National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025

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This brief presents national projections of U.S. supply and demand for behavioral health practitioners in 2025, with 2013 data serving as baseline. Projections were developed using the Health Resources and Services Administration's (HRSA) Health Workforce Simulation Model (HWSM). A total of nine types of behavioral health practitioners were considered in these estimates: psychiatrists; behavioral health nurse practitioners (NPs); behavioral health physician assistants (PAs); clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; school counselors; and marriage and family therapists. These professions were chosen because they have the largest number of providers within behavioral health care.

The HWSM is an integrated microsimulation model that estimates current and future supply and demand for health care workers in multiple professions and care settings. Projections presented here represent a range based on two workforce scenarios: a baseline scenario and an alternative scenario. Under the first scenario, the baseline demand for each behavioral health profession, with the exception of psychiatrists, was assumed to be in equilibrium with 2013 provider supply consistent with standard workforce research methodology as there were no consistent data sources available to estimate shortages/surpluses by profession in 2013. For psychiatrists, however, baseline demand was assumed to exceed 2013 supply by the approximately 2,800 psychiatrists needed to de-designate the mental Health Professional Shortage Areas (HPSAs).[1] A detailed description of the HWSM can be found in the accompanying technical document available at http://bhw.hrsa.gov/healthworkforce/index.html.

The second scenario uses findings from the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2013 National Survey on Drug Use and Health[2,3] to estimate

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration. 2014. Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations. Accessed 11/16/2015: http://www.hrsa.gov/shortage/index.html.

[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2014. *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD.

[3] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2014. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD.

current workforce shortages and to assess projected effects on the demand for behavioral health care. Several researchers have proposed different criteria for assessing the need for behavioral health services; the SAMHSA survey provides a strong basis for an estimate of demand for behavioral health services as it is derived from a national survey. The second scenario assumes that everyone who responded to the SAMHSA survey and reported having a mental illness or substance use disorder would seek treatment. The results of the survey indicated that approximately 20 percent of the 2013 U.S. population that reported having a behavioral health disorder did not receive treatment for mental illness, and/or substance use disorder in 2013. However, it is not clear that all of these individuals needed care or would have sought care. Therefore, the second scenario may be viewed as an upper bound on demand.

Under both scenarios, all supply and demand projections are reported as full time equivalents (FTEs) and are projective relative to 2013.

Key Findings

Scenario One (baseline)

- By 2025, shortages are projected for: psychiatrists; clinical, counseling, and school psychologists; mental health and substance abuse social workers; school counselors; and marriage and family therapists.
- Mental health and substance abuse social workers and school counselors will have shortages of more than 10,000 FTEs.
- These projections are made relative to 2013 and reflect an assumption of approximate equivalence between baseline supply and demand for all practitioners except psychiatrists.

Scenario Two (alternative)

- There are estimated shortages for all nine types of behavioral health practitioners in 2013.
- Six provider types have estimated shortages of more than 10,000 FTEs (psychiatrists; clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; school counselors).

- By 2025, shortages are projected for all but two provider types—behavioral health NPs and PAs. Those shortages are projected to be greater than 10,000 FTEs.
- These projections are also made relative to 2013, but, unlike the baseline scenario, they incorporate a 20 percent unmet demand for all behavioral health professions in 2013.

Background

SAMHSA defines behavioral health to include "the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders."[4] Mental illnesses and substance use disorders are common, frequently recurrent, and often serious.[5] A strong, well-trained and well-distributed behavioral health workforce is necessary to help the United States act on the vision embodied in SAMHSA's guiding tenets: behavioral health is essential to overall wellbeing; prevention works; treatment is effective; and people recover from mental and substance use disorders.[6]

To support development of a strong behavioral health workforce, HRSA collaborated with SAMHSA to prepare these projections. Nine behavioral health practitioner types were considered in these projections: psychiatrists; behavioral health NPs; behavioral health PAs; clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; school counselors; and marriage and family therapists. Appendix A provides a short overview of each type of behavioral health practitioner addressed in this brief. However, different state laws may allow for behavioral health practitioners to address demand using varying types of health care delivery models.

