairly similar with only a few exceptions. The distribution within most counties falls within one percentage point in all but Davis, Salt Lake, Utah, and Weber counties. Mental health providers are underrepresented in Davis by 5.0%, in Utah by 2.9% and in Weber by 1.8%. Providers are overrepresented in Salt Lake by 11.1%.

Salt Lake County holds 51.9% (1,823) of the state's Social Workers and 50.9% (483) of its Psychologists, but only 28.3% of Marriage and Family Therapists. Utah County holds 23.6% (137) of the state's MFTs and 21.7% (206) of Psychologists, but only 13.6% (151) of CMHCs and 14.2% (500) of LCSWs. Davis County holds only 4.6% (44) of Psychologists but 7.2% (80) of CMHCs.

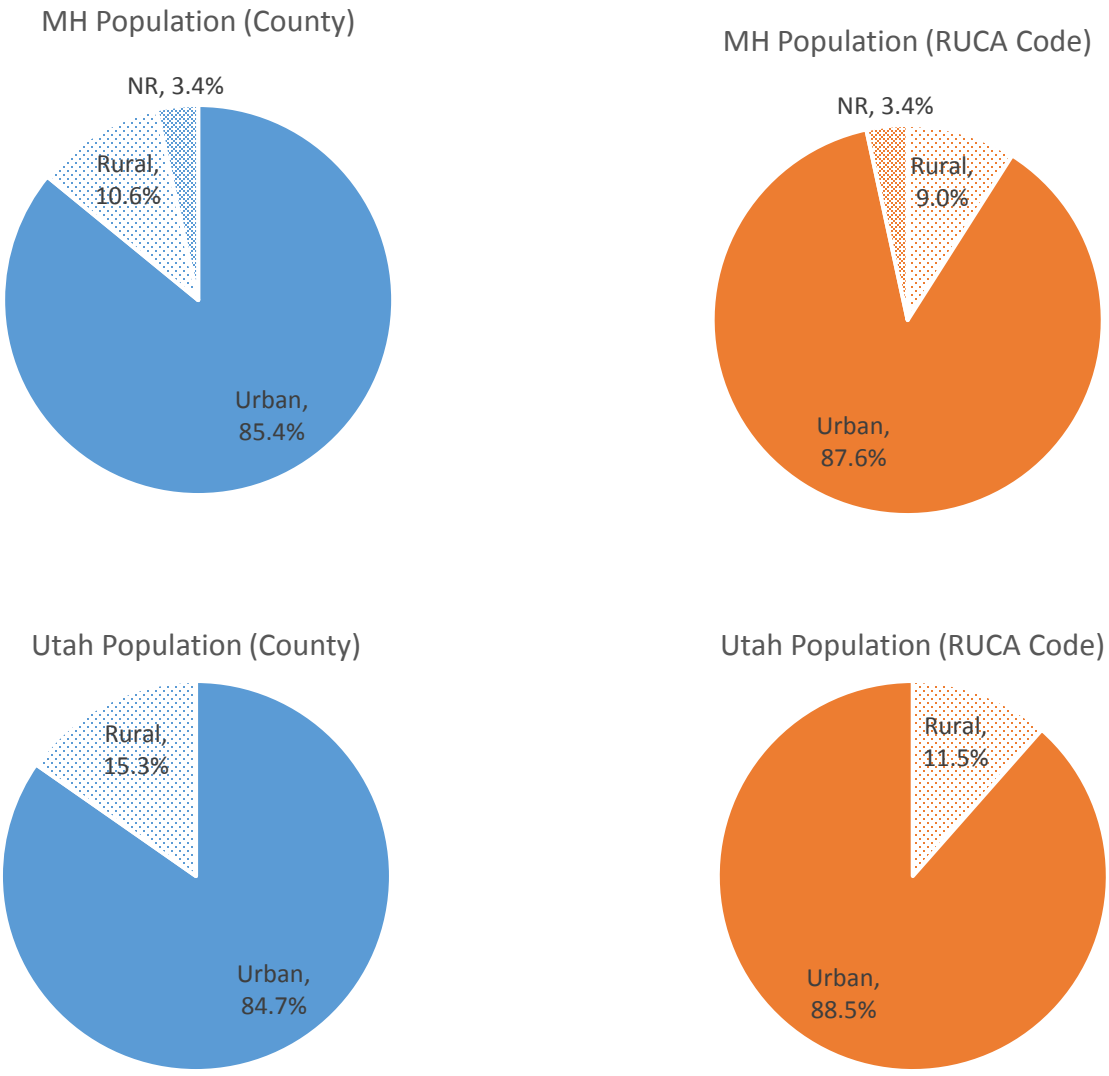
Table 17: County Distribution by Profession

County	CMHC	LCSW	MFT	PSYCH	ALL	UT Pop
Beaver	---	0.5%	---	---	0.3%	0.2%
Box Elder	1.0%	0.6%	2.4%	0.6%	0.8%	1.8%
Cache	1.2%	2.2%	6.6%	6.4%	3.1%	4.0%
Carbon	0.5%	0.6%	0.9%		0.6%	0.7%
Daggett	---		---	---		0.04%
Davis	7.2%	6.3%	6.6%	4.6%	6.2%	11.2%
Duchesne	---	0.6%			0.4%	0.7%
Emery	---	.02%		---	0.1%	0.4%
Garfield	---		---	---		0.2%
Grand	0.5%	.05%	---	0.6%	0.5%	0.3%
Iron	3.0%	1.5%	0.9%		1.5%	1.6%
Juab	---	0.2%	---	---	0.1%	0.4%
Kane				---	0.1%	0.2%
Millard	0.7%	0.2%	---	---	0.3%	0.4%
Morgan	---	0.2%	---	---	0.1%	0.4%
Piute	---	---	---	---	---	0.1%
Rich	0.5%		---	---	0.1%	0.1%
Salt Lake	44.6%	51.9%	28.3%	50.9%	48.2%	37.1%
San Juan		0.2%	---	---	0.2%	0.5%
Sanpete	2.2%	0.6%	1.4%		0.9%	1.0%
Sevier		0.5%	---		0.4%	0.7%
Summit	2.2%	1.0%	4.2%	1.7%	1.7%	1.3%
Tooele	1.7%	0.8%	0.9%		0.9%	2.1%
Uintah	0.5%	0.8%	1.4%		0.7%	1.3%
Utah	13.6%	14.2%	23.6%	21.7%	16.2%	19.1%
Wasatch	1.5%	0.5%	1.4%	---	0.7%	0.9%
Washington	7.4%	4.8%	7.5%	3.2%	5.3%	5.2%
Wayne	---	---		---		0.1%
Weber	5.4%	6.9%	7.5%	5.2%	6.4%	8.2%

Fewer than 5 providers --- Zero

Another way to look at geographic distribution is through Rural-Urban Commuting Area (RUCA) Codes (United States Department of Agriculture, 2014). Rather than looking at entire counties, RUCA Codes allow for a zip-code distribution based on both population and commuting habits. When splitting up rural and urban areas based on RUCA codes, the distribution of providers seems closely aligned to the rural population. While 11.5% of the general population lives in rural areas (United States Census Bureau, 2015), 9.0% of the mental health workforce practices in rural locations.

Figure 16: Mental Health and Utah Populations Location, County and RUCA Code

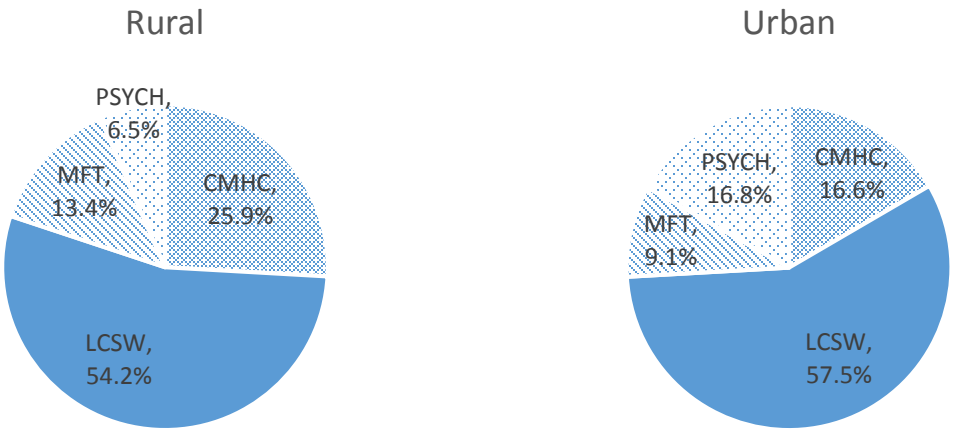


While the breakdown of rural/urban providers looks fairly even, the population to provider ratio is still skewed in favor of urban populations. For every 100,000 people, urban areas in Utah have 170 full-time equivalent (FTEs) providers and rural areas have 141 FTEs. Combined, there are 171

FTEs for every 100,000 people throughout the state, whereas nationally, there are 311 providers for every 100,000 people.

The rural/urban breakdown of professions is not even. CMHCs and MFTs share a larger portion of the rural workforce while LCSWs and Psychologists share a larger portion of the urban workforce.

Figure 17: Profession Breakdown by Rural and Urban Settings



Practice Setting

The vast majority of respondents are working in a mental health setting that requires a license (89.8%, 5,528). Other respondents stated that they are in a mental health setting that doesn't require a license (3.2%, 198) or working on a volunteer basis only (0.1%, 8). There are no major variations among the different professions.

Most (43.9%, 2,699) of the mental health providers are working on a salary-basis. Another 22.2% (1,365) work at an hourly rate and 31.3% (1,925) are self-employed. However, this does vary by profession.

Table 18: Employment Arrangement by Profession

	CMHC	LCSW	MFT	PSYCH	ALL
Self-employed	28.7%	26.1%	42.9%	46.2%	31.3%
Hourly	30.4%	24.2%	19.8%	6.4%	22.2%
Salaried	36.9%	47.1%	35.4%	45.1%	43.9%

Almost a quarter (24.8%, 1,527) of all mental health providers work in either an independent solo or group practice. Independent solo practices are the most common primary setting among all professions apart from Mental Health Therapists. Also common among all four professions are mental health clinics with 13.7% (840) of mental health providers, although a smaller share of Psychologists work in clinics compared to CMHCs, LCSWs, and MFTs. A larger percentage of Psychologists work in college or university counseling centers than the other professions (12.7% vs. about 1.5%).

Table 19: Primary Work Setting Distribution by Profession

Setting	CMHC	LCSW	MFT	PSYCH	ALL
Public Hospital	1.2%	8.8%	---	3.5%	5.8%
Private Hospital	0.7%	4.1%	1.9%	2.0%	2.9%
Psychiatric Hospital	2.5%	3.3%	1.4%	2.3%	2.8%
Mental Health Clinic	16.1%	13.3%	17.9%	9.5%	13.7%
Primary/Specialist Medical Facility		0.5%	0.9%	2.6%	0.8%
Substance Abuse Treatment Facility	9.7%	4.4%	2.4%	0.6%	4.6%
College/University Counseling	1.5%	1.3%	1.4%	12.7%	3.1%
Methadone Clinic	1.0%	0.2%		---	0.4%
Child Welfare Facility	2.0%	2.4%		---	1.8%
Criminal/Juvenile Justice Facility	1.5%	0.8%	1.9%	0.6%	1.0%
Correctional Facility	2.7%	1.2%	0.9%	0.6%	1.3%
Hospice Setting	---	2.3%	0.9%	---	1.4%
Independent Solo Practice	15.3%	14.1%	26.9%	29.2%	17.8%
Independent Group Practice	7.7%	5.3%	10.8%	9.8%	7.0%
Academic Institution		1.2%	2.8%	3.8%	1.6%
Veterans Facility		2.8%	---	5.5%	2.5%
Long-term Care Facility		0.6%	---	0.6%	0.5%
Organization/Business Setting	1.7%	1.9%	0.9%	0.6%	1.6%
Rehabilitation Facility	0.5%	0.2%	---	---	0.2%
Residential Facility	8.7%	5.7%	9.4%	2.3%	6.1%
School Based Facility	3.2%	4.4%	1.4%	2.0%	3.5%
Community Health Center	1.7%	0.8%	---		0.8%
State Mental Health Agency	1.7%	2.0%	1.4%		1.7%
Other Private For-profit Organization	5.2%	3.8%	4.7%	2.6%	4.0%
Other Private Non-profit Organization	4.7%	6.3%	5.7%	1.2%	5.1%
Other	5.2%	5.2%	3.3%	3.8%	4.8%

Fewer than 5 providers --- Zero

About a third (33.6%, 1,862) of all mental health providers work in more than one setting. This includes 32.4% (338) of Clinical Mental Health Counselors, 28.7% (1,142) of Social Workers, 38.2% (242) of Marriage and Family Therapists, and 34.1% (342) of Psychologists. Independent solo practices are again, the most common with 6.9% (77) of CMHCs, 5.3% (187) of LCSWs, 10.4% (60) of MFTs, and 12.4% (118) of Psychologists. Mental health clinics are also common among CMHCs, LCSWs, and MFTs.

