

2021 Behavioral Health Workforce Surveys Supporting Statement

Part A. Justification

A1. Circumstances Necessitating Data Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting to field two new surveys designed to provide important insights on the workforce treating mental health and substance use disorders: 1) a one-time Survey of Behavioral Health Workforce Employers to obtain input from behavioral health provider organizations regarding workforce needs and challenges with recruitment and retention, and 2) a one-time survey of Clinical Behavioral Health Providers (defined as licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors) to assess the strength of state licensure data for determining the number of actively practicing clinicians serving clients with mental illness or substance use disorders. The instruments were developed by the George Washington University (GW) Mullan Institute for Health Workforce Equity as part of the Mental and Substance Use Disorder Practitioner Data grant funded by SAMHSA, grant number H79FG000028. SAMHSA can use this information to develop strategies for strengthening the behavioral health workforce.

2021 Behavioral Health Workforce Employer Survey

The Behavioral Health Workforce Employer Survey focuses on the adequacy of the available supply of the following professions: psychiatrists, addiction medicine specialists, primary care physicians, advanced practice psychiatric nurses, nurse practitioners (NPs), physician assistants, nurses, social workers, psychologists, licensed professional counselors, marriage and family counselors, pharmacists, peer support specialists, case managers, community health workers, and other support staff. The information gathered by the survey will be used to gain insights into, and to document, the behavioral health staffing mix, type of patients served, challenges in recruiting and retaining behavioral health staffing, and workforce needed to address gaps in care. The survey includes questions to assess the following measures: facility type (e.g., outpatient facility, inpatient, residential); type of behavioral health staff employed (e.g., addiction medicine specialists, psychiatric NPs, marriage and family therapists); services offered (e.g., assertive community treatment, partial hospitalization); roles and training needs of peer support specialists, case managers, care managers, and pharmacists (e.g., certification, population served, paid status, reimbursement); professions with recruitment and retention challenges (e.g., select from list of professions) and the reasons behind these challenges (e.g., low wages, high case load) and work-arounds (e.g., use of locum tenens); average wait-time for appointments (e.g., new patient visits); staffing needed to address gaps in care (e.g., estimated FTEs needed by profession type); use of telehealth (e.g., percent of visits); patient mix (e.g., immigrants, LGBTQ communities, number of clients); and form of payment (e.g., percent commercial, Medicaid, self-pay). The survey will be administered online through Qualtrics.

Employer Survey Participants

SAMHSA is requesting to field a survey of approximately 2,800-member organizations of the National Council for Behavioral Health (NCBH) that provide direct services. NCBH members are healthcare organizations and management entities that offer treatment and supports to more than ten million adults and children living with mental illnesses and addictions. Its members are located in all 50 states and include behavioral health provider organizations (e.g., community mental health centers, residential providers, rehabilitation programs); hospitals/health systems that provide behavioral health services; state and county behavioral health departments; managed care organizations; and local associations of behavioral health and human service providers.

2021 Clinical Behavioral Health Provider Survey

The information gathered by the provider survey will be used to better understand the roles and experiences of licensed clinical behavioral health specialists (licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors) – a portion of the overall behavioral health workforce that is not well documented in other national data sources. In a separate part of this grant, we are using prescription data to obtain insight into the activities and distribution of psychiatrists, addiction medicine specialists and other physicians, NPs and PAs that provide behavioral health services, but there is no analogous data source that provides similar information about psychologists, counselors and therapists. The *Clinical Behavioral Health Provider Survey* aims to fill this gap.

The survey includes questions to assess the following measures: current active status (e.g. currently providing behavioral health treatment or services to clients in a position that requires a professional license); demographics (e.g., age, race/ethnicity, sex); professional and practice setting (e.g., self-employed, outpatient mental health clinic, zip code, hours worked); level of education (e.g., Masters in Social Work, Doctorate in Social Work); types of services provided (e.g., assertive community treatment); number of and type of clients served (e.g., Medicaid, Medicare, veterans, immigrants); telehealth use; and, career satisfaction and burnout (e.g., very satisfied, “I enjoy my work, I have no symptoms of burnout”). The survey will be administered online through Qualtrics. Results from survey will provide critical information on the accuracy and adequacy of state licensure data and national practitioner data for estimating the clinical behavioral health workforce that is actively providing counseling and therapy services as well as new insights on their professional activities and demographics.