Results

[4] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2015. Grants Glossary. Accessed 11/16/2015: http://www.samhsa.gov/grants/grants-glossary#B.
[5] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2015. Behavioral Health Treatments. Accessed 11/16/2015: http://www.samhsa.gov/treatment.
[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2015. Who We Are. Accessed 11/16/2015: http://www.samhsa.gov/about-us/who-we-are.

Future supply and demand for behavioral health practitioners will be affected by a host of factors related to population growth, aging of the nation's population, overall economic conditions, expansion of insurance coverage, changes in health care reimbursement, retirement, attrition, availability of training, and geographic location of the health workforce. The HWSM is an integrated microsimulation model that estimates future supply and demand for health workers in multiple professions and care settings, and accounts for most of these factors.[7]

The supply projections presented here reflect the estimated number of new entrants to each behavioral health profession and the number of practitioners lost due to retirement and mortality, as well as changes in the average number of hours worked based on provider demographics. Demand projections reflect impacts associated with both changes in population demographics and changes in insurance coverage.[8]

The following subsections detail a range of supply and demand projections by provider type based on two scenarios. Under Scenario One (baseline), the 2013 demand for each behavioral health profession, with the exception of psychiatrists, was assumed to be equal to 2013 supply[9] consistent with standard workforce methodology as there were not consistent data sources available to estimate shortages/surpluses by profession in 2013. For psychiatrists, however, baseline demand was assumed to exceed 2013 supply by the approximately 2,800 psychiatrists needed to de-designate the mental health HPSAs.

Under Scenario Two (alternative), the findings from SAMHSA's 2013 National Survey on Drug Use and Health were used to estimate current demand which is assumed to be unmet and exceed

[7] For additional information about the HWSM, please see technical documentation at http://bhw.hrsa.gov/healthworkforce/index.html.

[8] The Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend federal parity protections to 62 million Americans. The parity law aims to ensure that when coverage for mental health and substance use conditions is provided, it is generally comparable to coverage for medical and surgical care. The Affordable Care Act requires coverage of mental health and substance use disorder benefits for millions of Americans in the individual and small group markets who currently lack these benefits, and expanding parity requirements to apply to millions of Americans whose coverage did not previously comply with those requirements. [U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2013. Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits. Accessed 12/4/2015: http://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans].

[9] Because of the availability of published shortage estimates (see http://www.hrsa.gov/shortage/index.html) psychiatrists are an exception to this assumption of approximate equivalence between supply and demand under the baseline scenario.

baseline supply.[10, 11] SAMHSA's 2013 National Survey found an estimated 43.8 million U.S. adults had any mental illness in the past year, yet only 19.6 million of those 43.8 million received mental health services.[12] SAMHSA also estimated that 22.7 million adolescents and adults reported having an illicit drug or alcohol use problem, yet only 2.5 million of those 22.7 million received treatment at a specialty facility and only 4.1 million people received any treatment for a problem related to the use of alcohol or illicit drugs.[13]

These estimates suggest that between 40 million and 45 million individuals (roughly 20 percent of the U.S. 2013 population[14]) may have needed but did not receive behavioral health care in 2013.[15] Because this population did not receive care in 2013, they would not have been included in the baseline scenario's 2013 demand estimates, and, consequently, the 2025 demand projections developed under the baseline scenario would underestimate future demand for behavioral health services.[16]

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[10] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2014. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD.

[11] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2014. Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD.

[12] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2014. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD. Accessed 11/16/2015: http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf.

[13] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2014. Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD. Accessed 11/16/2015: http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf.

[14] U.S. Department of Commerce, Bureau of the Census. U.S. 2013 Population. Accessed Nov 16, 2015: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk. [Adolescent/adult population = 267.56 million]

[15] Reasons for not receiving behavioral health care may include an individual's determination that they do not need treatment; cost; lack of available services in an individual's geographic area; not knowing where to go for services; perceived stigma and negative opinions by family, friends, and coworkers; uncertainty about whether there are effective treatments or whether symptoms reflect a treatable condition; concerns about confidentiality; and other factors. [See U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2014. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD. Accessed 12/8/2015: http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf].