Table 20: Secondary Work Setting Distribution by Profession

Setting	CMHC	LCSW	MFT	PSYCH	ALL
Public Hospital	0.7%	2.1%	0.9%	0.9%	1.6%
Private Hospital	0.5%	1.2%	---	0.9%	0.9%
Psychiatric Hospital		0.8%	---	1.2%	0.7%
Mental Health Clinic	4.5%	3.4%	6.6%	2.3%	3.7%
Primary/Specialist Medical Facility	---	0.5%	---	0.9%	0.4%
Substance Abuse Treatment Facility	1.5%	1.7%	0.9%		1.4%
College/University Counseling	1.2%	0.9%	1.4%	1.4%	1.1%
Methadone Clinic	---		---	---	
Child Welfare Facility		0.5%	---	---	0.3%
Criminal/Juvenile Justice Facility		0.3%	---	---	0.2%
Correctional Facility	0.5%	0.7%	---		0.5%
Hospice Setting	---	0.8%	---		0.5%
Independent Solo Practice	6.9%	5.3%	10.4%	12.4%	7.2%
Independent Group Practice	3.0%	1.8%	7.1%	3.2%	2.7%
Academic Institution	---	0.6%	2.8%	1.4%	0.8%
Veterans Facility	---	0.2%	---		0.1%
Long-term Care Facility	---	0.5%	---		0.4%
Organization/Business Setting	0.7%	0.8%		0.9%	0.8%
Rehabilitation Facility	0.5%	0.3%	---		0.3%
Residential Facility	2.2%	0.9%	1.4%	0.6%	1.2%
School Based Facility	0.7%	0.3%	---	0.6%	0.4%
Community Health Center	---	0.3%			0.4%
State Mental Health Agency	---	0.63%	---	---	0.2%
Other Private For-profit Organization	3.2%	2.3%	3.8%	0.9%	2.4%
Other Private Non-profit Organization	3.0%	2.1%	1.9%	1.4%	2.1%
Other	2.0%	3.8%	3.3%	3.2%	3.3%

Fewer than 5 providers --- Zero

Hours Worked

On average, when combining both primary and secondary practice settings, mental health providers work 36 hours per week. That mean goes down for part-time providers (those who work fewer than 36 hours per week) to 20 hours and up for full time providers (those who work at least 36 hours per week) to 44 hours. A majority (58.2%, 3,581) of providers work full-time while 34.0% (2,090) work part-time.

Table 21: Total Hours per Week by Profession

Hours	CMHC	LCSW	MFT	PSYCH	ALL
	Percent	Percent	Percent	Percent	Percent
Part-time	36.1%	32.1%	44.3%	32.1%	34.0%
Full-time	55.2%	59.7%	48.6%	61.8%	58.2%
20 or fewer	21.0%	16.8%	28.8%	19.4%	19.1%
21-35	15.1%	15.2%	15.6%	12.7%	14.9%
36-40	30.9%	37.3%	22.2%	35.0%	34.4%
41-50	16.3%	16.6%	22.6%	19.4%	17.5%
51-60	5.9%	5.2%	3.3%	6.1%	5.3%
61+	2.0%	0.7%		1.4%	1.0%
Missing	8.7%	8.2%	7.1%	6.1%	7.9%

Fewer than 5 providers

Table 22: Mean Hours per Week at Primary and Secondary Setting by Profession

	CMHC	LCSW	MFT	PSYCH	ALL
Part-time	21	21	18	19	20
Full-time	45	44	45	45	44
All	35	36	32	36	35

When only taking into account primary settings, the mean hours worked goes down to 41 hours per week for full-time providers and 19 hours for part-time providers.

Table 23: Mean Hours per Week at Primary Setting Only by Profession

	CMHC	LCSW	MFT	PSYCH	ALL
Part-time	19	20	17	18	19
Full-time	41	41	39	42	41
All	29	31	26	32	30

A total of 33.2% (1,247) of women and 35.5% (816) of men work part-time while 59.1% (2,271) of women and 56.6% (1,299) of men work full-time. Mean hours worked are virtually the same for both part-time (20.3 for women and 20.5 for men) and full-time providers (44.2 for both). Differences in hours worked per week vary extensively when looking at work setting. Hours worked by primary setting varied from 27.5 hours per week on the low end and 45.5 hours on the high end.

Table 24: Settings with Highest Mean Hours/Week

Setting	Mean Hours/Week
Child Welfare Facility	45.5
Methadone Clinic	44.3
Correctional Facility	44.1
State Mental Health Agency	43.8
Residential Facility	43.6

Table 25: Settings with Lowest Mean Hours/Week

Setting	Mean Hours/Week
Hospice Setting	27.5
Independent Solo Practice	27.7
Other Private For-profit	30.8
Academic Institution	32.4
Independent Group Practice	32.9

Direct Client Care

The workforce spends an average of 23.2 hours per week on direct client care at primary settings, or roughly 77.3% of their work week. Small variations were found with CMHCs (23.8 hours) and MFTs (21.9 hours). On average, full-time providers are spending 65.1% of their week on direct client care and part-time providers are spending 91.6% of their time on direct client care.

Mental health providers see an average of 5.4 individual clients per day and 1.7 groups per day. MFTs and Psychologists saw slightly fewer individuals than average and MFTs saw slightly more groups than the average, but no large differences are found across the four professions overall. Although part-time providers work fewer hours, no difference is found between the number of clients seen when comparing full- and part-time workers, suggesting providers working part-time are spending more of their time directly with clients than full-time providers.

Table 26: Number of Individuals and Groups Seen per Day

	CMHC	LCSW	MFT	PSYCH	ALL
Individuals	5.3	5.7	4.9	4.9	5.4
Groups	1.8	1.6	2.3	1.6	1.7

Practice setting had more of an impact on number of individual clients seen per day than profession. Numbers ranged from 2.8 to 8.1 per day and settings such as schools, hospitals, medical facilities, and correctional facilities had the highest number of clients seen.

Table 27: Number of Individuals and Groups Seen per Day by Setting

Setting	Individuals	Groups
Public Hospital	6.5	1.2
Private Hospital	7.0	1.2
Psychiatric Hospital	4.8	1.7
Mental Health Clinic	5.7	1.3
Primary Medical Facility	7.2	0.8
Substance Abuse Treatment Facility	5.1	1.6
College/University Counseling Center	4.8	1.0
Methadone Clinic	5.6	1.7
Child Welfare Facility	3.7	0.9
Criminal/Juvenile Justice Facility	3.1	1.9
Correctional Facility	8.1	2.9
Hospice Setting	3.6	0.6
Independent Solo Practice	5.6	1.8
Independent Group Practice	5.8	1.4
Veterans Facility	4.7	1.2
Long-term Care Facility	4.9	0.8
Organization/Business Setting	2.8	1.1
Rehabilitation Facility	3.4	1.3
Residential Facility	4.3	1.2
School Based Facility	5.9	1.9
Community Health Center	5.5	1.7
State Mental Health Agency	5.0	0.8
Other Private For-profit Organization	4.9	1.3
Other Private Non-profit Organization	7.8	1.2

Client Demographics

The majority of clients seen by all mental health providers are between the ages of 18 and 34, with 70.9% of providers reporting seeing clients in this age group. Only 11.3% of providers reported seeing individuals aged 85 or older. This number varies from 2.4% for MFTs and 14.4% for LCSWs.

Table 28: Client Age Range by Profession

Age Group	CMHC	LCSW	MFT	PSYCH	ALL
0-12	26.0%	33.2%	35.4%	28.3%	31.4%
13-17	52.7%	52.1%	61.8%	47.1%	52.3%
18-34	73.8%	67.5%	74.1%	78.0%	70.9%
35-64	71.0%	65.1%	72.2%	72.5%	68.0%
65-84	30.7%	37.7%	32.5%	44.2%	36.9%
85+	5.7%	14.4%	2.4%	11.8%	11.3%

The number of providers who see equal amounts of male and female clients is 24.2% (1,487) for all four professions. However, providers see more women on average, as 38.6% (2,373) reported that women were more than 50% of their caseload, while only 22.6% (1,392) reported men being a majority of their caseload.

Table 29: Client Gender by Profession

CMHC		
% of Clients	**Male**	**Female**
>50%	33.4%	26.0%
50%	20.3%	20.3%
<50%	29.7%	36.4%
LCSW		
% of Clients	**Male**	**Female**
>50%	34.9%	19.0%
50%	26.0%	26.0%
<50%	21.0%	37.7%
MFT		
% of Clients	**Male**	**Female**
>50%	40.6%	14.2%
50%	25.0%	25.0%
<50%	17.0%	42.5%

PSYCH		
% of Clients	**Male**	**Female**
>50%	37.6%	22.0%
50%	21.3%	21.3%
<50%	24.0%	41.9%
ALL		
% of Clients	**Male**	**Female**
>50%	35.6%	20.3%
50%	24.2%	24.2%
<50%	22.6%	38.6%

Respondents were asked which specific populations they generally serve (see Appendix B). While there doesn't appear to be any populations that are particularly underserved, providers who identify as a racial or ethnic minority more often serve racial or ethnic minority clients. The table below outlines provider populations that see minority clients more than 5.0% than the average for all providers.

Table 30: Populations Served by Minority Providers

Populations Seen	Provider Race/Ethnicity					
	American Indian	Asian	African American	Hispanic	Pacific Islander	All
American Indian	**33.3%**	10.0%	**25.0%**	10.3%	**20.0%**	14.7%
Asian	**20.0%**	13.3%	12.5%	12.1%	**20.0%**	15.0%
African American	**26.7%**	13.3%	**25.0%**	15.9%	21.8%	17.9%
Hispanic	26.7%	23.3%	25.0%	**36.4%**	27.3%	25.7%
Pacific Islander	**20.0%**	13.3%	12.5%	12.1%	**20.0%**	14.5%
Refugees/Immigrants	6.7%	**16.7%**	12.5%	8.4%	**14.5%**	9.0%

Telemental Health

Telemental health is still relatively uncommon. Only 7.0% (428) of providers reported providing therapeutic services including therapy, consultation, or assessment remotely. Even less common was remote interaction with a supervisor (2.6%, 162). Of those that provide remote therapeutic services, 26.4% (113) have experienced licensure or practice obstacles when providing services across state lines.

Table 31: Telemental Health Services

	CMHC	LCSW	MFT	PSYCH	ALL
Therapeutic Services	4.7% (52)	5.7% (200)	13.2% (77)	10.4% (99)	7.0% (428)
Issues Across State Lines	1.7% (19)	1.6% (58)	3.3% (19)	1.7% (16)	1.8% (113)
Supervisor Interaction	3.0% (33)	2.7% (93)	3.3% (19)	1.7% (16)	2.6% (162)

Non-Client Care Activities

Many mental health professionals spend time each week on activities that do not directly involve client care. Those activities include classroom training (21.8%, 1,340), clinical supervision or instruction (43.4%, 2,669), administration or management (42.8%, 2,633), practice management (46.6%, 2,870), consulting or research (35.9%, 2,211), and other activities not listed (10.9%, 673).

Table 32: Rates of Non-Direct Client Care Activities

	CMHC	LCSW	MFT	PSYCH	ALL
Classroom Training	20.8%	21.7%	19.3%	24.6%	21.8%
Clinical Supervision/Instruction	39.6%	45.0%	39.2%	44.5%	43.4%
Administration/Management	43.3%	42.0%	42.9%	45.1%	42.8%
Practice Management	49.0%	44.3%	52.8%	48.6%	46.6%
Consulting/Research	38.6%	34.8%	36.8%	36.4%	35.9%
Other	11.9%	10.9%	10.4%	10.4%	10.9%

Of those who spend at least one hour a week on these activities, providers spend, on average, 4.6 hours on classroom training, 3.1 hours on clinical supervision or instruction, 9.1 hours on administration or management, 5.3 hours on practice management, and 4.4 hours on research each week.

Table 33: Mean Hours per Week Spent on Non-Direct Client Care Activities

	CMHC	LCSW	MFT	PSYCH	ALL
Classroom Training	3.9	4.2	5.2	6.3	4.6
Clinical Supervision/Instruction	3.0	3.0	3.2	3.3	3.1
Administration/Management	7.2	10.3	7.7	7.9	9.1
Practice Management	5.0	5.7	5.3	4.3	5.3
Consulting/Research	3.8	4.1	4.3	6.3	4.4

Spending more time on these other activities can have an impact on income. Across the board, incomes are higher for each professional where they spent at least ten hours per week on each of these activities, save Clinical Mental Health Counselors working on consulting/research.