Provider Survey Participants

The survey will be administered via email to a random sample of 5,000 licensed clinical behavioral health providers selected from state licensure files where email addresses are included with the data. This approach will reach the broadest national sample possible for maximum representativeness of the data. Approximately 1,250 licensed clinical behavioral health specialists from each of the four professions will be randomly selected from the pool of available email rosters. The available states with email addresses represent all six U.S. Census regions and varying scope of practice regulatory environments which makes the sampling frame as broad as possible while accommodating an email survey distribution platform as specified in the grant proposal. The list of state licensure rosters will continue to be updated as data becomes available but currently includes:

- 16 states for licensed psychologists (AR, FL, KS, MI, MN, MS, ND, NE, NY, OH, OR, RI, TX, UT, WI, WV)
- 12 states for licensed clinical social workers (FL, KS, LA, MI, MN, NE, NY, OH, OR, RI, UT, WI)
- 10 states for licensed professional counselors (FL, KS, MI, NE, NY, OH, OR, RI, UT, WI)
- 11 states for licensed marriage and family therapists (FL, KS, IA, MI, NE, NY, OH, OR, RI, UT, WI)

A2. Purpose and Use of Information

The purpose of the data collection is to address important gaps in knowledge about 1) the active status of a poorly documented portion of the behavioral health workforce (psychologists, licensed clinical social workers, licensed professional counselors, and marriage and family therapists) as well as the proportion that offer particular mental health and substance use disorder related services or treat particular populations, 2) the employer perspective on the adequacy of the current behavioral health supply across a broad range of behavioral health organization types and the workforce needed to address gaps in availability, training, and job satisfaction. This information will help enable SAMHSA and the National Mental Health and Substance Use Policy Laboratory (Policy Lab) to meet the 21st Century Cures Act goals of ensuring better coordination across the entire Federal Government related to addressing the needs of individuals and their families with serious mental illness or serious emotional disorders, to promote evidence-based practices and service delivery models, and evaluate models that would benefit from further development and expansion. Further, the provider survey data can also inform health equity priorities by obtaining previously unavailable data on the diversity of the clinical behavioral health workforce and the proportion caring for underserved populations versus treating only privately insured clients.

Access to evidence-based treatment provided by behavioral health practitioners is necessary to ameliorate the impact of substance use disorder (SUD) and mental illness (MI) in the U.S. In 2019, 13.3 million adults in the U.S. self-reported needing mental health (MH) services or counseling within the past year but not receiving it. In the same year, nearly 19 million people needed, but did not receive specialty treatment for SUD, and 6.2 million with serious mental illness perceived an unmet need for mental health services in the past year. The reasons for these gaps are varied, but both inadequate supply and distribution of MH/SUD practitioners and treatment facilities are key drivers.¹ Today, there are over 5,000 Mental Health Professional Shortage Areas in the U.S., representing about one-third of the population. Over half of U.S. counties lack a single MH/SUD practitioner.

Effective tracking of the MH/SUD workforce has been plagued by a series of data limitations. Efforts to estimate this workforce face several challenges. First, there is no standard definition of

¹ Substance Abuse and Mental Health Services Administration. (2020). 2019 National Survey of Drug Use and Health (NSDUH) Releases. Retrieved from <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFRRPDFWHTML/2019NSDUHFRR1PDFW090120.pdf>

the MH/SUD workforce. Treatment of SUD and MI involves a broad and evolving range of professional and paraprofessional disciplines. Data collection and surveillance tools have therefore not targeted a standardized, consistent pool of MH/SUD practitioner disciplines. The Employer Survey will provide a way to consistently identify which professions are being used to provide MH/SUD services and how that varies across states and practice settings. This includes use of peer support specialists, community health workers and case managers which are notoriously difficult to track professions yet crucial members of SUD and MI evidence-based treatment teams. Further, the survey will show which workforce providers are most needed to address gaps in service delivery. Employers will be asked to outline how many Full-Time Equivalents (FTEs) are needed to address gaps in care at their organizations and this previously unavailable data can be used to help prioritize local, state and national behavioral health workforce investments. Further the survey will capture data on factors associated with recruitment and retention challenges which can point toward needed policies and programs that will make it easier for behavioral health provider organizations to have the workforce needed to provide robust MH/SUD care.

Second, there are large gaps in workforce data for counselors and therapists. Many states may not have the capacity or desire to undertake rigorous data collection, management, and dissemination efforts. These challenges result in an incomplete picture of the MH/SUD practitioners in the U.S., preventing a strategic and targeted workforce response. The GW team is amassing a robust national database of licensed clinical behavioral health providers as part of the Practitioner Data grant, but licensure status does not always equate with active clinical practice and lacks the specificity required to perform the accurate workforce supply analyses and projections. Conducting a national survey of clinical behavioral health providers will help to identify how many are actively licensed as well as capture important new data on the types of services offered and populations served by these professions, including their role in caring for clients with serious mental illness and SUD.

