Congressional Research Service
Informing the legislative debate since 1914

The Mental Health Workforce: A Primer

Updated April 20, 2018

Congressional Research Service
https://crsreports.congress.gov
R43255

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

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

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

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

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

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

Contents

Introduction 1
Mental Health Workforce Definition: No Consensus 1
Mental Health Workforce Overview 2
Licensure Requirements 3
Degree 3
Supervised Practice 4
Exam 4
Scope of Practice 7
Mental Health Workforce Size 8
Clinical Social Workers 9
Clinical Psychologists 10
Marriage and Family Therapists 10
Psychiatrists 10
Advanced Practice Psychiatric Nurses (APPN) 11
Mental Health Workforce Annual Wages 11
Concluding Comments 12

Tables

Table 1. Common Licensure Requirements, by Mental Health Provider Type 5
Table 2. Scope of Practice, by Mental Health Provider Type 7
Table 3. Annual Wages, by Mental Health Provider Type 12

Appendixes

Appendix A. Additional Resources 14

Contacts

Author Contact Information 15

Introduction

The federal government is involved in mental health care in various ways, including direct provision of services, payment for services, and indirect support for services (e.g., grant funding, dissemination of best practices, and technical assistance).[1] Policymakers have demonstrated interest in the federal government's broad role in mental health care. They have done so primarily by holding hearings[2] and introducing legislation[3] addressing the interrelated topics of quality of mental health care, access to mental health care, and the cost of mental health care.

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

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

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

Mental Health Workforce Definition: No Consensus

No consensus exists on which provider types make up the mental health workforce. While some define the workforce as a broad range of provider types, others take a more narrow approach. For example, the National Academy of Medicine (NAM)—a private, nonprofit organization that aims to provide evidence-based health policy advice to decisionmakers, often through congressionally

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

[2] See, for example, U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers*, 115th Cong., 1st sess., March 22, 2017; U.S. Congress, Senate Committee on Appropriations, Subcommittee on Departments of Labor, Health and Human Services, and Education, and Related Agencies, "*Mental Health Care: Examining Treatments and Services*," 115th Cong., 1st sess., February 15, 2017.

[3] For example, in the 115th Congress, bills were introduced intended to improve mental health care overall (e.g., H.R. 1253, H.R. 4778, H.R. 2345), and for specific populations such as Asian American, Native Hawaiian, and Pacific Islanders (e.g., H.R. 2677), youth in foster care, (e.g., S. 439), veterans (e.g., H.R. 897, S. 1881), law enforcement officers (e.g., H.R. 2228, S. 867), and Medicare beneficiaries (e.g., H.R. 1290, H.R. 1173, S. 448) among others.

mandated studies—has conceptualized the mental health workforce broadly, including primary care physicians, psychologists, nurses, mental health and substance abuse counselors, care managers and coordinators, and social workers.[4] The Substance Abuse and Mental Health Services Administration (SAMHSA)—the public health agency within the Department of Health and Human Services (HHS) that leads efforts to improve the nation's mental health—has defined the mental health workforce to include psychiatry, clinical psychology, clinical social work, advanced practice psychiatric nursing, marriage and family therapy, substance abuse counseling, and counseling.[5] Previously, SAMSHA's definition also included psychosocial rehabilitation, school psychology, and pastoral counseling and excluded substance abuse counseling.[6]

The Health Resources and Services Administration (HRSA)—the public health agency within HHS with primary responsibility for increasing access to health care (including mental health care) for vulnerable populations[7]—provides a more narrow definition of the mental health workforce that is tied to existing federal programs aimed at alleviating provider shortages (e.g., Medicare bonus payments and health workforce recruitment programs). Eligibility for such programs is determined in part by the designation of a Mental Health Professional Shortage Area (MHPSA).[8] The MHPSA designation is based on a limited number of core provider types because it is intended to identify the most extreme workforce shortages in order to target federal investments. For purposes of designating MHPSAs, HRSA has identified mental health providers as licensed psychiatrists, psychiatric nurses,[9] psychiatric social workers, clinical psychologists, clinical social workers, and family therapists, who meet specified training and licensing criteria. Notably, this definition is limited to highly trained mental health professionals.