Figure 18: CMHC Median Income by Non-Direct Client Activities

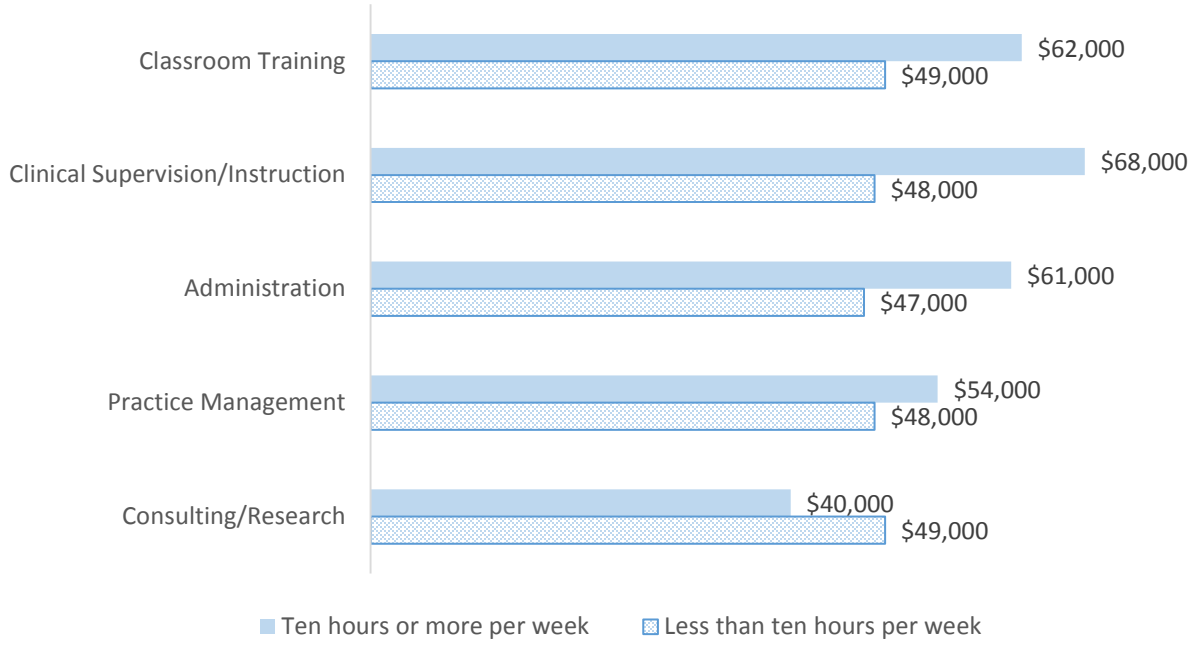


Figure 19: LCSW Median Income by Non-Direct Client Activities

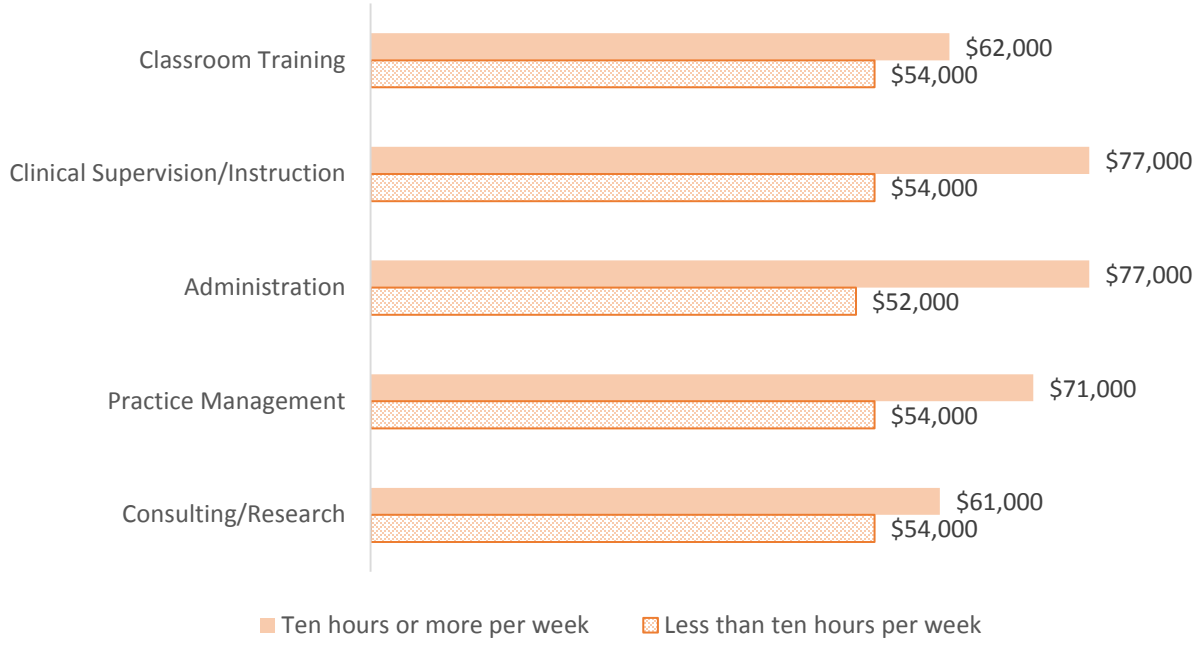


Figure 20: MFT Median Income by Non-Direct Client Activities

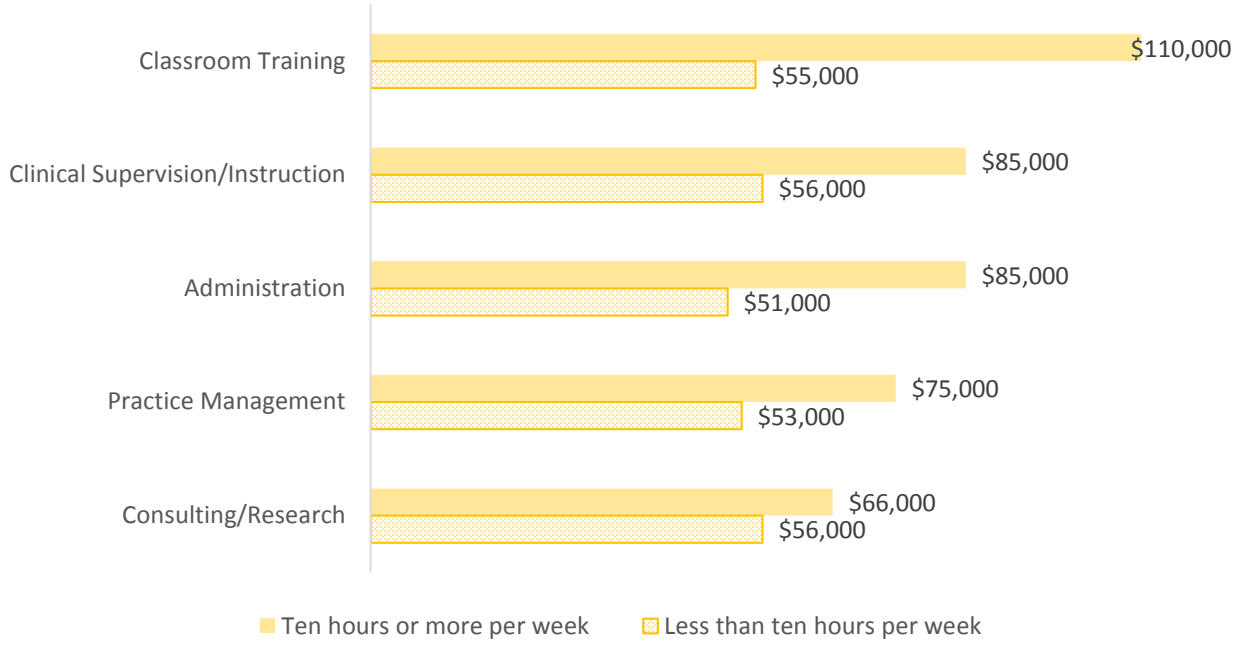


Figure 21: PSYCH Median Income by Non-Direct Client Activities

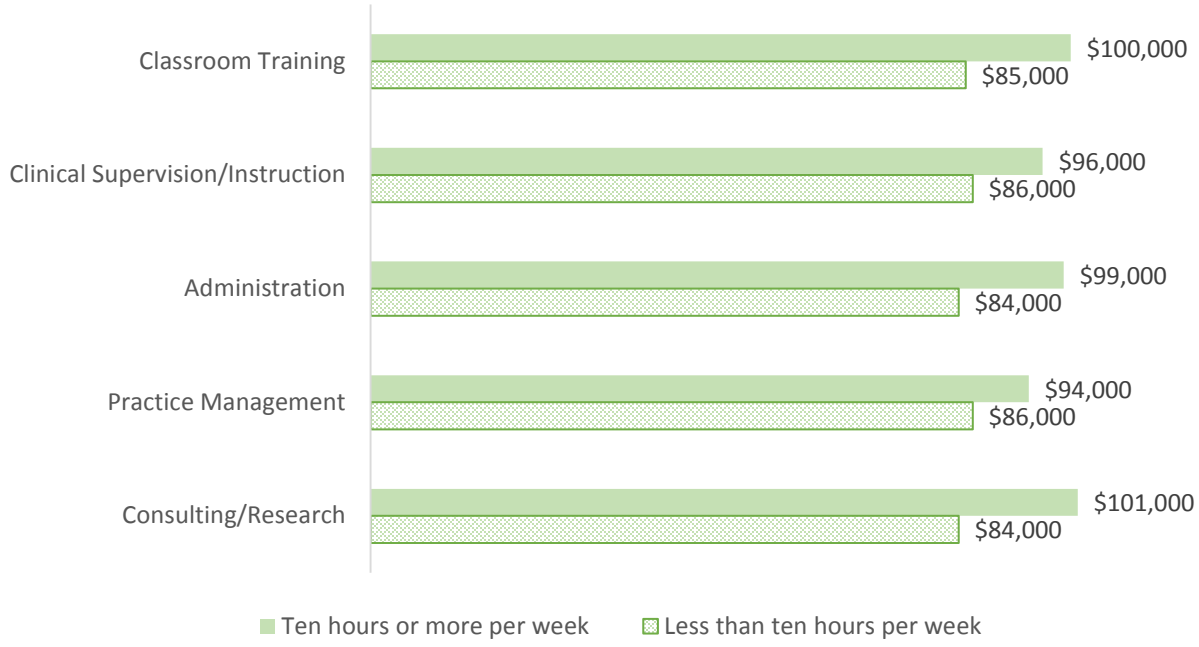
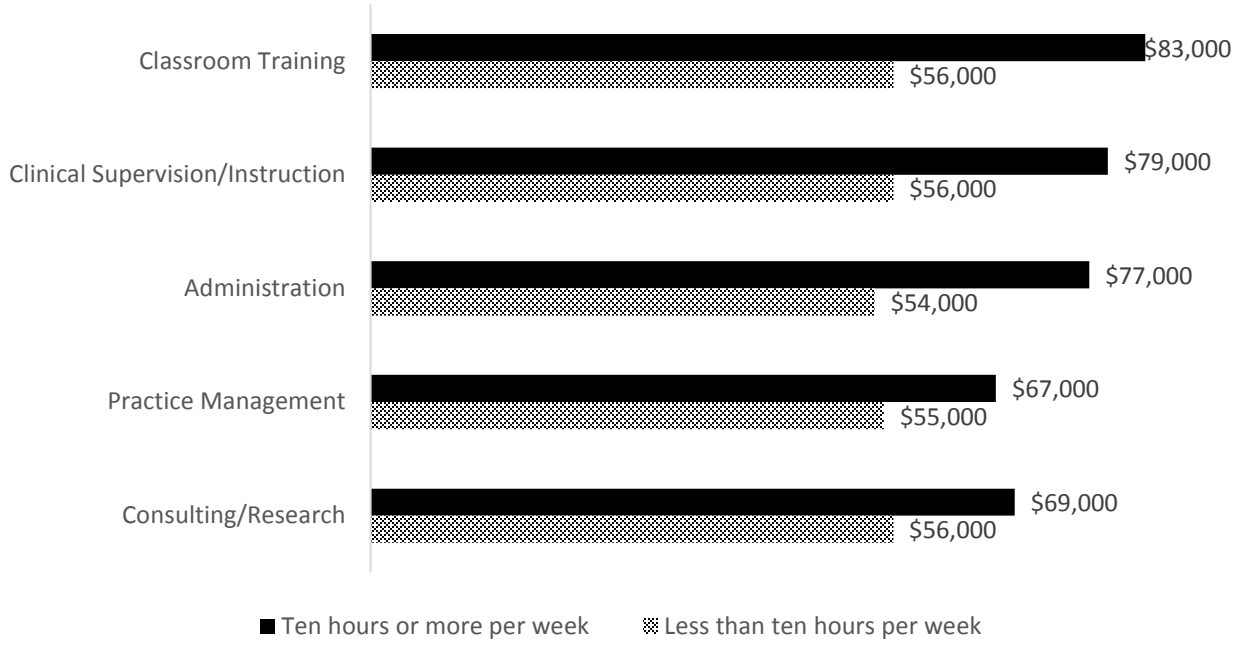


Figure 22: Mental Health Median Income by Non-Direct Client Activities



Provider Accessibility

About half (48.2%, 2,968) of providers say their practice is nearly full. However, only 11.0% (678) say their practice is full and 17.0% (1,043) say their practice is unfilled. These numbers vary slightly among professions, as outlined in the table below.

Table 34: Practice Status by Profession

	CMHC	LCSW	MFT	PSYCH	ALL
Full	11.1%	10.1%	10.8%	14.5%	11.0%
Nearly full	49.5%	44.3%	57.5%	55.8%	48.2%
Unfilled	22.5%	16.4%	18.9%	11.3%	17.0%

Mean wait time is 9.0 days for new clients and 5.0 days for established clients. There are no major differences among the professions apart from a mean wait time of 15.1 days for new clients to see a Psychologist. For full practices the mean wait time is 15.7 days for new patients and 5.8 days for established patients, nearly full practices have a wait time of 9.1 days for new patients and 5.3 days for established patients, and unfilled practices have a wait time of 4.7 days for new patients and 2.9 days for established patients. There was no major difference in wait time between rural and urban practices.