[16] For additional information about how demand is estimated in the HWSM, please see technical documentation at http://bhw.hrsa.gov/healthworkforce/index.html.

The estimates of the alternative scenario are consistent with other research.[17] Of particular note are the behavioral health care needs of children and the elderly who may not be adequately served by current delivery models and whose behavioral health care demand may not be reflected in current utilization patterns.[18, 19] Other populations whose behavioral health care needs may not be captured by current utilization patterns include veterans and their families, the incarcerated and those recently released from incarceration, and rural populations.[20]

In reviewing the range of results presented here through the two scenarios, note that variations in provider scopes of practice exist across states for certain professions, such as NPs. Even where provider surpluses are projected at the national level, differences in provider distribution and provider scopes of practice at the state level may mask local behavioral health care shortages.

Psychiatrists: Approximately 45,580 psychiatrists[21] were in active practice in the U.S. workforce in 2013. Trending forward to 2025, approximately 20,470 FTE psychiatrists will enter the workforce (assuming new physicians continue to be trained at the current rate), and an estimated 20,500 FTE psychiatrists will leave the workforce. A net decrease of 370 FTE psychiatrists (1 percent decrease) will result in a national workforce of 45,210 FTE psychiatrists in 2025 (Exhibit 1).

Based on 2013 health care delivery and staffing patterns and assuming a current, unmet demand equal to the approximately 2,800 FTE psychiatrists needed to de-designate the mental health HPSAs, the demand for psychiatrists is projected to reach 51,290 FTEs in 2025 (6 percent increase). Of this total 2,910 FTE increase, the aging and growth of the population contribute to an increased demand of 2,010 FTE psychiatrists (69 percent of the total increase in demand), while expanded health insurance coverage and stronger parity protections for behavioral health

[17] D. Mechanic. 2014. More People than Ever Before are Receiving Behavioral Health Care in the United States, but Gaps and Challenges Remain. Health Affairs, 33, No. 8 (2014):1416-1424.
[18] National Academy of Sciences, Engineering, and Medicine. 2015. Opportunities to promote children's behavioral health: Health care reform and beyond: Workshop summary. Washington, DC: The National Academies Press.
[19] Institute of Medicine. 2012. The mental health and substance use workforce for older adults: In whose hands? Washington, DC: The National Academies Press.
[20] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2013. Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues. Accessed 11/16/2015 from: http://store.samhsa.gov/product/Report-to-Congress-on-the-Nation-s-Substance-Abuse-and-Mental-Health-Workforce-Issues/PEP13-RTC-BHWORK.
[21] This estimate reflects psychiatrists below the age of 75 who have completed their graduate medical education.

conditions increase demand by an additional 900 psychiatrists (31 percent of the total increase in demand).

Under the baseline scenario, the projected decrease in psychiatrist supply (1 percent decrease) coupled with the projected increase in demand (6 percent increase) results in an estimated 2025 shortage of 6,080 FTE psychiatrists (12 percent of 2025 demand).

Under Scenario Two, the 2013 demand is projected to grow by 3,630 FTEs (from 56,980 FTEs in 2013 to 60,610 FTEs in 2025; 6 percent increase), and 2025 demand exceeds 2025 supply by 15,400 FTE psychiatrists (25 percent of 2025 demand).