Federal agencies, states, and academic and medical institutions urgently need data on the geographic distribution of the practitioner workforce and a better understanding of where and how this supply matches (or does not match) population MH/SUD needs. Ultimately, these two surveys will address important MH/SUD workforce data gaps that will allow SAMSHA to better inform Congress and other policy leaders regarding strategies for ensuring an adequate supply of MH/SUD providers. The information collected through these two surveys can be used to influence public policy and programming as they relate to the workforce needed to ensure access to MH/SUD services. For example, the information can be used to:

- Inform reports to Congress on key behavioral health workforce questions, including how employers of behavioral health providers would prioritize additional workforce investments. Additionally, the data can offer new insights on the use and availability of peer support specialists in treating SUD or whether clinical behavioral health providers who practice in states where Medicaid reimburses for diagnosis and treatment services for their profession are more likely to see Medicaid beneficiaries.
- Help program planners and policy makers understand the strength of the MH/SUD workforce currently available and identify the MH/SUD workforce needed to address gaps in care. For example, the Employer Survey can capture data on the number and type

of providers needed to address workforce gaps. The Practitioner Survey will show how many licensed clinical behavioral health specialists offer particular MH/SUD services and for which populations and how that varies by scope of practice regulations and Medicaid reimbursement policies.

- Plan appropriate technical assistance services for MH/SUD organizations as well as to inform policies needed to help address recruitment and retention challenges. The data can help inform whether employers of behavioral health providers are most in need of psychiatrists, addiction medicine specialists, counselors, peer support specialists, or other specialists and which factors are hindering recruitment and retention by organization type.
- Support SAMHSA publications and materials on MH/SUD staffing as an important resource for public and private organizations involved in the design and implementation of addressing SUD or MI.

The findings from these data will be a crucial resource for SAMHSA in setting behavioral health workforce policy priorities, assessing workforce needs, and designing and promoting optimally effective workforce initiatives. SAMHSA will ensure that the data on the behavioral health workforce will be shared with the Centers for Disease Control and Prevention, the Health Resources and Services Administration, as well as other relevant agencies of the Department of Health & Human Services.

A3: Use of Technology

To maximize data accuracy and reliability, the surveys be administered using Qualtrics, a web-based tool that participants complete online.

The system being planned for the instruments will require a web browser and access to the Internet. Users will be able to access the system 24 hours a day, 7 days a week, aside from scheduled maintenance windows, through the use of a unique, anonymous link sent via email. Participants will receive an initial survey invitation and up to four follow-up reminders. Upon clicking or copying the link into the browser, participants will be able to respond to the survey. Skip patterns will facilitate navigation through the survey by only displaying items that apply to the participant, based on information already entered into the system.

Upon completion of the *Provider Survey*, the first 1,500 respondents will be directed to a separate website to claim a \$20 gift card as an incentive. (The *Employer Survey* does not include an incentive because it will be fielded in collaboration with NCBH, which regularly surveys its members and typically achieves high response rates (50% or higher) without providing incentives.) The research team will use a system called Rybbon to distribute gift cards to *Provider Survey* participants.

A4. Efforts to Identify Duplication

GW conducted an extensive literature search, consulted with staff in federal agencies and organizations that work with substance use and mental illness surveys, and discussed the proposed surveys with MH/SUD experts. Specifically, GW:

- Reviewed surveys conducted by SAMHSA and other organizations (e.g., NCBH, University of Michigan Behavioral Health Workforce Research Center (BHWRC) Partner Consortium) to identify the most salient workforce data gaps and types of information needed to enrich understanding of the MH/SUD workforce and to inform MH/SUD policies. GW also sought methodological guidance to strengthen the validity, generalizability, or policy application of results.
- Conducted reviews and pilot testing with NCBH staff and the University of Michigan's BHWRC Partner Consortium. These trade organizations represent a broad range of behavioral health professions including but not limited to those included in the *Provider Survey*. The Consortium includes:
 - a. University of Michigan School of Public Health Center of Excellence in Public Health Workforce Studies
 - b. American Psychiatric Association
 - c. National Association for Alcoholism and Drug Abuse Counselors
 - d. American Academy of PAs
 - e. American Association for Marriage and Family Therapy
 - f. Behavioral Health Education Center of Nebraska
 - g. The National Council for Behavioral Health
 - h. Southwest Michigan Behavioral Health
 - i. American Psychological Association
 - j. National Board for Certified Counselors
 - k. Council on Social Work Education
 - l. American Psychiatric Nurses Association
 - m. American College of Academic Addiction Medicine
 - n. American Society of Addiction Medicine
 - o. American Hospital Association
- The BHW Consortium members and NCBH staff agree these surveys will collect valuable new information.
- Consulted with staff in SAMHSA. While SAMHSA has extensive data on organizations providing services and populations in need of these services, very little data is available on how MH/SUD staffing varies across facility types, the particular recruitment or retention challenges faced, or the specific workforce staffing needed to address gaps in care. No federal surveys collect data similar to that being proposed in this submission.