Practice setting also impacted wait time. To some extent, settings with the highest and lowest wait times for new patients also have the highest and lowest wait times for established patients, but that pattern was not found across the board. Wait times for new patients ranged from 1 day to 21.7 days while wait times for established patients ranged from half a day to 12.5 days.

Table 35: Average Wait Time by Setting

Setting	New Patients	Established Patients
Public Hospital	13.4	6.9
Private Hospital	10.2	2.3
Psychiatric Hospital	3.1	2.1
Mental Health Clinic	10.0	6.2
Primary Medical Facility	21.7	12.5
Substance Abuse Treatment Facility	5.7	3.2
College/University Counseling Center	15.3	9.7
Methadone Clinic	1.4	2.3
Child Welfare Facility	2.6	2.7
Criminal/Juvenile Justice Facility	5.5	9.9
Correctional Facility	7.9	3.9
Hospice Setting	2.0	3.8
Independent Solo Practice	8.8	4.3
Independent Group Practice	9.4	5.4
Veterans Facility	10.6	8.4
Long-term Care Facility	1.9	3.8
Organization/Business Setting	7.3	3.9
Rehabilitation Facility	1.0	0.5
Residential Facility	5.7	2.3
School Based Facility	4.4	2.6
Community Health Center	9.4	5.9
State Mental Health Agency	5.6	5.2
Other Private For-profit Organization	7.2	4.0
Other Private Non-profit Organization	10.6	4.3

Many settings, such as veterans facilities and college/university counseling centers have first appointment metrics and emergency services available if needed The wait times listed above do not represent that. Additionally, the nature of the setting likely plays a role in wait time.

Client Insurance

A majority (51.5%, 3,172) of the workforce sees clients with private insurance. Medicaid (35.7%, 2,197) and full self-pay (35.6%, 2,191) are also common. Variation among the four professions is not universal, however differences in the percentage of providers seeing patients with Medicaid, Medicare, and full self-pay are prominent.

Table 36: Percentage of Providers Seeing Clients by Insurance Type

	CMHC	LCSW	MFT	PSYCH	ALL
Medicaid	36.1%	42.1%	19.8%	21.1%	35.7%
Medicare	8.7%	25.3%	4.2%	24.0%	20.4%
Managed Care	10.1%	12.4%	13.7%	15.9%	12.6%
Private	55.4%	50.8%	54.7%	47.7%	51.5%
TriCare	9.4%	13.1%	13.2%	18.2%	13.3%
Workers Comp	2.7%	3.6%	2.8%	7.2%	3.9%
Charity/No Charge	25.5%	24.9%	22.6%	21.4%	24.2%
Self-Pay: Full	36.4%	31.5%	58.0%	36.1%	35.6%
Self-Pay: Sliding	26.5%	19.9%	20.8%	23.1%	21.7%

Non-English Services

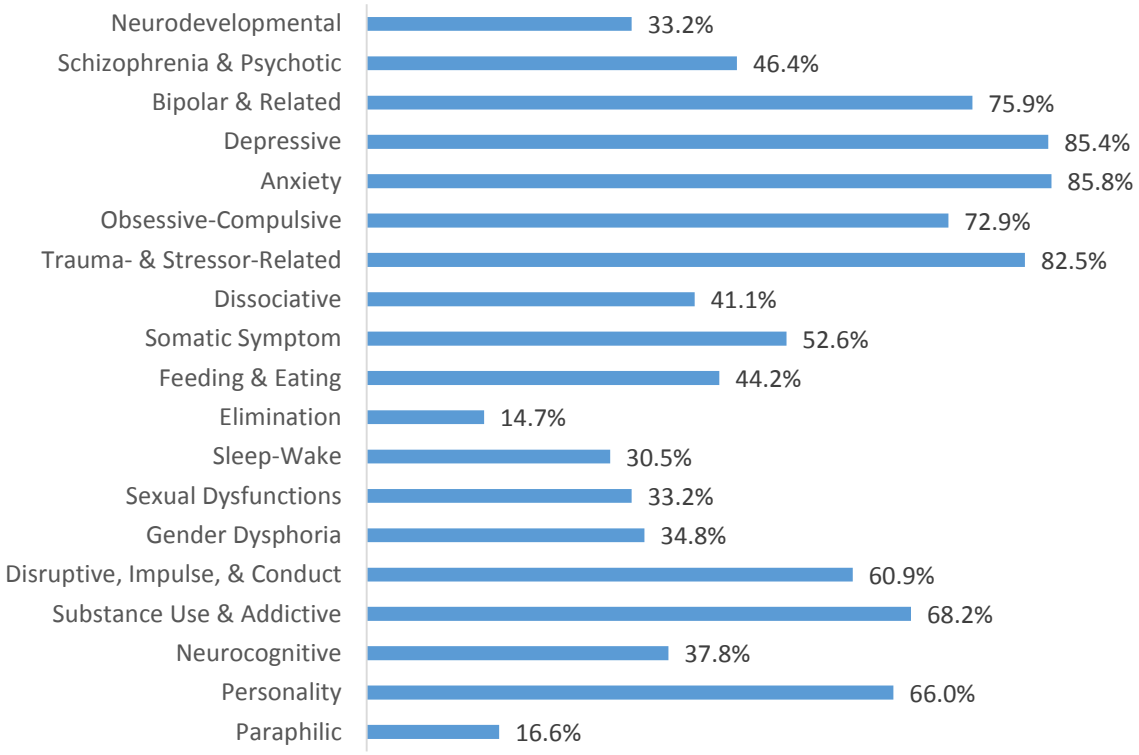
Over a third (38.0%, 2,337) of providers report working in practices that provide services in a language other than English. A small percentage (6.4%) said their settings can provide services in any or multiple languages and 24.5% said their settings can provide services specifically in Spanish. A reported 14.4% of providers said they were able to provide therapy in a language other than English without the assistance of a translator and 8.7% said they could provide therapy in Spanish. It should be noted that the survey did not ask if the provider conducted non-English therapy, only if he/she potentially could.

While there are no major differences among each profession, Marriage and Family Therapists have the highest rates of providers able to conduct non-English therapy at 22.6% (135). Over half of MFTs who could provide therapy in another language cited Spanish (13.2% of all MFTs).

Therapeutic Treatments

Respondents were asked which disorders they treated based on the DSM-V categories as well as two additional categories regarding co-occurring disorders and obesity/diabetes. There does not appear to be any specific disorders that could be potentially under-treated.

Figure 23: Percent of Mental Health Providers Treating DSM-V Disorders



While differences in treatment rates among the four professions are small, a handful stand out at more or less than 5.0% of the mean. The table below outlines those differences.

Table 37: Treatment Differences of More Than 5.0% of Mean by Profession

	CMHC	LCSW	MFT	PSYCH	ALL
Neurodevelopmental Disorders	32.2%	33.5%	**26.9%**	37.0%	33.2%
Schizophrenia & Psychotic Disorders	47.0%	47.5%	**34.0%**	48.8%	46.4%
Obsessive-Compulsive Disorders	75.5%	70.4%	**79.7%**	74.9%	72.9%
Dissociative Disorders	39.9%	41.9%	**34.4%**	43.6%	41.1%
Feeding & Eating Disorders	45.0%	42.9%	**49.1%**	44.8%	44.2%
Sleep-Wake Disorders	30.2%	28.6%	29.7%	**38.2%**	30.5%
Sexual Dysfunction	33.7%	**28.1%**	**50.5%**	**40.8%**	33.2%
Gender Dysphoria	33.4%	33.9%	34.4%	**39.9%**	34.8%
Disruptive, Impulse, & Conduct Disorders	**67.6%**	59.5%	**67.0%**	**54.6%**	60.9%
Substance Use & Addictive Disorders	**77.0%**	67.7%	71.7%	**57.8%**	68.2%
Neurocognitive Disorders	36.9%	37.4%	33.5%	**43.1%**	37.8%
Paraphilic Disorders	17.1%	15.3%	14.2%	**22.3%**	16.6%

Care Coordination

The vast majority (80.0%, 4,924) of mental health providers report coordinating care with another provider. Variation among professions is small with 78.3% (456) of Marriage and Family Therapists on the low end and 83.2% (791) of Psychologists on the high end. Larger differences are found when controlling for setting, however only three settings have coordination rates lower than 80.0%: rehabilitation facilities (61.5%), organization/business settings (67.5%), and criminal or juvenile justice facilities (75.9%).

Primary Care Providers are the most commonly cited professionals that mental health providers coordinate care with (56.0%, 3,446) followed by Psychiatrists (54.3%, 3,339). Nurse Practitioners (39.6%, 2,438) and Case Managers (34.0%, 2,092) are also common. Psychologists coordinate care with Primary Care Providers and Psychiatrists more than CMHCs, LCSWs, and MFTs (65.0% and 68.2%, respectively) and less with Case Managers (22.8%).

Prescribing Access

When asked what kind of health care provider their main point of contact is when prescribing medication, Primary Care Physicians (41.6%, 2,562) and Psychiatrists (29.2%, 1,796) far outstripped any other provider. Psychiatric APRNs are third most commonly cited at 8.1% (497). A majority (54.6%, 3,361) reported having excellent or good access to their prescribing partner while 31.4% (1,933) reported fair or poor access.

Table 38: Access to Prescribing Partner by Profession

	Excellent	Good	Fair	Poor
CMHC	22.8%	30.7%	22.8%	11.9%
	53.5%		34.7%	
LCSW	30.1%	26.0%	19.2%	9.0%
	56.1%		28.1%	
MFT	22.6%	29.2%	26.4%	11.3%
	51.9%		37.7%	
PSYCH	26.9%	25.1%	25.7%	10.1%
	52.0%		35.8%	
ALL	27.6%	27.0%	21.5%	9.9%
	54.6%		31.4%	

Although both rural and urban areas experience high levels of fair or poor access to prescribing partners, urban areas report higher levels of insufficient access, even when controlling for type of prescribing partner.

Table 39: Access to Prescribing Partner by Provider and Practice Location

All Prescribing Partners		
	Excellent/Good	**Fair/Poor**
Rural Settings	69.7%	30.3%
Urban Settings	62.8%	37.2%
Primary Care Physician		
	Excellent/Good	**Fair/Poor**
Rural Settings	66.0%	34.0%
Urban Settings	52.8%	47.2%
Psychiatrist		
	Excellent/Good	**Fair/Poor**
Rural Settings	81.0%	19.0%
Urban Settings	72.0%	28.0%

Practice setting plays a large role in prescribing partner access. The rates of inadequate access range from 7.8% to 58.3%. Not surprisingly, settings such as hospitals, in-patient facilities, and veterans facilities have lower rates of inadequate access.

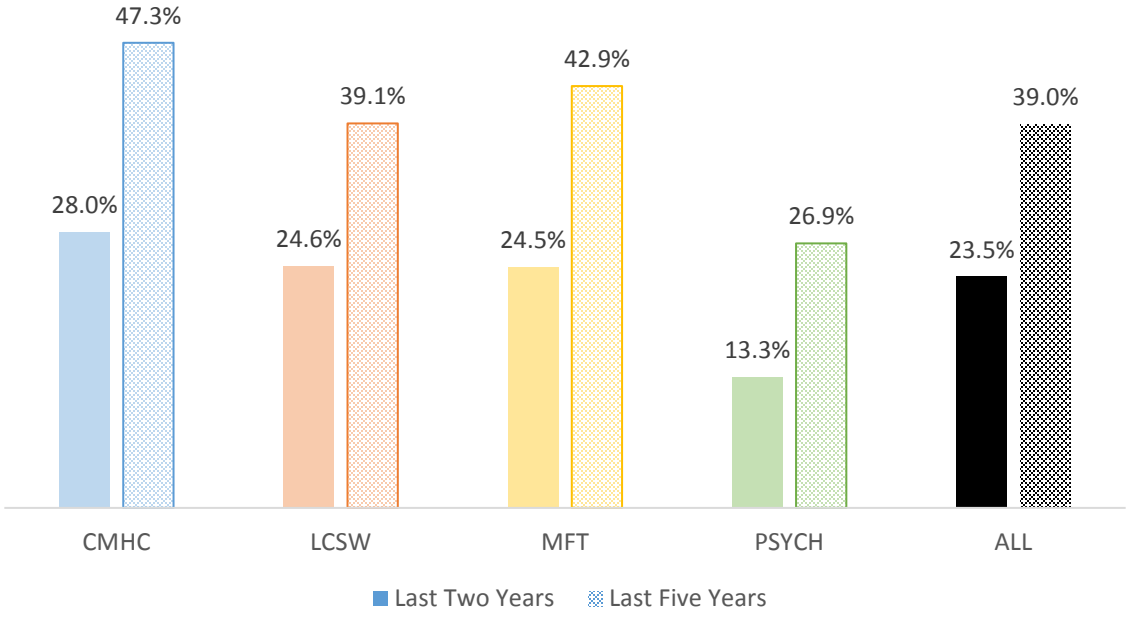
Table 40: Percent of Workforce Reporting Inadequate Access to Prescribing Partner by Setting

Primary Setting	Fair/Poor Access
Hospice Setting	7.8%
Residential Facility	10.2%
Psychiatric Hospital	13.5%
Veterans Facility	13.9%
Primary Medical facility	16.3%
State Mental Health Agency	16.9%
Public Hospital	17.0%
Long-term Care Facility	18.5%
Private Hospital	20.3%
Methadone Clinic	27.3%
Community Health Center	34.1%
Mental Health Clinic	34.2%
Substance Abuse Treatment Facility	36.9%
Other Private For-profit Organization	39.7%
College/University Counseling Center	40.4%
Rehabilitation Facility	42.9%
Other Private Non-profit Organization	43.6%
School Based Facility	45.5%
Criminal/Juvenile Justice Facility	51.0%
Independent Group Practice	51.0%
Independent Solo Practice	51.8%
Organization/Business Setting	52.2%
Correctional Facility	52.7%
Child Welfare Facility	58.3%

Turnover and Employment Issues

Almost a quarter (23.5%, 1,444) of all mental health providers switched employers within the last two years and 39.0% (2,403) switched employers within the last five years. However, these numbers vary among the professions, especially among those who switched employers within five years.