Mental Health Workforce Overview

In conceptualizing and outlining the mental health workforce, this report relies on the HRSA definition of mental health providers, including clinical social workers, clinical psychologists, marriage and family therapists, psychiatrists, and advanced practice psychiatric nurses.[10] For each

[4] James Knickman et al., Improving Access to Effective Care for People Who Have Mental Health and Substance Use Disorders: A Vital Direction for Health and Health Care, National Academy of Medicine, September 9, 2016, https://nam.edu/wp-content/uploads/2016/09/Improving-Access-to-Effective-Care-for-People-Who-Have-Mental-Health-and-Sustance-Use-Disorders.pdf. The NAM definition also includes all fields in the SAMHSA definitions.

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

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

[7] HRSA, *About HRSA*, http://www.hrsa.gov/about/.

[8] Health professional shortage areas (HPSAs) are defined in 42 U.S.C. §254e. HRSA developed operational definitions of HPSAs and of MHPSAs specifically, available at http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html. HRSA designates MHPSAs based on the ratio of mental health providers to population. As of March 2018, HRSA had designated 5,042 MHPSAs. See U.S. Department of Health and Human Services, Health Resources and Services Administration, "Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P)," http://datawarehouse.hrsa.gov/topics/shortageAreas.aspx#chart.

[9] This report uses the term "advanced practice psychiatric nurse," which is more common than the term "psychiatric nurses" used in HRSA's Health Center Program Terms and Definitions. See U.S. Department of Health and Human Services, Health Resources and Services Administration, "Health Center Program Terms and Definitions," https://www.hrsa.gov/sites/default/files/grants/apply/assistance/Buckets/definitions.pdf.

[10] The HRSA definition is used because of its relevance to federal workforce programs and other incentive programs designed to improve access to care. See U.S. Department of Health and Human Services Administration, Health Resources and Services Administration, "Types of Designations," https://bhw.hrsa.gov/shortage-designation/types.

of the five mental health professions, **Table 1** summarizes licensure requirements (including degree, supervised practice, and exam) and **Table 2** summarizes scope of practice; each of these terms is explained briefly below. Although the licensure requirements vary widely across provider types, the scopes of practice converge into provider types that generally can prescribe medication (psychiatrists and advanced practice psychiatric nurses) and provider types that generally cannot prescribe medication (clinical psychologists, clinical social workers, and marriage and family therapists). All provider types in this report can provide psychosocial interventions (e.g., talk therapy). Administration and interpretation of psychological tests is generally the province of clinical psychologists.

Licensure Requirements

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

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

Degree

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

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

[11] See, for example, "About FSMB," Federation of State Medical Boards at http://www.fsmb.org/about-fsmb/fsmb-overview.