Exhibit 1: National Supply and Demand of Psychiatrists, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline) (with Mental Health HPSA adjustment)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	45,580	45,580
Estimated supply growth, 2013-2025	-370	-370
New entrants	*20,470*	*20,470*
Attrition[a]	*-20,500*	*-20,500*
Change in average work hours[b]	*-340*	*-340*
Projected supply, 2025	45,210	45,210
Demand		
Estimated demand, 2013[c]	48,380	56,980
Estimated demand growth, 2013-2025	2,910	3,630
Changing demographics impact	*2,010*	*2,510*
Insurance coverage impact[d]	*900*	*1,120*
Projected demand, 2025	51,290	60,610
Projected Supply (minus) Demand, 2025	**-6,080**	**-15,400**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirement and mortality.
[b]This represents the change in psychiatrist full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]2013 supply is assumed to fall short of demand by the approximately 2,800 psychiatrists needed to de-designate the mental health, Health Professional Shortage Areas (mental health HPSAs) under Scenario One.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Behavioral Health Nurse Practitioners: Approximately 7,670 behavioral health NPs were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants (e.g., entry and attrition patterns), approximately 8,880 FTE behavioral health NPs

will enter the workforce and 2,330 FTE NPs will leave the workforce. A net growth of 5,290 FTE NPs (69 percent increase) will result in a projected national workforce of 12,960 FTE behavioral health NPs by 2025 (Exhibit 2).

Under the baseline scenario, the demand for NPs is projected to reach 8,120 FTEs by 2025 (6 percent increase), leading to an estimated surplus of 4,840 FTE behavioral health NPs in 2025 under the baseline scenario. Aging and population growth account for 69 percent of the increased demand. The projected increase in behavioral health NP supply (69 percent increase) exceeds the increase in demand (6 percent increase), producing an estimated 2025 surplus of 4,840 FTE behavioral health NPs (60 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 570 FTEs (from 9,590 FTEs in 2013 to 10,160 FTEs in 2025; 6 percent increase), and 2025 supply exceeds 2025 demand by 2,800 FTE behavioral health NPs (27 percent of 2025 demand).

Exhibit 2: National Supply and Demand of Behavioral Health Nurse Practitioners, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	7,670	7,670
Estimated supply growth, 2013-2025	5,290	5,290
New entrants	*8,880*	*8,880*
Attrition[a]	*-2,330*	*-2,330*
Change in average work hours[b]	*-1,260*	*-1,260*
Projected supply, 2025	12,960	12,960
Demand		
Estimated demand, 2013[c]	7,670	9,590
Estimated demand growth, 2013-2025	450	570
Changing demographics impact	*310*	*390*
Insurance coverage impact[d]	*140*	*180*
Projected demand, 2025	8,120	10,160
Projected Supply (minus) Demand, 2025	**4,840**	**2,800**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.
[b]This represents the change in nurse practitioner full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Behavioral Health Physician Assistants: Approximately 1,280 behavioral health PAs were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants, approximately 920 FTE behavioral health PAs will enter the workforce and 390 FTE PAs will leave the workforce. A net growth of 520 FTE PAs (41 percent increase) will result in a projected national workforce of 1,800 FTE behavioral health PAs by 2025 (Exhibit 3).

Under the baseline scenario, the demand for PAs is projected to reach 1,350 FTEs by 2025 (5 percent increase). Aging and population growth account for 71 percent of the increased demand.

The projected increase in behavioral health PA supply (41 percent increase) exceeds the increase in demand (5 percent increase), producing an estimated 2025 surplus of 450 FTE behavioral health PAs (33 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 90 FTEs (from 1,600 FTEs in 2013 to 1,690 FTEs in 2025; 6 percent increase), and 2025 supply exceeds 2025 demand by 110 FTEs behavioral health PAs (7 percent of 2025 demand).

Exhibit 3: National Supply and Demand of Behavioral Health Physician Assistants, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	1,280	1,280
Estimated supply growth, 2013-2025	520	520
New entrants	*920*	*920*
Attrition[a]	*-390*	*-390*
Change in average work hours[b]	*-10*	*-10*
Projected supply, 2025	1,800	1,800
Demand		
Estimated demand, 2013[c]	1,280	1,600
Estimated demand growth, 2013-2025	70	90
Changing demographics impact	*50*	*60*
Insurance coverage impact[d]	*20*	*30*
Projected demand, 2025	1,350	1,690
Projected Supply (minus) Demand, 2025	**450**	**110**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.