SAMHSA did not identify any redundancy in that there were no precedents for a data collection effort similar to the one being proposed. Thus, it is clear that the data to be collected will be unique to the SAMHSA. In other words, the data collected through these instruments will be non-duplicative.

A5. Involvement of Small Entities

This data collection will have no significant impact on small entities.

A6. Consequences If Information Collected Less Frequently

The information will be collected only once.

A7. Consistency with Guidelines in 5 CFR 1320.5(d) (2)

This information collection fully complies with 5 CFR 1320.5(d) (2).

A8. Consultation outside the Agency

A8a. Federal Registry Announcement

The notice required in 5 CFR 1320.8(d) was published in the Federal Register on December 31, 2020 (85 FR 86942). No comments were received.

A8b. Consultations Outside the Agency

GW consulted with experts on behavioral health workforce, behavioral health counseling and therapy, and SAMHSA. Consultations resulted in the refinement of the instruments based on current federal data reporting needs.

A9. Payment to Participants

Participants in the *Provider Survey* will receive a \$20 gift card. Participants in the *Employer Survey* will not receive any payment for participation.

A10. Assurance of Confidentiality

SAMHSA has statutory authority to collect data under GPRA or the Government Performance and Results Act (Public Law 1103(a), Title 31) and is subject to the Privacy Act for the protection of these data. Only aggregate data will be reported, hence protecting the privacy and confidentiality of survey participants. The survey does not collect any data on individual clients.

The information from participants and potential SAMHSA grantees will be kept private and secure through all points in the data collection and reporting process. All data will be closely safeguarded, and no institutional or individual identifiers will be used in reports. The IRB-approved informed consent form will include the following language to explain confidentiality protections to participants:

“All identifying information (e.g., email and IP addresses) will be separated from your responses immediately after you complete the survey. To maintain confidentiality, survey responses will be stored on secure, password-protected computer servers and data files will only be available to

authorized members of the research team. All reports and published papers will only report aggregated survey results.”

Following the de-identification process, a member of the research staff will destroy the raw, identifiable version of the survey data. The data will be stored in password-protected files on GW’s secure server.

A11. Questions of a Sensitive Nature

No data regarding individual clients will be collected. Furthermore, data will only be reported in aggregate such as by facility type (e.g., outpatient facility, inpatient, residential), by services offered (e.g., assertive outpatient treatment, partial hospitalizations), or geographic location (e.g., state or region). No individual institution level results will be reported.

A12. Estimates of Annualized Hour Burden

Participants included in collection include the following:

2,800 member organizations of NCBH.

Exhibit 1 below displays the calculation of annualized burden for the survey.

Exhibit 1: Total Estimated Annualized Burden by Instrument

Type of participant activity	Number of Participants	Responses per Participant	Total Responses	Hours per Response	Total Burden Hours	Wage Rate	Total Hour Cost
Employer Survey	2,800	1	2,800	.25	700	\$50.13	\$35,091.00
Provider Survey	5,000	1	5,000	.25	1,250	\$27.98	\$34,971.88
Total	7,800		7,800		1,950		\$70,062.88

A13. Estimates of Annualized Cost Burden to Participants

There will be no capital, start up, or operation and maintenance costs to participants.

A14. Estimates of Annualized Cost to the Government

GW Project Staff	Role	FTE	Year 1	FTE	Year 2	Totals
Leah	Investigator	5%	\$7,500	20%	\$30,000	\$37,500
Peter	Investigator	20%	\$35,000	0%	\$0	\$35,000
Catarina	Project Manager	5%	\$5,000	10%	\$8,000	\$13,000
Clese	Primary Investigator	5%	\$10,000	5%	\$10,000	\$20,000
NCBH	Subaward		\$10,000		\$10,000	\$20,000
GW Staff Total						\$125,500
Survey Incentives					\$30,000	
SAMHSA	1 Project Officer	10%	\$11,635.30	10%	\$11,635.30	\$23,270.60
Survey Total						\$178,770.60

The annualized cost is approximately \$178,770.60 including SAMHSA FTE time. This includes approximately \$67,500 of GW staff time for developing the survey instruments in year 1, \$58,000 of GW time for survey administration and analysis in year 2, and \$30,000 for survey incentives. In addition, approximately \$11,635.30 per year represents SAMHSA costs to monitor and approve grantee reporting in these instruments (10% time of 1 Project Officer at \$116,353 annual salary).