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

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

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

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

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

Supervised Practice

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

Exam

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

Table 1. Common Licensure Requirements, by Mental Health Provider Type

Provider Type[a]	Licensure Requirements		
	Degree[b]	Supervised Practice	Exam
Clinical Social Worker	Master of Social Work (MSW), which typically requires 2 years. Coursework emphasizes human and community well-being. Requires a supervised field practicum (internship).	Generally requires 3,000 postdegree supervised clinical hours, which take approximately 2 years.	Generally requires a passing score on the Clinical Exam of the Association of Social Work Boards.
Clinical Psychologist	Doctoral degree in psychology or a related field, which generally takes between 5 and 7 years to complete and requires academic coursework, clinical training, a dissertation, and an exam.	Generally requires 3,000 hours of supervised clinical training, which take approximately 2 years.[c]	Generally requires a passing score on the Examination for Professional Practice in Psychology (EPPP).[d]
Marriage and Family Therapist (MFT)	Master's degree (2-3 years), doctoral degree (3-5 years), or postgraduate clinical training (3-4 years) in marriage and family therapy or a related field.[e] Coursework emphasizes the individual's mental health in the context of interpersonal relationships (e.g., family and peers). Generally requires a field practicum or internship.	Generally requires 2 years of postdegree supervised clinical training.	Generally requires a passing score on the Association of Marital and Family Therapy Regulatory Board's Examination in Marriage and Family or the equivalent California Exam.[f]
Psychiatrist	Medical Doctorate (MD) or Doctorate of Osteopathic Medicine (DO), both of which typically require 4 years to complete (including 2 years of clinical rotations). Coursework emphasizes physical medicine.	Generally requires 3 or 4 years of postdegree supervised clinical training (residency) in the specialty of psychiatry.	Generally requires a passing score on the United States Medical Licensing Examination (USMLE) for MDs or DOs.[g] DOs can also elect to take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). Becoming *board certified* generally requires a passing score on an exam administered by the American Board of Psychiatry and Neurology.[h]

Provider Type[a]	Licensure Requirements		
	Degree[b]	Supervised Practice	Exam
Advanced Practice Psychiatric Nurse (APPN)[i]	Master of Science (MS) in nursing, which generally requires 2 years of coursework and clinical hours (generally 500 or more).[j] Coursework and clinical experience focus on psychiatric mental health nursing.	No separate postgraduate clinical training is required.	Generally requires a passing score on an exam offered by the American Nurses Credentialing Center.

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

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

a. The provider type may not correspond to the name of the license (which may vary by state for some provider types). The provider types correspond to HRSA's mental health providers (with the exception of advanced practice psychiatric nurses, which HRSA calls "psychiatric nurses").

b. The table focuses on graduate degree requirements (i.e., postbaccalaureate training requirements).

c. Generally, states require that at least 1,500 hours (of the 3,000 hours required) be a postdoctoral experience. See Association of State and Provincial Psychology Boards, "Entry Requirements for the Professional Practice of Psychology, 2008," http://www.asppb.net/resource/resmgr/Guidelines/09_Entry_Requirements.pdf#page=3.

d. A board certified psychologist is one who has completed training in a specific specialty and has passed an examination that assesses the basic knowledge and skills in that particular area. As in psychiatry, board certification is not required, but some employers may require it. Board certification is conducted by the American Board of Professional Psychology, see http://www.abpp.org/.

e. Related fields may include psychology, social work, nursing, education, or pastoral counseling. See American Association for Marriage and Family Therapy, *About Marriage and Family Therapists, What are the qualifications to be a Marriage and Family Therapist?*, http://www.aamft.org/iMIS15/AAMFT/Content/About_AAMFT/About_Marriage_and_Family_Therapists.aspx.

f. Marriage and Family Therapists (MFTs) who practice in California (representing more than half of all MFTs), must pass a separate California licensing exam.

g. Graduates of certain foreign medical schools may also be eligible to take the USMLE.

h. The term "board certified physician" means one who has completed the required training in a specific specialty and has passed an examination that assesses the basic knowledge and skills in a particular area (in this case psychiatry or neurology). Board certification is not required to practice as a psychiatrist but may be a condition of employment for some employers.

i. This includes mental health/psychiatric nurse practitioners and clinical nurse specialists. This report uses the term "advanced practice psychiatric nurse," which is more common than the term "psychiatric nurses" used by HRSA.

j. The nursing profession is moving toward requiring doctoral degrees in these fields, which requires an additional two years of training. See American Psychiatric Nurses Association, "What is an Advanced Practice Psychiatric Nurse?" http://www.apna.org/i4a/pages/index.cfm?pageID=3866.