Figure 24: Switched Employers within Two and Five Years by Profession



Clinical Mental Health Counselors, Social Workers, and Marriage and Family Therapists all left mental health clinics more than any other setting. However, mental health clinics are the second most common setting the workforce moved to. Psychologists left college/university counseling centers more than the other professions. All four professions moved to independent solo practices more than anything else. All told, 13.4% of the workforce left mental health clinics in the last five years and 14.6% of the workforce moved to independent solo practices.

Table 41: Five Most Common Settings Left and Moved To in Last Five Years by Profession

CMHC	
Setting Left From	**Percent**
Mental Health Clinic	7.2%
Residential Facility	6.7%
Independent Group Practice	4.7%
Other Private Non-profit	3.5%
Substance Abuse Facility	3.2%
Setting Moved To	**Percent**
Independent Solo Practice	6.7%
Substance Abuse Facility	5.2%
Residential Facility	5.0%
Mental Health Clinic	4.7%
Independent Group Practice	3.7%

LCSW	
Setting Left From	**Percent**
Mental Health Clinic	4.8%
Other Private Non-profit	3.2%
Public Hospital	2.9%
Substance Abuse Facility	2.9%
Residential Facility	2.9%
Setting Moved To	**Percent**
Independent Solo Practice	5.3%
Mental Health Clinic	4.4%
Public Hospital	3.4%
Residential Facility	2.3%
Independent Group Practice	2.3%

MFT	
Setting Left From	**Percent**
Mental Health Clinic	9.4%
Residential Facility	5.7%
Substance Abuse Facility	3.8%
Other Private Non-profit	3.3%
Psychiatric Hospital	2.8%
Setting Moved To	**Percent**
Independent Solo Practice	8.0%
Mental Health Clinic	7.1%
Independent Group Practice	6.1%
Residential Facility	3.8%
Substance Abuse Facility	2.8%

PSYCH	
Setting Left From	**Percent**
College/University Counseling	3.8%
Independent Group Practice	2.9%
Mental Health Clinic	2.0%
Veterans Facility	2.0%
Private Hospital	1.7%
Setting Moved To	**Percent**
Independent Solo Practice	4.6%
Independent Group Practice	4.3%
College/University Counseling	2.9%
Public Hospital	1.7%
Private Hospital	1.4%

ALL	
Setting Left From	**Percent**
Mental Health Clinic	13.4%
Residential Facility	9.1%
Other Private Non-profit	7.4%
Substance Abuse Facility	6.6%
Public Hospital	5.1%
Setting Moved To	**Percent**
Independent Solo Practice	14.6%
Mental Health Clinic	10.9%
Independent Group Practice	8.2%
Residential Facility	7.1%
Public Hospital	6.1%

The most common reasons for switching employers include higher pay (42.4%), desire for change (36.1%), for a better fit (31.7%), preferred hours (27.9%), and professional advancement (24.6%).

Reported involuntary unemployment within the last two years is low at 3.5% (214). However, other employment issues, such as working two or more jobs, working part-time but preferring full-time, and thinking about leaving the mental health field entirely, are much higher. Additionally, some differences among the professions, such as working part-time but preferring full-time work, involuntary unemployment, and working two or more jobs are pronounced.

Table 42: Reported Employment Issues in Last Two Years by Profession

	CMHC	LCSW	MFT	PSYCH	ALL
Voluntary Unemployment	5.2%	5.5%	4.7%	2.3%	4.9%
Switched Employers	28.0%	24.6%	24.5%	13.3%	23.5%
Worked Part-time, Preferred Full-time	16.3%	9.3%	11.8%	3.2%	9.9%
Involuntary Unemployment	6.7%	3.4%	1.9%	1.2%	3.5%
Worked Two or More Jobs	34.7%	27.8%	32.5%	19.1%	28.1%
Considered Leaving Mental Health (not retirement)	19.1%	19.2%	15.1%	10.4%	17.4%

Some employment issues may be correlated with considering leaving the mental health field. Those who worked part-time and those who worked multiple jobs considered leaving the field at higher rates than the entire workforce, 33.5% and 27.8% respectively. Those who are between the ages of 30 and 39 worked part time more often than those of other age ranges at an average of 16.7% as opposed to an average of 10.2%. Those aged 30 to 34 worked two or more jobs at a higher rate than others (11.6% average).[7]

Setting also influenced rates of those who considered leaving the field. Child welfare facilities (35.0%), community health centers (33.3%), state mental health agencies (27.0%), psychiatric hospitals (25.4%), and private hospitals (24.2%) have the highest rates of employees who have considered leaving. Academic institutions (8.6%), primary or specialist medical facilities (10.5%), independent group practices (11.5%), independent solo practices (12.5%), and methadone clinics (12.5%) have the lowest rates of employees who have considered leaving. It should be noted that these data may not align exactly as presented as the survey only asked about *current* practice setting and thoughts of leaving the field in the *last two years*. These data do not account for those who switched employers since considering leaving mental health.

Satisfaction

Mental health providers are largely satisfied with their current employment situation. Indeed, 88.4% (5,440) of all providers say they are either satisfied or very satisfied compared to 7.7% (475) who report being dissatisfied or very dissatisfied. However, there are small variations when controlling for profession.

[7] 25-29 year olds were considered outliers and were excluded from this analysis as they had much lower levels of working part-time (3.6%) and working two or more jobs (1.3%) than any other age cohort.

Table 43: Satisfaction Rates by Profession

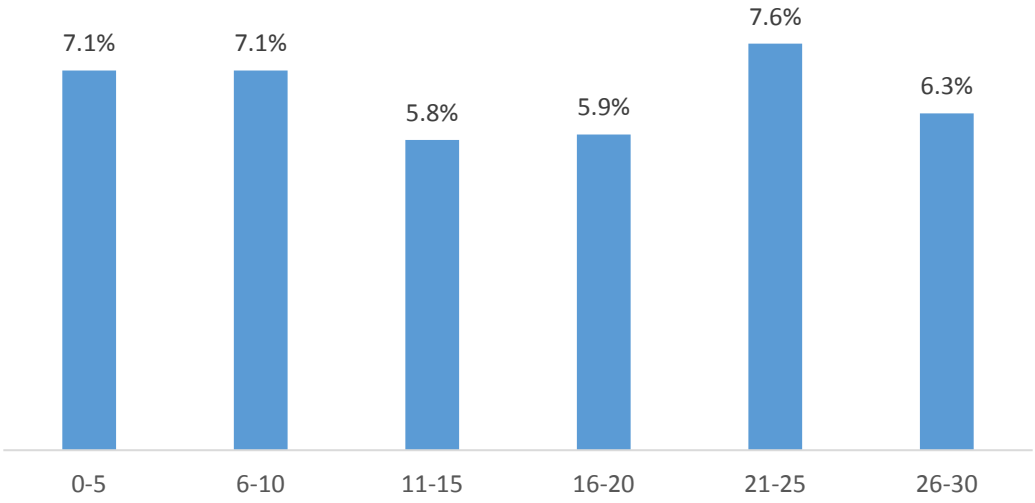
	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
CMHC	49.5%	35.4%	6.4%	3.7%
	84.9%		10.1%	
LCSW	54.6%	33.6%	6.2%	2.1%
	88.2%		8.3%	
MFT	60.4%	30.7%	3.8%	1.4%
	91.0%		5.2%	
PSYCH	70.5%	21.1%	3.8%	0.6%
	91.6%		4.3%	
ALL	56.7%	31.7%	5.6%	2.1%
	88.4%		7.7%	

Those who worked part-time while wanting to work full-time in the last two years experience higher levels of dissatisfaction at 18.6% and those who considered leaving the field in the last two years also have higher rates of dissatisfaction at 22.0%.

Retirement and Pre-Retirement Hour Reduction

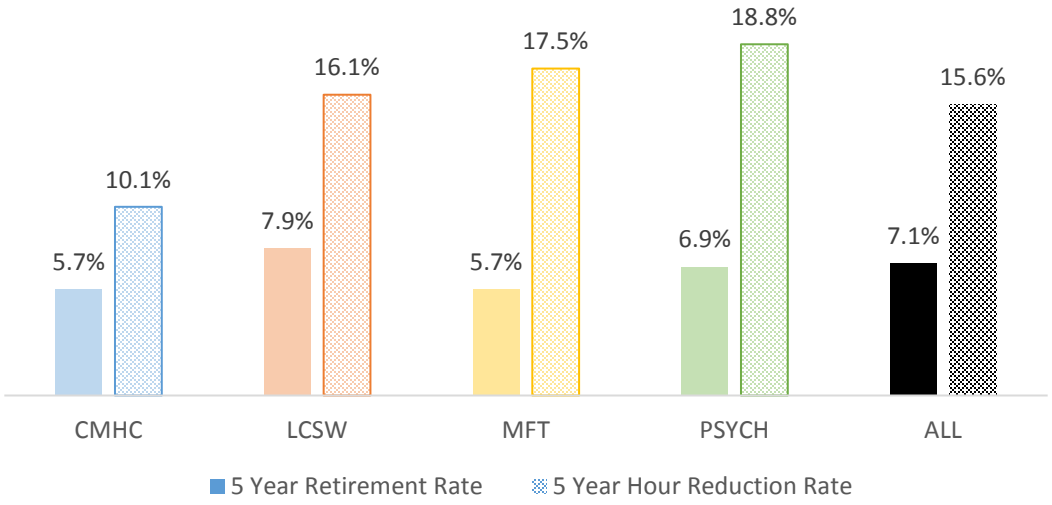
Almost a third (31.6%, 1,944) of all mental health providers do not plan on retiring while half (50.0%) plan on reducing their hours in the future. While only 7.1% of the workforce plans on retiring in the next five years, 15.6% plans on reducing their hours in the same timeframe. Retirement rates become increasingly inaccurate the further out the projected retirement date is, however self-expected rates are fairly steady across the next 30 years.

Figure 25: Total Workforce Years to Expected Retirement



Expected retirement rates within the next five years are highest among Social Workers at 7.9% and lowest among Clinical Mental Health Counselors and Marriage and Family Therapists at 5.7%. Mean age for those who plan on retiring within five years is 63.3. Rates of hour reduction within the next five years range from 10.1% of Clinical Mental Health Counselors to 18.8% of Psychologists and mean age is 55.

Figure 26: Projected Retirement and Hour Reduction within Five Years by Profession



Those who say they will reduce their hours plan on working a mean of 17.6 hours and a median of 20 hours after the reduction. In other words, it is likely that the workforce will lose roughly 1 FTE for every 2 people who reduce their hours. Without accounting for new providers entering the workforce, it is possible that the number of FTEs in the workforce will shrink by 14.9% from expected retirement and hour reduction in the next five years. This breaks down to 10.8% of CMHCs, 16.0% of LCSWs, 14.5% of MFTs, and 16.3% of Psychologists.

TRAINING CAPACITY

Utah currently has 2 CMHC programs, 3 MSW programs, 2 MFT programs, and 3 clinical psychology programs spread across 4 different universities: the University of Utah (CMHC, MSW, MFT, PSYCH), Utah State University (MSW, PSYCH), Brigham Young University (MSW, MFT, PSYCH), and Westminster College (CMHC). This does not include the various online programs, nor the MSW program that Utah Valley University plans to open in the fall of 2017.

With these 10 programs combined, Utah has the capacity to graduate 576 mental health professionals each year but has averaged 496 for the last 5 years. At the time of publication, the new MSW program at Utah Valley University did not have information on class size and is thus not included in these numbers. For purposes of the following projection models, the UMEC has

assumed retention rates of 75.0% and 90.0% of Utah trained graduates due to the large percentage of Utah natives and Utah graduates currently in the workforce. Actual retention rates for Utah training programs are unknown at this time and would require future data collection and analysis to be determined.

WORKFORCE PROJECTIONS

In 2015, Utah had a total of 5,026 mental health FTEs. This equates to 171 FTEs per 100,000 people. Nationally, the Bureau of Labor Statistics estimates that there are 311 providers for every 100,000 people (BLS, 2016). It should be noted that the BLS estimates are of providers only while the following projection numbers are based on FTEs.