[b]This represents the change in physician assistant full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d] This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Clinical, Counseling, and School Psychologists: Approximately 186,710 clinical, counseling, and school psychologists were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants, approximately 68,930 FTE clinical, counseling, and school psychologists will enter the workforce and 65,020 FTEs will leave the workforce. A net growth of 2,220 FTEs (1 percent increase) will result in a projected national workforce of 188,930 FTE clinical, counseling, and school psychologists by 2025 (Exhibit 4).

Under the baseline scenario, the demand for clinical, counseling, and school psychologists is projected to reach 197,150 FTEs by 2025 (6 percent increase). Aging and population growth account for 65 percent of the increased demand. The projected increase in the supply of clinical, counseling, and school psychologists (1 percent increase) is less than the increase in demand (6 percent increase), producing an estimated 2025 shortage of 8,220 FTE clinical, counseling, and school psychologists (4 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 13,030 FTEs (from 233,390 FTEs in 2013 to 246,420 FTEs in 2025; 6 percent increase), and 2025 demand exceeds 2025 supply by 57,490 FTE clinical, counseling, and school psychologists (23 percent of 2025 demand).

Exhibit 4: National Supply and Demand of Clinical, Counseling, and School Psychologists, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	186,710	186,710
Estimated supply growth, 2013-2025	2,220	2,220
New entrants	*68,930*	*68,930*
Attrition[a]	*-65,020*	*-65,020*
Change in average work hours[b]	*-1,690*	*-1,690*
Projected supply, 2025	188,930	188,930
Demand		
Estimated demand, 2013[c]	186,710	233,390
Estimated demand growth, 2013-2025	10,440	13,030
Changing demographics impact	*6,820*	*8,530*

	Scenario One (Baseline)	Scenario Two (Alternative)
Insurance coverage impact[d]	*3,600*	*4,500*
Projected demand, 2025	197,150	246,420
Projected Supply (minus) Demand, 2025	**-8,220**	**-57,490**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.
[b]This represents the change in psychologist full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Substance Abuse and Behavioral Disorder Counselors: Approximately 85,120 substance abuse and behavioral disorder counselors were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants, approximately 47,050 FTE substance abuse and behavioral disorder counselors will enter the workforce and 25,850 FTE counselors will leave the workforce. A net growth of 20,850 FTEs (24 percent increase) will result in a projected national workforce of 105,970 FTE substance abuse and behavioral disorder counselors by 2025 (Exhibit 5).

Under the baseline scenario, the demand for substance abuse and behavioral disorder counselors is projected to reach 98,040 FTEs by 2025 (15 percent increase). Aging and population growth account for 96 percent of the increased demand. The projected increase in the supply of substance abuse and behavioral disorder counselors (24 percent increase) is greater than the increase in demand (15 percent increase), producing an estimated 2025 surplus of 7,930 FTE substance abuse and behavioral disorder counselors (8 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 16,130 FTEs (from 106,380 FTEs in 2013 to 122,510 FTEs in 2025; 15 percent increase), and 2025 demand exceeds 2025 supply by 16,540 FTEs substance abuse and behavioral disorder counselors (13 percent of 2025 demand).

Exhibit 5: National Supply and Demand of Substance Abuse and Behavioral Disorder Counselors, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	85,120	85,120
Estimated supply growth, 2013-2025	20,850	20,850
New entrants	*47,050*	*47,050*
Attrition[a]	*-25,850*	*-25,850*
Change in average work hours[b]	*-350*	*-350*
Projected supply, 2025	105,970	105,970
Demand		
Estimated demand, 2013[c]	85,120	106,380
Estimated demand growth, 2013-2025	12,920	16,130
Changing demographics impact	*12,400*	*15,500*
Insurance coverage impact[d]	*500*	*630*
Projected demand, 2025	98,040	122,510
Projected Supply (minus) Demand, 2025	**7,930**	**-16,540**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.
[b]This represents the change in substance abuse and behavioral disorder counselor full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Mental Health and Substance Abuse Social Workers: Approximately 110,880 mental health and substance abuse social workers were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants, approximately 31,990 FTE mental health and substance abuse social workers will enter the workforce and 33,350 FTEs will leave the workforce. A net reduction of 1,660 FTEs (1 percent decrease) will result in a projected national workforce of 109,220 FTEs by 2025 (Exhibit 6).