Scope of Practice

The scope of practice for each provider type is established at the state level by state statute, regulation, or guidance. **Table 2** highlights elements within scope of practice that involve *diagnosing* and *treating* mental illness. The scope of practice for most provider types includes other activities, such as preventive care, case management, and consultation with other providers. The scope of practice described in the table reflects what is generally true in most states. For example, prescribing medication is included in the scope of practice for advanced practice psychiatric nurses, a provider type that comprises both nurse practitioners (allowed to prescribe medication in all states) and clinical nurse specialists (allowed to prescribe medication in only some states).

Table 2. Scope of Practice, by Mental Health Provider Type

Provider Type[a]	Can Diagnose Mental Disorders	Can Provide Psychosocial Treatment for Individuals, Families, and Groups	Can Administer and Interpret Psychological Tests	Can Diagnose and Treat Physical Conditions	Can Prescribe Medication
Clinical Social Worker	Yes	Yes	No	No	No
Clinical Psychologist	Yes	Yes	Yes	No	No[b]
Marriage and Family Therapist (MFT)	Yes	Yes	No	No	No
Psychiatrist	Yes	Yes	No	Yes	Yes
Advanced Practice Psychiatric Nurse (APPN)[c]	Yes	Yes	No	Yes[d]	Yes

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

Notes: The table focuses on the elements within scope of practice that involve diagnosing and treating mental illness. The scope of practice for most provider types includes other activities, such as preventive care, case management, and consultation with other providers.

a. The provider type may not correspond to the name of the license (which may vary by state for some provider types). The provider types correspond to HRSA's mental health providers (with the exception of advanced practice psychiatric nurses, which HRSA refers to as "psychiatric nurses").

b. In New Mexico, Louisiana, Illinois, Iowa, Idaho, Guam, the U.S. Department of Defense (DOD) system, the Indian Health Service, and the U.S. Public Health Service, licensed psychologists who obtain additional training can apply to have prescription writing privileges as part of their scope of practice. See Robert E. McGrath, "Prescriptive Authority for Psychologists," *Annual Review of Clinical Psychology*, vol. 6 (April 27, 2010), pp. 21-47; and American Psychological Association, "Idaho Becomes Fifth State to Allow Psychologists to Prescribe Medications," press release, April 5, 2017, https://www.apa.org/news/press/releases/2017/04/idaho-psychologists-medications.aspx.

c. This includes mental health/psychiatric nurse practitioners and clinical nurse specialists. This report uses the term "advanced practice psychiatric nurse," which is more common than the term "psychiatric nurses" used by HRSA.

d. Some states may require that advanced practice psychiatric nurses be supervised by physicians.

Mental Health Workforce Size

Access to mental health care depends, in part, on the number of practicing mental health providers relative to the population; however, such information is not systematically available for analysis.[16] Workforce data are collected and reported by multiple sources. However, each source has its limitations in assessing the overall size of the workforce.

HRSA designates Mental Health Professional Shortage Areas (MHPSAs) based on the ratios of psychiatrists, APPNs, clinical psychologists, clinical social workers, and MFTs to the population; however, HRSA does not systematically collect the data used to designate MHPSAs (see text box).

Data Used to Designate MHPSAs

When designating MHPSAs, HRSA attempts to capture the deficit in a particular geographic area of practicing mental health clinicians. As of March 2018, HRSA had designated 5,042 MHPSAs, including one or more in each state, the District of Columbia, and each of the territories. HRSA estimates the population of designated MHPSAs to be 95,399,011 in 2018.[17] To be designated a MHPSA, a state, through its Primary Care Office, applies to HRSA, with the data necessary to demonstrate that a particular area meets the designation criteria. States use a variety of sources when providing these data including professional association data, state licensing data, and state specific survey data. HRSA then reviews these data and makes a final determination about the designation.

Source: Health Resources and Services Administration, Data Warehouse, *Health Professional Shortage Areas (HPSA) and Medically Underserved Areas / Populations (MUA/P)*," http://datawarehouse.hrsa.gov/topics/shortageAreas.aspx#chart.