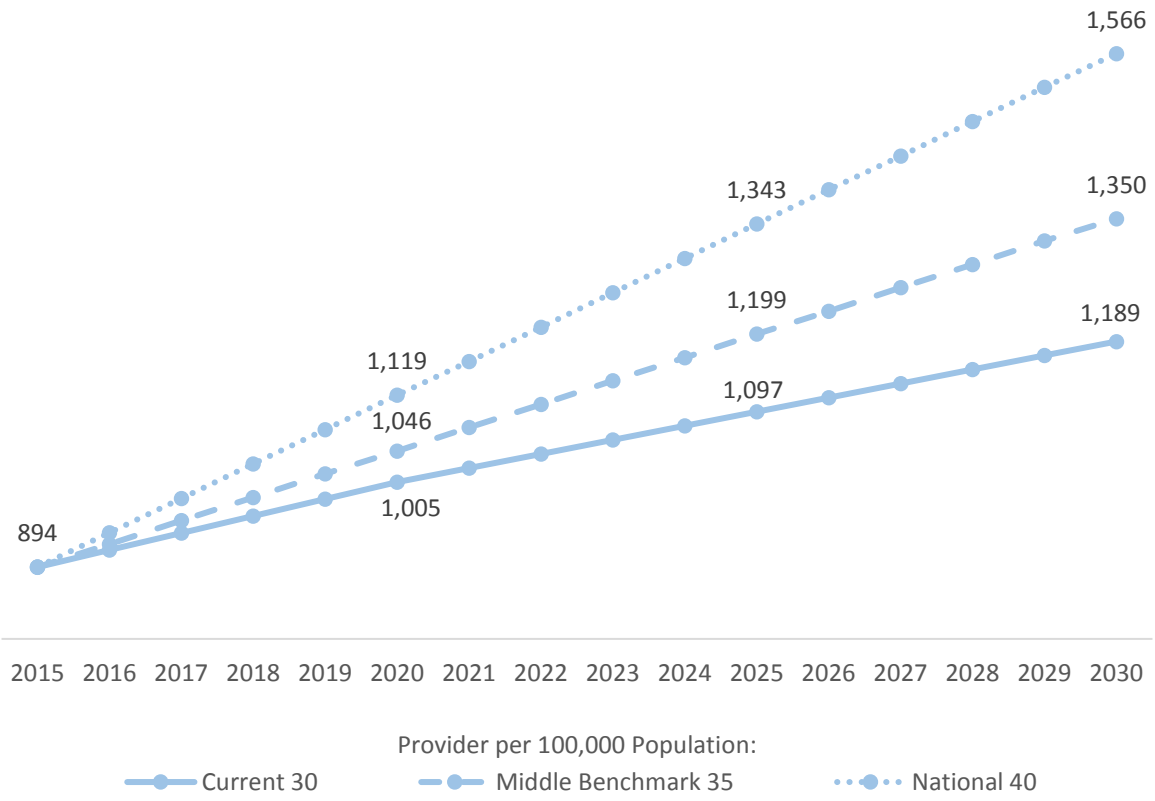
Table 44: Utah FTEs and U.S. Providers per 100,000

	CMHC	LCSW	MFT	PSYCH	ALL
Utah FTEs per 100,000 People	30	98	15	27	171
U.S. Providers per 100,000 People	41	204	12	55	311

While the number of providers lags far lower than the national average, Utah is experiencing robust population growth with the second fastest growing population in the nation (Utah Governor's Office of Economic Development, 2016). Additionally, while alcohol dependence or abuse among those at least 12 years old is lower in Utah than the national average, rates of major depressive episodes, thoughts of suicide, and serious mental illness are all higher in Utah than the national average. Among adults with any mental illness in Utah, only 45.3% receive mental health treatment. That percentage drops to 41.4% among adolescents (SAMHSA, 2015). If the Utah workforce is to increase with population growth as well as move closer to the 2015 national provider to population ratio by 2030, the state will have to more than double the number of FTEs in the workforce over the next 15 years.

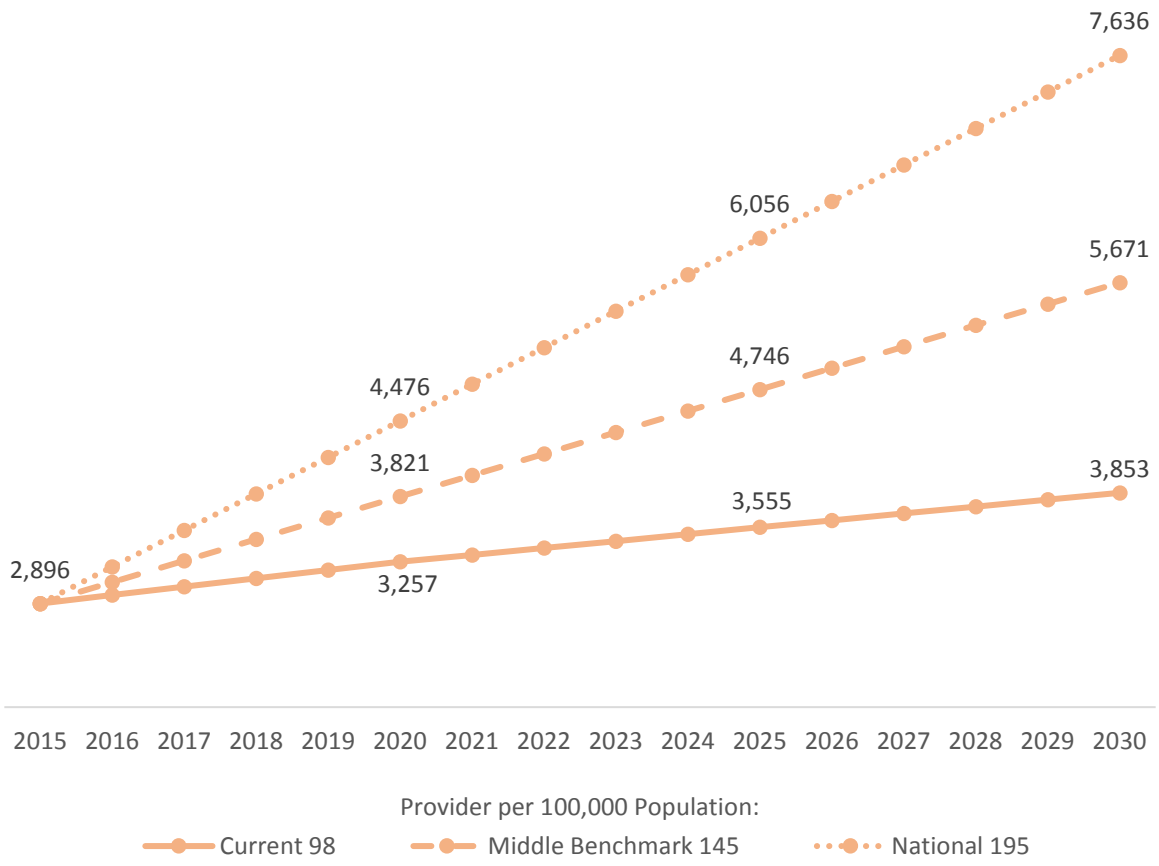
The following workforce projections are an estimate of how many FTEs Utah will need in order to at least maintain current ratios as well as move closer to the national ratios. The national provider ratios are slightly lower in the projection models in an effort to account for differences between FTEs and the number of providers. Middle ratios have also been included to provide an example of a more modest workforce goal. Although the severity can differ, mental illness affects adolescents and adults at roughly the same rate (National Alliance on Mental Illness, 2016). Therefore, only population growth, and not age breakdowns, was considered when building the workforce projections.

Figure 27: CMHC Workforce Projection



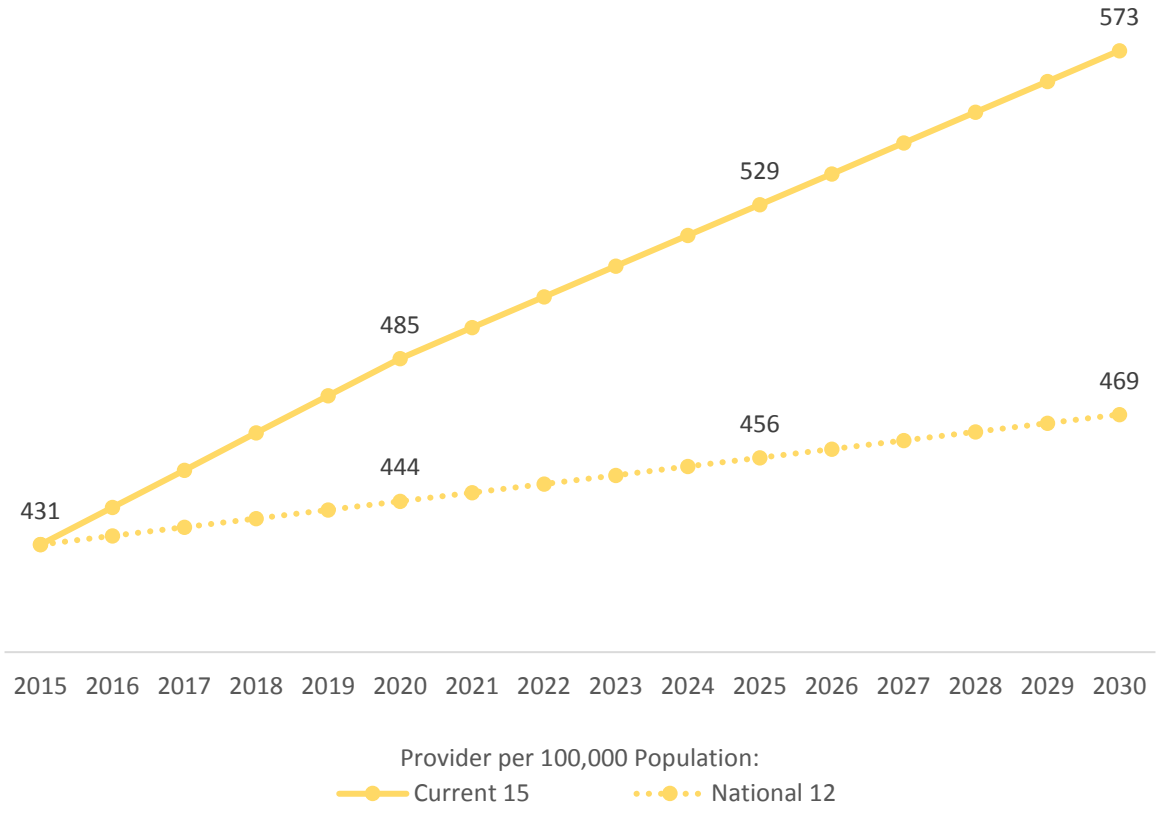
While it is difficult to paint a picture of each profession, Clinical Mental Health Counselors may be the most difficult. An average of 30 graduates complete brick and mortar programs in Utah each year. Graduation numbers for online programs are more elusive, however in 2015 Agrosy University graduated 10 CMHCs and the University of Phoenix graduated 75. The UMEC was not able to obtain graduation numbers from Capella University. With 85 graduates from two online programs alone, these schools are training a significant portion of the workforce. As with brick and mortar programs, the retention rate with online programs is unknown. In order to catch up to the national average of 41 providers per 100,000, the CMHC workforce must have a net average growth of 5.0% per year. A self-reported 2.1% of FTEs dropping out of the workforce each year over the next 5 years due to retirement and hour reduction coupled with a 75.0% retention rate for both brick and mortar and online programs, the CMHC workforce may reach as high as 1,763 by 2030, or 45 per 100,000, outpacing current national numbers. If online programs continue to train significant amounts of the workforce, CMHCs may help make up for the lack of other mental health professionals in the future.