A15. Burden Level

The participant burden for both surveys is approximately 0.25 hours on average. Several sections of the *Employer Survey* will only appear for some participants due to skip logic, so most participants will not see all of the questions in the paper version. The research team has verified this estimate through pilot testing.

A16. Time Schedule, Analysis and Publication Plans

Analysis Plans

The main purpose of monitoring data is to provide SAMHSA with timely information about the behavioral health counseling and therapy workforce.

The proposed analysis utilizing the survey data includes several distinct steps:

Employer Survey

- Descriptive analysis of organizational characteristics, behavioral health services offered, telehealth use, patient volume and mix, current staffing, workforce needs, and populations served.

- Comparative analysis between behavioral health staffing models, workforce needs and telehealth use in different types and sizes of organizations/settings, and organizations offering different types of behavioral health services.
- Multiple regression models analyzing organizational factors associated with behavioral health workforce challenges with recruitment and retention and/or being understaffed. The research team plans to develop more detailed models after conducting descriptive data analysis. Independent variables used to predict recruitment/retention or staffing challenges could be (e.g.) organization type, services provided, types of clients served, or reimbursement types. Control variables could include state or urban/rural location.

Provider Survey

- Descriptive analysis of participant demographics, professional and practice activities, employment settings, educational background, telehealth use, and client volume and mix.
- Comparative analysis of services provided, telehealth use, patient volume and mix, job satisfaction and burnout between participants with different educational backgrounds, license types, settings, and states.
- Multiple regression models analyzing factors associated with job satisfaction and burnout. We plan to develop more detailed models after conducting descriptive data analysis. Independent variables used to predict burnout & satisfaction could be type of organization, types of clients served, services provided, weekly volume. Control variables could include participant demographics, state, etc. The key independent variable used to predict working with vulnerable populations (racial/ethnic minorities, LGBTQ individuals, Medicaid beneficiaries, etc.) would be participant race/ethnicity or LGBTQ status, with control variables including type of license held, state, etc.

Analysis Techniques and Statistical Test Determination

In assessing organizational behavioral health workforce needs and challenges based on the survey data, statistical tests appropriate to each type of variable will be employed. For categorical outcome measures, Wilcoxon rank-sum or chi-square tests will be used to test for differences between groups. For normally distributed continuous variables, two-sample t-tests or analysis of variance (ANOVA) will be used to test for differences between groups. For ordinal or skewed continuous measures will be tested using Wilcoxon rank-sum tests.

For the multiple regression analyses, logistic regression will be used to examine associations between organizational or provider characteristics and dichotomous dependent variables (e.g. recruitment/retention challenges with a particular profession, whether a provider reports burnout or dissatisfaction, whether a provider serves a particular vulnerable population). Ordered logistic regression models may also be used to examine associations between organizational or provider characteristics and levels of burnout or satisfaction.

Reporting and Dissemination Plan

The overall Mental Health and Substance Use Disorder Practitioner Data grant seeks to build a national database of behavioral health providers and to understand current practice patterns,

gaps, and training needs. There is currently no national database on the BH workforce—especially providers who are not physicians, NPs or PAs. The surveys aim to fill this gap by generating data that can be used to assess factors associated with behavioral health workforce challenges with both recruitment and retention, as well as the types of providers needed to address service gaps. Some data will also be reported for GPRA purposes needed in the Congressional Justification. SAMHSA may use the data for presentations to their stakeholders or senior leadership.

Timeline

Year 1 of the Mental Health and Substance Use Disorder Practitioner Data grant focused on survey development. The surveys will be fielded in Year 2 of the grant with an estimated start date of August 2021, pending conclusion of the OMB clearance process.

	Date
Mental Health and Substance Use Disorder Practitioner Data Grant Awarded	09/2019
Survey Development	10/2019 – 09/2020
Data Collection	08/2021 – 09/2021
Analysis and Reporting	10/2021 – 11/2021

A17. Display of Expiration Date

The expiration date will be displayed.

A18. Exceptions to Certification Statement

No exceptions are required.