HRSA's **Area Health Resource Files (AHRF)** compiles health-related data from various sources.[18] The AHRF draws much of its health workforce data from datasets created by—and more readily available from—the Department of Labor. Some other sources of health workforce data in the AHRF are updated infrequently, if at all. For example, the 2016-2017 ARHF includes the number of psychologists from a 2009 analysis by a private research center.[19] Thus, other sources of mental health workforce size estimates may be more useful than the AHRF to policymakers.

National workforce data—which are not limited to the health care workforce—are generally collected by the Bureau of Labor Statistics (BLS) within the Department of Labor. Each data source has important limitations, as described below.

[16] One of the primary challenges in assessing the overall size of the mental health workforce is that there is no uniform definition; see "Mental Health Workforce Definition: No Consensus." Using the HRSA definition of mental health providers, a relatively narrow definition, yields a smaller estimate than would be found using a somewhat broader definition such as the one used by SAMSHA or a much broader definition such as the one used by the NAM.

[17] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, Designated Professional Shortage Areas Statistics, January 2018.

[18] U.S. Department of Health and Human Services, Health Resources and Services Administration, "Area Health Resources Files, State and National Level Data," https://datawarehouse.hrsa.gov/DataDownload/AHRF/AHRF_SN_User_Tech_2016-2017.zip.

[19] The 2009 data were obtained by the National Center for the Analysis of Healthcare Data (NCAHD) from state licensing boards. Established in 2007, NCAHD is a private research center that collects and analyzes healthcare workforce data.

The **Occupational Employment Statistics (OES)** program produces employment estimates for more than 800 occupations based on a semiannual survey of establishments selected by the BLS from lists maintained by State Workforce Agencies for unemployment insurance purposes.[20] An important limitation of OES data is that it excludes the self-employed. The OES includes specific categories for psychiatrists and MFTs. Within the field of psychology, the OES has a subcategory for "clinical, counseling, and school psychologists." Within the field of social work, the OES has a subcategory for "mental health and substance abuse social workers." The OES does not distinguish APPNs from the broad category of nurse practitioners.

The **Current Population Survey (CPS)** provides information about employed persons by occupation based on a monthly household survey.[21] The CPS does not distinguish licensed clinical psychologists from other psychologists, mental health social workers from other social workers, psychiatrists from other physicians, APPNs from other nurse practitioners, or MFTs from counselors. Thus the CPS overestimates the size of the workforce in these professions in such cases where it provides an estimate at all.

The **Occupational Outlook Handbook (OOH)** provides information about occupations based on the National Employment Matrix, which combines employment data from both the OES and the CPS.[22] Like the OES, the OOH includes specific categories for psychiatrists and MFTs and subcategories within psychology (clinical, counseling, and school psychologists) and social work (mental health and substance abuse social workers). The OOH does not distinguish APPNs from the broad category of nurse practitioners.

Additional sources of workforce data may be available on a case-by-case basis from professional associations or other organizations. Various estimates of each mental health profession are provided below, along with their limitations.

Clinical Social Workers

Where comparable data are available for the various disciplines, estimates show that clinical social workers are the most abundant of the mental health professions in this report. The OES estimates 112,040 mental health and substance abuse social workers in 2017, *excluding* those who are self-employed.[23] The workforce size of mental health and substance abuse social workers decreased from 2016 to 2017 by 1.8%. The OOH estimates 123,900 mental health and substance abuse social workers in 2016.[24] The CPS does not distinguish mental health social workers from school social workers, medical social workers, or other social workers. Recent estimates of the number of mental health social workers are not publicly available from membership organizations or licensing boards.

[20] U.S. Department of Labor (DOL), Bureau of Labor Statistics (BLS), *Occupational Employment Statistics: Frequently Asked Questions*, updated March 31, 2017, https://www.bls.gov/oes/oes_ques.htm.