Figure 28: LCSW Workforce Projection



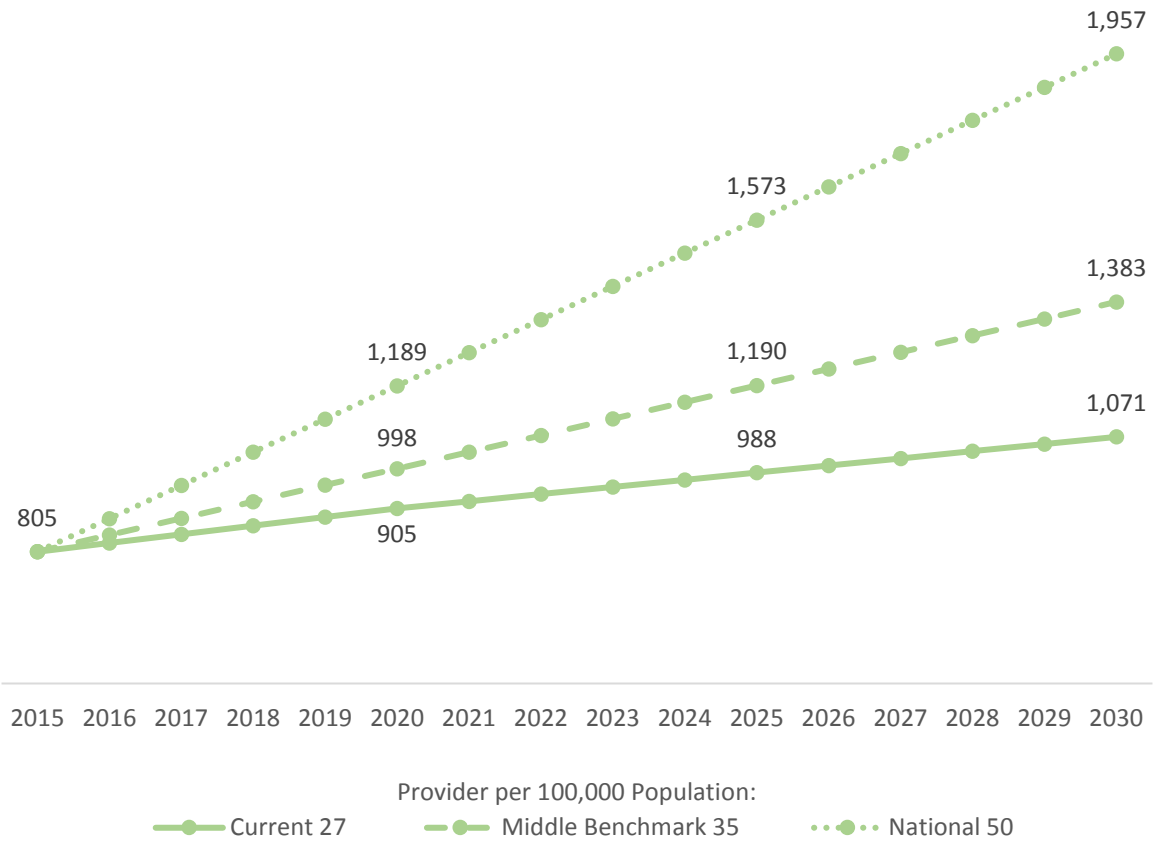
Over the last five years, it is estimated that 426 new Social Work graduates in Utah have entered the workforce each year. Assuming a 75.0% retention rate, this means that an estimated 362 LCSWs have entered the workforce each year. A 90.0% retention rate brings that yearly average up to 383. According to self-reported retirement data, an average of 3.2% of FTEs plan to drop out of the workforce each year over the next five years due to retirement and hour reduction. Using these figures, the number of LCSWs may reach between 6,145 and 6,400 depending on the retention rate. However, if historical licensing data trends continue, totals may fall below even current ratios by 2030. These licensing trends include those who are not working in the state, therefore an average of 13.2% of the workforce dropping out each year may be an overestimation. In order to move towards the national average of 204 providers per 100,000, LCSWs must have a net average growth of 10.9% per year.

Figure 29: MFT Projection Model



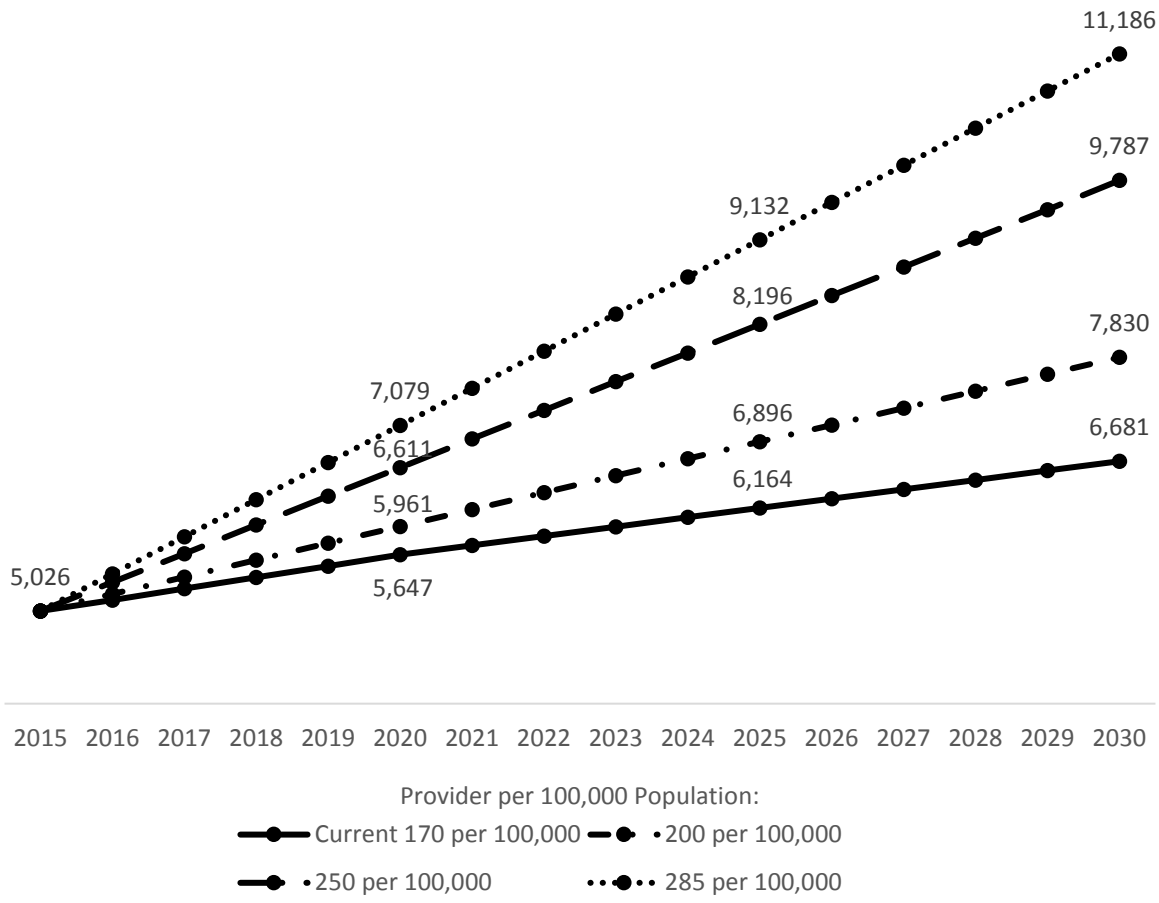
Utah is already experiencing higher numbers of Marriage and Family Therapists per 100,000 than the U.S. Although it is estimated that Utah only graduates 21 MFTs per year from brick and mortar programs, Arogsy University graduated 15 more in 2015. Assuming a 75.0% retention rate and a reported 2.9% of FTEs dropping out each year due to retirement and hour reduction would mean that Utah may have 609 MFTs by 2030, or close to 16 FTEs per 100,000, still above the current 12 providers for every 100,000 nationally. As with CMHCs, it is possible that more MFTs than the national average may help alleviate shortfalls in other professions. However, the historical licensing data has a much higher rate of license expiration and could lead to a large shortfall, although license expiration rates may be lower overall for those who are both licensed and working in Utah.

Figure 30: PSYCH Projection Model



On average, Utah graduates 19 Clinical Psychologists per year. Assuming 75.0% retention and 3.3% self-reported FTE reduction each year, the Psychologist workforce will likely fall well short of current ratios with only 678 Psychologists by 2030. Assuming a 90.0% retention rate still falls short at 690 providers. Even increasing the number of graduates and recruiting Psychologists from out of state will require an increase in the number of other professions to make up for the shortfall. In order to move towards the national average of 55 providers per 100,000, Psychologists must have a net average growth of 9.5% per year.

Figure 31: Overall Mental Health Workforce Projection[8]



Overall, assuming 422 graduates from brick and mortar training programs choose to practice in Utah after graduation and a self-reported annual FTE loss of 3.0%, the workforce is expected to reach 8,340 by 2030, or 213 providers per 100,000 population. This equates to an annual net average growth rate of 4.4%. Combining what we know of online programs, if we assume an additional 83 graduates enter the workforce, this may lead to a 5.7% net annual increase and 9,356 providers by 2030. However, in order to move towards the national ratio of 311 providers per 100,000, the net growth rate must increase to 8.2% per year.

[8] Numbers from individual professions do not add up to numbers from the entire workforce due to rounding discrepancies.

CONCLUSION

Mental health workforce shortages are pervasive across much of the nation, and Utah is no different. Despite facing a gaping shortfall in the number of providers, the workforce in Utah is growing and with low unemployment and higher than average wages, the state may attract practitioners from elsewhere.

As the population increases, the demand for mental health treatment will only continue to rise. While the ratio of providers to population may be increasing, more needs to happen in order for the state to catch up with national averages and meet the mental health needs of the state.

POLICY RECOMMENDATIONS

1. **Increase the Number of Providers.** Despite suffering from higher rates of mental illness than the national average, Utah has fewer providers per 100,000 people than the nation (171 FTEs and 209 providers per 100,000 people compared to 311 providers per 100,000 people nationally). In order to keep up with population growth and move closer to national ratios over the next 15 years, Utah must more than double the current workforce.
    a. Encourage employers and insurance providers to hire and reimburse all mental health professionals more transparently and equally according to training, scope of practice, and the type of services provided, thereby attracting more providers to either stay in or move to Utah.
    b. Support state and federally funded student loan repayment programs for mental health practitioners in Utah.
    c. Support increases in state funding for mental and behavioral health services.
2. **Promote a More Diverse Workforce.** Only 9.7% of the mental health workforce in Utah identifies as a racial or ethnic minority, compared to 19.7% of the population in the state. Increasing diversity can help ensure that the mental health needs of an increasingly diverse state are being met.
    a. Encourage collaboration with organizations such as United Way, Healthinsight and the Utah Department of Health, local high schools, etc. to encourage minority youth to consider a career in the mental health field.
3. **Strengthen the Rural Workforce.** Utah is facing a mental health provider shortage across all 29 counties, but rural areas are experiencing higher shortfalls than urban areas. While urban Utah has 171 FTEs per 100,000, rural Utah has 141 FTEs per 100,000.
    a. Support state funding for loan repayment programs for mental health providers who practice in rural areas.
    b. Encourage graduate programs to target applicants who come from rural backgrounds as they tend to practice in rural settings more often than their urban counterparts.
    c. Encourage graduate programs to build and maintain rural practicum placements.
4. **Enhance Data Collection.** With this baseline analysis, the UMEC has begun the vital task of tracking the mental health workforce, however additional data is needed in order to make an accurate prediction of the demand for mental health providers.
    a. Continue to conduct regular surveys of the mental health workforce.
    b. Conduct employer surveys and track the workforce that moves into independent practice settings in order to better understand demand and workforce movement.
    c. Support efforts to request legislative change in order to incorporate the UMEC survey into the DOPL licensing process.

d. Partner with graduate schools in the state in order to obtain accurate information on class size and student demographics.
e. Encourage efforts to track retention rates of mental health providers trained in Utah as well as those from Utah who are training out of state.

5. **Support Health Care Integration.** Integrating mental and physical health has so far shown to cut down on repeat ER visits, decrease health care costs, and improve overall health outcomes. Health care integration may increase both the number of mental health providers in the state and the percentage of the population accessing mental health services.
6. **Encourage Further Analysis of Gender Pay Disparities.** The UMEC cannot presently make any firm conclusions regarding the gender pay gap within mental health. The advisory committee recommends further analysis into the subject.

APPENDIX A – BIBLIOGRAPHY

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APPENDIX B – SURVEY INSTRUMENT

Utah Medical Education Council
230 South 500 East, Suite 210
Salt Lake City, Utah 84102

Utah Medical Education Council
2015 Mental Health Workforce Survey

Dear «Prefix» «LAST_NAME»

The Utah Medical Education Council (www.utahmec.org) was created in 1997 with the mission to conduct healthcare workforce research. The UMEC's advises on Utah's medical workforce needs, influences graduate medical education financing policies, and works with state legislators, universities, and numerous healthcare organizations to ensure that Utah's healthcare workforce is sufficient to serve Utah's communities.

The UMEC, in conjunction with the Utah Department of Health, Utah Division of Occupational and Professional Licensing, the University of Utah, Utah State University, Brigham Young University, as well as the National Association of Social Workers-UT, Utah Association for Marriage and Family Therapy, the Utah Mental Health Counselors Association, and the Utah Psychological Association would like to invite you to participate in the first comprehensive survey of the mental health workforce in Utah. Your participation in this survey is crucial for determining the active mental health workforce makeup and distribution throughout the state. This information is critical for schools of mental health, the Utah legislature, and countless mental health organizations to prepare for current and future workforce needs. We are committed to maintaining your privacy. Only de-identified, aggregate data will be published.

For any questions regarding this survey please contact the UMEC at 801-526-4567 or by email at jennac@utah.gov. **Please return the completed survey to the UMEC within 30 days** in the enclosed postage paid envelope.