Under the baseline scenario, the demand for mental health and substance abuse social workers is projected to reach 126,160 FTEs by 2025 (14 percent increase). Aging and population growth account for 92 percent of the increased demand. The projected decrease in the supply of mental health and substance abuse social workers (1 percent decrease) coupled with the increase in demand (14 percent increase) results in an estimated 2025 shortage of 16,940 FTE mental health and substance abuse social workers (13 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 19,130 FTEs (from 138,630 FTEs in 2013 to 157,760 FTEs in 2025; 14 percent increase), and 2025 demand exceeds 2025 supply by 48,540 FTE mental health and substance abuse social workers (31 percent of 2025 demand).

Exhibit 6: National Supply and Demand of Mental Health and Substance Abuse Social Workers, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	110,880	110,880
Estimated supply growth, 2013-2025	-1,660	-1,660
New entrants	*31,990*	*31,990*
Attrition[a]	*-33,350*	*-33,350*
Change in average work hours[b]	*-300*	*-300*
Projected supply, 2025	109,220	109,220
Demand		
Estimated demand, 2013[c]	110,880	138,630
Estimated demand growth, 2013-2025	15,280	19,130
Changing demographics impact	*14,000*	*17,500*
Insurance coverage impact[d]	*1,300*	*1,630*
Projected demand, 2025	126,160	157,760
Projected Supply (minus) Demand, 2025	**-16,940**	**-48,540**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.
[b]This represents the change in mental health and substance abuse social worker full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Mental Health Counselors: Approximately 120,010 mental health counselors were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants, approximately 65,470 FTE mental health counselors will enter the workforce and 36,310 FTE mental health counselors will leave the workforce. A net growth of 25,690 FTEs (21 percent increase) will result in a projected national workforce of 145,700 FTE mental health counselors by 2025 (Exhibit 7).

Under the baseline scenario, the demand for mental health counselors is projected to reach 138,170 FTEs by 2025 (15 percent increase). Aging and population growth account for 97 percent of the increased demand. The projected increase in the supply of mental health

counselors (21 percent increase) is greater than the increase in demand (15 percent increase), producing an estimated 2025 surplus of 7,530 FTE mental health counselors (5 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 22,630 FTEs (from 150,000 FTEs in 2013 to 172,630 FTEs in 2025; 15 percent increase), and 2025 demand exceeds 2025 supply by 26,930 FTE mental health counselors (16 percent of 2025 demand).

Exhibit 7: National Supply and Demand of Mental Health Counselors, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	120,010	120,010
Estimated supply growth, 2013-2025	25,690	25,690
New entrants	*65,470*	*65,470*
Attrition[a]	*-36,310*	*-36,310*
Change in average work hours[b]	*-3,470*	*-3,470*
Projected supply, 2025	145,700	145,700
Demand		
Estimated demand, 2013[c]	120,010	150,000
Estimated demand growth, 2013-2025	18,160	22,630
Changing demographics impact	*17,660*	*22,000*
Insurance coverage impact[d]	*500*	*630*
Projected demand, 2025	138,170	172,630
Projected Supply (minus) Demand, 2025	**7,530**	**-26,930**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.
[b]This represents the change in mental health counselor full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

School Counselors: Approximately 246,480 school counselors were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants, approximately 73,250 FTE school counselors will enter the workforce and 75,220 FTE school counselors will leave the workforce. A net reduction of 3,030 FTEs (1 percent decrease) will result in a projected national workforce of 243,450 FTE school counselors by 2025 (Exhibit 8).