[21] U.S. DOL, BLS, "Current Population Survey, *Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity*," https://www.bls.gov/cps/cps_over.htm.

[22] U.S. DOL, BLS, "Occupational Outlook Handbook," https://www.bls.gov/ooh/home.htm.

[23] U.S. DOL, BLS, "Occupational Employment Statistics, Occupational Employment and Wages, May 2017, *Mental Health and Substance Abuse Social Workers*," https://www.bls.gov/oes/current/oes211023.htm.

[24] U.S. DOL, BLS, "Occupational Outlook Handbook, *Social Workers*," https://www.bls.gov/ooh/community-and-social-service/social-workers.htm#tab-3.

Clinical Psychologists

The number of clinical psychologists is generally estimated to be less than that of social workers and more than that of other disciplines included in this report. The American Psychological Association (APA)[25] identified "100,305 unique licensed psychologists with doctoral degrees" by collecting, standardizing, merging, and de-duplicating lists from the licensing boards of the 50 states and the District of Columbia in 2015.[26] Given that not all licensed psychologists are currently practicing in patient care, APA's number is likely the upper limit for licensed psychologists in the mental health workforce in 2015. This is not a data source that is regularly updated and made publicly available.

Estimates that are regularly updated are all greater than the APA estimate. The OES estimates 108,060 "clinical, counseling, and school psychologists" in 2017, *excluding* those who are self-employed and *including* school psychologists (whose licensure is different than that of clinical or counseling psychologists).[27] The workforce size of clinical, counseling, and school psychologists increased from 2016 to 2017 by .07%. The CPS estimates 187,000 psychologists in 2017, *including* school psychologists, industrial/organizational psychologists, and others.[28] The OOH estimates 147,500 "clinical, counseling, and school psychologists" in 2016.[29]

Marriage and Family Therapists

Estimates of the number of MFTs are substantially lower than those of social workers or psychologists and higher than those of psychiatrists or APPNs. The OES estimates 42,880 MFTs in 2017, *excluding* those who are self-employed.[30] The workforce size of MFTs increased from 2016 to 2017 by 13.8%.[31] The OOH estimates 41,500 MFTs in 2016, *including* those who are self-employed.[32] Recent estimates of the number of MFTs are not publicly available from the CPS, membership organizations, or licensing boards.

Psychiatrists

Estimates show that there are fewer psychiatrists than clinical social workers, psychologists, or MFTs; however, psychiatrists outnumber APPNs. The OES estimates 25,520 psychiatrists in 2017, *excluding* those who are self-employed.[33] The workforce size of psychiatrists increased

---

[25] A membership organization for psychologists.

[26] Auntré Hamp et al., *2015 APA Survey of Psychology Health Service Providers*, American Psychological Association, September 2016, http://www.apa.org/workforce/publications/15-health-service-providers/index.aspx.

[27] U.S. DOL, BLS, "Occupational Employment Statistics, Occupational Employment and Wages, May 2017, Clinical, Counseling, and School Psychologists," https://www.bls.gov/oes/current/oes193031.htm.

[28] U.S. DOL, BLS, "Current Population Survey, Labor Force Statistics, Psychologists," https://www.bls.gov/cps/cpsaat11.htm.

[29] U.S. DOL, BLS, "Occupational Outlook Handbook, Psychologists, Work Environment," https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm#tab-3.

[30] U.S. DOL, BLS, Occupational Employment Statistics, "Occupational Employment and Wages, May 2017, Marriage and Family Therapists," https://www.bls.gov/oes/current/oes211013.htm.

[31] The MFT workforce is projected to grow 23% from 2016 to 2026, much faster than the average for all occupations. See U.S. DOL, BLS, "Occupational Outlook Handbook," https://www.bls.gov/ooh/community-and-social-service/marriage-and-family-therapists.htm.

[32] U.S. DOL, BLS, "Occupational Outlook Handbook, Marriage and Family Therapists" https://www.bls.gov/ooh/community-and-social-service/marriage-and-family-therapists.htm.