Sincerely,

Richard Campbell
Executive Director
Utah Medical Education Council

Iona M. Thraen, PhD, ACSW
Utah State Innovation Model Director
Utah Department of Health

Tom Mullin, PhD
President
Utah Psychological Association

Paul Carver, CMHC, CFMHE
Past-President
Utah Mental Health
Counselors Association

Jonathan Sandberg, PhD
Board Member
Utah Association for
Marriage and Family Therapy

Emily Bleyl, LCSW
Executive Director
National Association of
Social Workers-UT

Utah's Mental Health Workforce Survey 2015

SECTION 1: GENERAL INFORMATION, BACKGROUND, AND EDUCATION

1. Please mark the mental health license you currently hold in the state of Utah:

☐ CMHC	☐ MFT	☐ LCSW	☐ Psychologist
☐ Temporary CMHC	☐ Temporary MFT	☐ CSW	☐ Psychologist Assistant
☐ Associate CMHC	☐ Associate MFT	☐ Temporary LCSW	☐ Temporary Psychologist
☐ Associate CMHC Extern	☐ Associate MFT Extern	☐ CSW Intern	☐ Psychology Resident
☐ Volunteer CMHC		☐ CSW Extern	

2. Are you providing direct or indirect mental health services in Utah (including administration, teaching, etc.)?
☐ Yes ☐ No

a. ***If* NO*, please specify why you maintain a Utah license.***

_____

b. **If NO, on a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the individual factors that have influenced your choice to work outside of Utah:**

Family _____ Wage/Pay scale _____ Climate _____
Lifestyle _____ Work Environment _____ Other _____ *(specify)*_____

IF YOU DO NOT PROVIDE DIRECT OR INDIRECT MENTAL HEALTH SERVICES IN THE STATE OF UTAH, PLEASE STOP HERE AND RETURN THE SURVEY IN THE INCLUDED PRE-PAID ENVELOPE.

3. On a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the following factors that have influenced your choice to practice in Utah:

Family in Utah _____ Practice Environment _____ Lifestyle _____ Utah Graduate _____
Military _____ Practice Opportunities _____ Other _____*(specify)*_____

4. Are you of Hispanic ethnicity? ☐ Yes ☐ No

5. What is your race? (*please mark only one*)

☐ American Indian/Alaska Native ☐ African American ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other *(specify)*_____

6. Please describe the area where you spent the majority of your upbringing *(when you lived there):*

State _____ ☐ Rural ☐ Suburban ☐ Urban/Metropolitan

7. What is the highest mental health degree you have obtained?

☐ Master's in Counseling	☐ PhD in Counseling	
☐ Master's in Marriage & Family Therapy	☐ PhD in Marriage & Family Therapy	
☐ Master's in Social Work	☐ PhD in Social Work	☐ Doctor of Psychology (PsyD)
☐ Master's in Psychology	☐ PhD in Psychology	☐ Other *(specify)*_____

8. Where and when was your degree conferred?

State:_____ Year of degree:_____ Check one that applies: ☐ State School ☐ Private School

9. Please enter a code from the list below to indicate the amount of your CURRENT student debt and TOTAL student debt from your mental health schooling (undergraduate and graduate). Current _____ Total _____

01=$0.00	04=$20,000 to $29,999	07=$50,000 to $59,999	10=$80,000 to $89,999
02=$0.01 to $9,999	05=$30,000 to $39,999	08=$60,000 to $69,999	11=$90,000 to $99,999
03=$10,000 to $19,999	06=$40,000 to $49,999	09=$70,000 to $79,999	12=$100,000 or more

10. Did/do you participate in a loan forgiveness/repayment program (LRP)? ☐ Yes ☐ No

a. If yes, which one(s)?

☐ Public Service LRP	☐ National Health Services Corps LRP	☐ Employer Based LRP
☐ Pediatric Specialty LRP	☐ AmericaCorps	☐ Volunteers in Service to America (VISTA)
☐ Military LRP	☐ Federal Employee LRP	☐ Other_____

SECTION 2: YOUR WORK SETTING/ SPECIALTY

11. Which best describes your primary work status? *(please check **one** of the following)*

☐ Employed in a mental health position that requires a license
☐ Employed in a mental health position that does not require a license
☐ Involuntary unemployment
☐ Voluntary unemployment
☐ Employed NOT in mental health
☐ Retired (with or without volunteer work)
☐ Volunteer work only

12. Which best describes your current employment arrangement at your primary practice location?

☐ Self-employed ☐ Hourly employment ☐ Salaried employment ☐ Locum tenens/temporary

13. Please list the city and zip code of your primary practice setting and secondary practice setting *(if applicable).* **Please also estimate the total hours worked per week** at each location.

Primary Practice City _____ Zip _____ Total hours/week _____
Secondary Practice City _____ Zip _____ Total hours/week _____

14. Please enter a code from the list to describe your Primary _____ and Secondary _____ practice settings:

01= Public Hospital
02= Private Hospital
03= Psychiatric Hospital
04= Mental Health Clinic
05= Primary or Specialist Medical Facility
06= Substance Abuse Treatment Facility
07= College/University Counseling/Health Center
08= Methadone Clinic
09= Child Welfare Facility
10= Criminal/Juvenile Justice Facility
11= Correctional Facility
12= Hospice Setting
13= Independent Solo Practice
14= Independent Group Practice
15= Academic Institution (teaching)
16= Veterans Facility
17= Long-term Care Facility
18= Organization/Business Setting
19= Rehabilitation Facility
20= Residential Facility
21= School Based Facility
22= Community Health Center
23= State Mental Health Agency
24= Other private for-profit organization
25= Other private non-profit organization
26= Other _____

15. Have you voluntarily switched employers/practices within the past five years?

☐ YES ☐NO

a. If YES, please use the list of settings above to indicate the practice setting you left and the work setting you moved to: Setting Code Left: _____ Setting Code Moved To: _____

b. If YES, please check the reason(s) for this change of work setting

☐ Better Work/Education Fit ☐ Desire for Change ☐ Higher Pay ☐ More Challenging
☐ Moved Residence ☐ Personal/Family Reasons ☐ Preferred hours ☐ Professional Advancement
☐ Work Responsibilities ☐ Other _____

16. Are you employed for or contracted by a Behavioral Health Management Organization?

☐ YES ☐NO Specify organization_____

17. What population(s) do you generally serve in your primary setting? *(check all that apply)*

☐ Any/all populations
☐ American Indian or Alaska Native
☐ Asian or Asian American
☐ Black or African American
☐ Hispanic/Latino/a
☐ Native Hawaiian or Pacific Islande
☐ White
☐ Refugees/Immigrants
☐ Children (under 13 years)
☐ Adolescents (13-17)
☐ Young adults (18-34)
☐ Mid-adults (35-64)
☐ Older adults (65-84)
☐ Elderly (85 and older)
☐ Families
☐ Couples
☐ Groups
☐ Individuals
☐ Homeless
☐ Rural
☐ Suburban
☐ Urban
☐ Working poor/unemployed
☐ Other:_____

SECTION 3: YOUR PRACTICE

18. Do you use telemedicine in your practice? ☐ Yes ☐No

a. If yes, do you use telemedicine to interact with a supervisor? ☐ Yes ☐No

b. Do you use telemedicine to provide therapy, consultation, or assessment across state lines? ☐ Yes ☐No

i. If yes, have you come across licensing or practice obstacles across state lines? ☐ Yes ☐No

19. Please indicate the average number of hours you spend in DIRECT CLIENT CARE (including client documentation and treatment) each week:

Primary Practice: _____ Secondary Practice _____

20. In a typical day, how many INDIVIDUAL clients do you see per day?
Primary Practice _____ Secondary Practice _____

21. If you provide group or family therapy, how many GROUPS do you see per day and how large is a typical group?

	Number of Groups	Size of Groups
Primary Practice	_____	_____
Secondary Practice	_____	_____

22. Please indicate the average hours per week you spend in the following NON-CLIENT CARE activities:
(Number of hours between non-client care and direct client care should not exceed the number of hours worked/week)

NON-CLIENT ACTIVITY	Hrs./Wk. PRIMARY SITE	Hrs./Wk. SECONDARY SITE
a. Classroom Training (clinical and/or classroom training of students)	_____	_____
b. Clinical Supervision/Instruction (of interns/students or required clinical hours for licensure)	_____	_____
c. Administration/Management (budgeting, personnel management, NOT in support of client care)	_____	_____
d. Practice Management (budgeting, planning, activities to maintain operation of a practice)	_____	_____
e. Consulting/Research (reports, applications, surveys, etc., NOT in support of client care)	_____	_____
f. Other: _____ (NOT in support of client care)	_____	_____

23. Please estimate the percentage of clients you see from each of the following age groups *(Should equal 100%)*

	0-12	13-17	18-34	35-64	65-84	85+
Primary Practice:	_____%	_____%	_____%	_____%	_____%	_____%
Secondary Practice:	_____%	_____%	_____%	_____%	_____%	_____%

24. What percentage of your clients are: Male _____% Female _____%

25. What percentage of your clients are insured by: *(percentages should add up to 100%)*

	Primary	Secondary		Primary	Secondary		Primary	Secondary
Medicaid	____%	____%	Private Insurance	____%	____%	Charity/No Charge	____%	____%
Medicare	____%	____%	TriCare (Champus)	____%	____%	Self-Pay (full)	____%	____%
Managed Care	____%	____%	Workers Comp.	____%	____%	Self-Pay (sliding scale)	____%	____%

26. On average, how many days must clients wait for an appointment?
Primary Practice: **New Clients**: _____days **Established Clients**: _____days
Secondary Practice: **New Clients**: _____days **Established Clients**: _____days

27. Please indicate a code for the status of your primary_____ and secondary_____ practice location(s).
01= Full (cannot accept additional patients) 03= Unfilled (can accept many new patients, far from full)
02= Nearly Full (can accept a limited number of new patients) 04= N/A (practice site is VA, military, or corrections)

28. Does your primary practice location provide mental health therapy in any language OTHER than English?
☐ Yes ☐No **a. If yes, please specify the language(s):** _____

29. Are YOU able to provide mental health therapy in any language OTHER than English (without an interpreter)?
☐ Yes ☐No **a. If yes, please specify the language(s):** _____

30. What models of therapy do you typically use? *(check all that apply)*
☐ Psychodynamic ☐ Experiential-humanistic ☐ Other*(specify):*
☐Cognitive-behavioral ☐ Transpersonal _____

31. Please indicate if you treat the following disorders: 1. Never; 2. Sometimes; or 3. Frequently

__ Neurodevelopmental Disorders
__ Schizophrenia & Psychotic Disorders
__ Bipolar & Related Disorders
__ Depressive Disorders
__ Anxiety Disorders
__ Obsessive-Compulsive Disorders
__ Trauma- & Stressor-Related Disorders
__ Dissociative Disorders
__ Somatic Symptom Disorders
__ Feeding & Eating Disorders
__ Elimination Disorders
__ Sleep-Wake Disorders
__ Sexual Dysfunctions
__ Co-occurring Disorders (NOT including diabetes & obesity)
__ Gender Dysphoria
__ Disruptive, Impulse & Conduct Disorders
__ Substance Use & Addictive Disorders
__ Neurocognitive Disorders
__ Personality Disorders
__ Paraphilic Disorders
__ Co-occurring Disorders (including diabetes & obesity)

32. Please estimate the percentage breakdown of source referrals for your client caseload *(should total 100%):*

____% Primary Care Clinician ____% Specialty Clinician ____% Self-referral ____% Workplace
____% School ____% Behavioral HMO ____% Other therapist ____% Other: _____

33. Do you coordinate your care with patients' other providers? ☐ Yes ☐No

a. If yes, please estimate the percentage of your caseload you coordinate care for: _____%

b. Please indicate the professionals you work with to coordinate care *(select all that apply)***:**

☐ Primary Care provider ☐ Care Coordinator ☐ Care Navigator
☐ Psychiatrist ☐ Care Manager ☐ Community Health Worker
☐ Nurse Practitioner ☐ Case Manager ☐ Other_____

34. Who is your main point of contact for prescribing medication? *(please mark only one)*

☐ Primary Care Physician ☐ Primary Care Physician Assistant ☐ Primary Care Advanced Practice Nurse
☐ Psychiatrist ☐ Psychiatric Physician Assistant ☐ Psychiatric Advanced Practice Nurse
☐ Other Physician ☐ Other Physician Assistant ☐ Other Advanced Practice Nurse

35. Would you say your access to a prescribing partner is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

SECTION 4: YOUR FINANCIAL OUTLOOK/JOB SATISFACTION

36. Within the past two years, have you experienced any of the following *(check all that apply):*

☐ Voluntary Unemployment
☐ Involuntary Unemployment
☐ Switched employers/practices
☐ Worked two or more positions at the same time
☐ Worked part-time or temporary positions, but would have preferred a full-time or permanent position
☐ Considered leaving the mental health field for something else (not including retirement)

37. What is your average gross compensation? *(before taxes and excluding benefits)*

☐ Less than $10,000 ☐ $30,000-$39,999 ☐ $60,000-$69,999 ☐ $90,000-$99,000
☐ $10,000-$19,999 ☐ $40,000-$49,999 ☐ $70,000-$79,999 ☐ $100,000-$109,999
☐ $20,000-$29,999 ☐ $50,000-$59,999 ☐ $80,000-$89,999 ☐ $110,000 or more

38. Do you plan to completely retire from mental health work? ☐ Yes ☐No

a. If yes, at what age do you plan to retire? _____

39. Do you plan to reduce the number of hours you practice per week before or in lieu of retirement? ☐ Yes ☐No

If yes, please specify:

a. How many years from now do you plan to reduce your hours? _____ Yrs
b. How many hours per week will you practice after reducing your hours? _____ Hrs/Wk

40. Overall, how satisfied are you with your *current* employment situation?

☐ Very satisfied ☐Somewhat satisfied ☐ Somewhat dissatisfied ☐ Very dissatisfied

Thank you for your participation. Please return the survey in the enclosed envelope.

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