Under the baseline scenario, the demand for school counselors is projected to reach 257,190 FTEs by 2025 (4 percent increase). Aging and population growth account for all (100 percent) of the increased demand. The projected decrease in the supply of school counselors (1 percent decrease) coupled with the increase in demand (4 percent increase) results in an estimated 2025 shortage of 13,740 FTE school counselors (5 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 13,370 FTEs (from 308,130 FTEs in 2013 to 321,500 FTEs in 2025; 4 percent increase), and 2025 demand exceeds 2025 supply by 78,050 FTE school counselors (24 percent of 2025 demand).

Exhibit 8: National Supply and Demand of School Counselors, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	246,480	246,480
Estimated supply growth, 2013-2025	-3,030	-3,030
New entrants	*73,250*	*73,250*
Attrition[a]	*-75,220*	*-75,220*
Change in average work hours[b]	*-1,060*	*-1,060*
Projected supply, 2025	243,450	243,450
Demand		
Estimated demand, 2013[c]	246,480	308,130
Estimated demand growth, 2013-2025	10,710	13,370
Changing demographics impact	*10,710*	*13,370*
Insurance coverage impact[d]	*(no impact)*	*0*
Projected demand, 2025	257,190	321,500
Projected Supply (minus) Demand, 2025	**-13,740**	**-78,050**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.
[b]This represents the change in school counselor full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Marriage and Family Therapists: Approximately 30,560 marriage and family therapists were active in the U.S. workforce in 2013. Trending forward to 2025 and using current supply determinants, approximately 8,560 FTE marriage and family therapists will enter the workforce and 9,140 FTE therapists will leave the workforce. A net reduction of 780 FTEs (3 percent

decrease) will result in a projected national workforce of 29,780 FTE marriage and family therapists by 2025 (Exhibit 9).

Under the baseline scenario, the demand for marriage and family therapists is projected to reach 32,220 FTEs by 2025 (5 percent increase). Aging and population growth account for 50 percent of the increased demand. The projected decrease in the supply of marriage and family therapists (3 percent decrease) coupled with the increase in demand (5 percent increase) results in an estimated 2025 shortage of 2,440 FTE marriage and family therapists (8 percent of 2025 demand).

Under Scenario Two, the demand is projected to increase by 2,000 FTEs (from 38,250 FTEs in 2013 to 40,250 FTEs in 2025; 5 percent increase), and 2025 demand exceeds 2025 supply by 10,470 FTE marriage and family therapists (26 percent of 2025 demand).

Exhibit 9: National Supply and Demand of Marriage and Family Therapists, 2013 and 2025 (Both Scenarios)

	Scenario One (Baseline)	Scenario Two (Alternative)
Supply		
Estimated supply, 2013	30,560	30,560
Estimated supply growth, 2013-2025	-780	-780
New entrants	*8,560*	*8,560*
Attrition[a]	*-9,140*	*-9,140*
Change in average work hours[b]	*-200*	*-200*
Projected supply, 2025	29,780	29,780
Demand		
Estimated demand, 2013[c]	30,560	38,250
Estimated demand growth, 2013-2025	1,660	2,000
Changing demographics impact	*830*	*1,000*
Insurance coverage impact[d]	*830*	*1,000*
Projected demand, 2025	32,220	40,250
Projected Supply (minus) Demand, 2025	**-2,440**	**-10,470**

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding.
[a]Includes retirements and mortality.
[b]This represents the change in marriage and family therapist full time equivalents resulting from a change in the demographic composition of the future workforce and the associated effect on average number of hours worked.
[c]The baseline scenario assumes that national supply and demand are in approximate equilibrium in 2013.
[d]This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

Summary

Scenario One (Baseline): Under Scenario One, only psychiatrists have an estimated shortage in 2013. This largely results from the methodological approach to developing estimates and the availability of documented shortages using the HPSA. By 2025, five provider types have projected shortages (psychiatrists; clinical, counseling, and school psychologists; mental health and substance abuse social workers; school counselors; marriage and family therapists), and two provider types have shortages of more than 10,000 FTEs (mental health and substance abuse social workers; school counselors). These projections are made relative to 2013 and reflect an assumption of approximate equivalence between baseline supply and demand for all practitioners except psychiatrists. Exhibit 10 summarizes the projections under Scenario One.