[33] U.S. DOL, BLS, "Occupational Employment Statistics, Occupational Employment and Wages, May 2017,

from 2016 to 2017 by 2.7%. The OOH estimates 27,500 psychiatrists in 2016, *including* those who are self-employed.[34] The American Medical Association (AMA), a physician membership organization, gathers physician workforce information in the Physician Masterfile.[35] Using the Physician Masterfile, the AMA estimated 37,938 self-designated psychiatrists in 2013 (the most recent data publicly available).[36] The CPS does not have publicly available estimates of the psychiatrist workforce size.

Advanced Practice Psychiatric Nurses (APPN)

The number of APPNs is generally found to be less than those of other mental health providers in this report. The American Nurses Credentialing Center—a subsidiary of the American Nurses Association that certifies specific practice areas—estimates 15,911 APPNs in 2016, based on certification data.[37] The OES, OOH, and CPS do not distinguish between APPNs and other advanced practice nurses.

Mental Health Workforce Annual Wages

Just as access to mental health care providers depends partly on the size of the mental health workforce, the cost of mental health care depends partly on the wages paid to mental health providers. **Table 3** presents mean and median annual wages from the BLS. These wage data are widely used because of their large sample size, broad geographic reach, and the comparable methodology used to collect data across occupations.[38] Information from BLS is likely to either over- or understate wages for some mental health providers; the data are based on a survey that excludes self-employed workers (i.e., those in private practice),[39] who may have different incomes. For example, for both clinical psychologists and clinical social workers, the categories used by the BLS include individuals who may earn substantially less than those who meet the HRSA definition of the provider type. The wage estimates for clinical psychologists are based on a category that includes school psychologists, who do not have to meet the same licensure requirements as HRSA-defined clinical psychologists and thus might receive lower wages.

Psychiatrists," https://www.bls.gov/oes/current/oes291066.htm.

[34] U.S. DOL, BLS," Occupational Outlook Handbook, Physicians and Surgeons, Work Environment," https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-3.

[35] Despite being widely used and considered to be the major source of data on the physician population, these data have been criticized by some because, for example, they do not adequately track retired physicians and because they do not count hours worked by physicians. For example, see Diane R. Rittenhouse et al., "No Exit: An Evaluation of Measures of Physician Attrition," *Health Services Research*, vol. 39, no. 5 (October 2004), pp. 1571-1588, and Chiang-Hua Chang et al., "Primary Care Physician Workforce and Medicare Beneficiaries' Health Outcomes," *Journal of the American Medical Association*, vol. 305, no. 20 (May 25, 2011), pp. 2096-2105.

[36] American Medical Association, *Physician Characteristics and Distribution in the US*, 2015, p. 26. The AMA is the largest association of physicians and medical students in the United States. Data is derived from the AMA's Physician Masterfile, which is the most comprehensive source of information for doctors of medicine (MDs) in the United States.

[37] Kathleen R. Delaney, "Psychiatric Mental Health Nursing Advanced Practice Workforce: Capacity to Address Shortages of Mental Health Professionals," *Psychiatric Services*, vol. 68, no. 9 (September 2017). To calculate the number of APPNs in 2015, the author adds the American Nurses Credentialing Center's numbers of certified psychiatric mental health nurse practitioners and certified psychiatric clinical nurse specialists. Estimates for 2016 were calculated using the same methodology. See American Nurses Credentialing Center, 2016 Certification Data, https://www.nursingworld.org/globalassets/docs/ancc/2016ancccertificationdatawebsite-1.pdf.

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

[39] Providers in private practice may or may not be considered self-employed.

Similarly, the wage estimates for clinical social workers are based on a category that includes individuals who are not licensed for independent practice and who also might earn less.

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

Table 3. Annual Wages, by Mental Health Provider Type

Provider Type	Annual Wage		Standard Occupational Classification[a]
	Mean	Median	
Clinical Social Worker	$47,830	$43,250	Mental Health and Substance Abuse Social Workers (SOC 21-1023). No distinction is made between levels of education or licensure.
Clinical Psychologist	$81,330	$75,090	Clinical, Counseling, and School Psychologists (SOC 19-3031).
Marriage and Family Therapist (MFT)	$53,860	$48,790	Marriage and Family Therapists (SOC 21-1013).
Psychiatrist	$216,090	≥$208,000[b]	Psychiatrists (SOC 29-1066).
Advanced Practice Psychiatric Nurse (APPN)	$107,480	$103,880	Nurse Practitioners (SOC 29-1171). No estimate is provided for the psychiatric/mental health specialty.

Source: CRS summary of data from U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, May 2017 Occupation Profiles, http://www.bls.gov/oes/current/oes_stru.htm.

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

b. BLS does not provide dollar amounts where the median wage is equal to or greater than $208,000 per year.

Concluding Comments

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

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

Another way policymakers may influence the size of the mental health workforce (and thus access to mental health services) is through the provision or expansion of federal programs.[40] For example, the federal government may provide grants to establish or expand training programs for mental health providers. The federal government may also provide incentives such as loan repayment or loan forgiveness to encourage individuals to enter mental health occupations, which are projected to grow faster than the overall workforce.[41] Policymakers may consider strategies to direct people into these high growth fields as part of larger labor force policy considerations. Initiatives may be targeted to certain provider types or to certain locations (e.g., MHPSAs).

Policymakers may also wish to consider the relative wages of different provider types, particularly when addressing domains within which the federal government employs mental health providers. For instance, agencies which employ these mental health professionals include the Department of Defense, the Veterans Health Administration (within the Department of Veterans Affairs), the Bureau of Prisons (within the Department of Justice), and the Indian Health Service (within HHS), among other agencies. The federal government is the largest employer of some provider types, such as clinical psychologists and social workers.[42] As such, the cost of employing different provider types—as well as their scopes of practice—may be a consideration in determining staffing priorities.

[40] For a description of health workforce programs, see CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline* and U.S. Government Accountability Office (GAO), Health Care Workforce: Federally Funded Training Programs in Fiscal Year 2012, 13-709R, August 15, 2013, http://www.gao.gov/products/GAO-13-709R.

[41] BLS projects the growth rate between 2016 and 2026 to be 7% among all occupations, 15% among health care practitioners, and higher within some of the mental health professions (e.g., 23% among marriage and family therapists and 19% among mental health and substance abuse social workers). Department of Labor, Bureau of Labor Statistics, "Employment Projections, Employment by Occupation," January 30, 2018, http://www.bls.gov/emp/ep_table_102.htm.

[42] See, for example, U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veteran Affairs, and Related Agencies, *Public Witness Hearing*, committee print, prepared by Heather O'Beirne Kelly, Director for Veterans and Military Health Policy of the American Psychological Association, 115th Cong., March 29th, 2017, http://docs.house.gov/meetings/AP/AP18/20170329/105774/HHRG-115-AP18-Wstate-KellyH-20170329.pdf. See also social work recruiting information from the Department of Veterans Affairs at http://www.vacareers.va.gov/resources/downloads/MHEI_Brochure.pdf.

Appendix A. Additional Resources

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

Psychiatrists

American Academy of Addiction Psychiatry (AAAP): http://www.aaap.org/

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

American Academy of Clinical Psychiatrists (AACP): http://www.aacp.com/

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

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

American Psychiatric Association (APA): http://www.psychiatry.org/

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

Psychologists

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

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

Social Workers

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

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

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

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

Advanced Practice Psychiatric Nurses

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

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

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

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

National Council of State Boards of Nursing (NCSBN): http://www.ncsbn.org/

Marriage and Family Therapists

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

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

Author Information

Elayne J. Heisler
Specialist in Health Services

Acknowledgments

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.