Exhibit 10: National Supply and Demand, Scenario One (Baseline), All Behavioral Health Practitioner Categories, 2013 and 2025

	2013 Estimates Scenario One (Baseline)			2025 Projections Scenario One (Baseline)		
Practitioner	**Supply**	**Demand**	**Difference[a]**	**Supply**	**Demand**	**Difference[a]**
Psychiatrists	45,580	48,380	-2,800	45,210	51,290	-6,080
Behavioral Health Nurse Practitioners	7,670	7,670	0	12,960	8,120	4,840
Behavioral Health Physician Assistants	1,280	1,280	0	1,800	1,350	450
Clinical, Counseling, and School Psychologists	186,710	186,710	0	188,930	197,150	-8,220
Substance Abuse and Behavioral Disorder Counselors	85,120	85,120	0	105,970	98,040	7,930
Mental Health and Substance Abuse Social Workers	110,880	110,880	0	109,220	126,160	-16,940
Mental Health Counselors	120,010	120,010	0	145,700	138,170	7,530
School Counselors	246,480	246,480	0	243,450	257,190	-13,740
Marriage and Family Therapists	30,560	30,560	0	29,780	32,220	-2,440

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding. For psychiatrists, Scenario One assumes that 2013 supply falls short of demand by the approximately 2,800 psychiatrists needed to de-designate the mental health, Health Professional Shortage Areas (mental health HPSAs). For all other practitioners, Scenario One assumes that national supply and demand are in approximate equilibrium in 2013. This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

[a]Difference = (supply – demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Scenario Two (Alternative): Under the alternative scenario, there are shortages of all nine behavioral health practitioner types in 2013, and six provider types have estimated shortages of more than 10,000 FTEs: psychiatrists; clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; and school counselors (Exhibit 11). Trending forward to 2025, shortages are projected for all provider types except behavioral health NPs and PAs. All projected 2025 shortages are greater than 10,000 FTEs.

Exhibit 11: National Supply and Demand, Scenario Two (Alternative), All Behavioral Health Practitioner Categories, 2013 and 2025

	2013 Estimates Scenario Two (Alternative)			2025 Projections Scenario Two (Alternative)		
Practitioner	**Supply**	**Demand**	**Difference[a]**	**Supply**	**Demand**	**Difference[a]**
Psychiatrists	45,580	56,980	-11,400	45,210	60,610	-15,400
Behavioral Health Nurse Practitioners	7,670	9,590	-1,920	12,960	10,160	2,800
Behavioral Health Physician Assistants	1,280	1,600	-320	1,800	1,690	110
Clinical, Counseling, and School Psychologists	186,710	233,390	-46,680	188,930	246,420	-57,490
Substance Abuse and Behavioral Disorder Counselors	85,120	106,380	-21,260	105,970	122,510	-16,540
Mental Health and Substance Abuse Social Workers	110,880	138,630	-27,750	109,220	157,760	-48,540
Mental Health Counselors	120,010	150,000	-29,990	145,700	172,630	-26,930
School Counselors	246,480	308,130	-61,650	243,450	321,500	-78,050
Marriage and Family Therapists	30,560	38,250	-7,690	29,780	40,250	-10,470

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding. Scenario Two assumes that approximately 20 percent of the 2013 U.S. population needed but did not receive treatment for mental illness, substance use and/or substance dependence in 2013. This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

[a]Difference = (supply – demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Exhibit 12 provides the range of workforce surplus/shortage using the baseline scenario and Scenario Two. Under the baseline scenario, five provider types have projected shortages in 2025; while, under Scenario Two, seven provider types have projected shortages, all of which are greater than 10,000 FTEs. As noted, projections under Scenario Two reflect information

from SAMHSA that approximately 20 percent of the 2013 U.S. population may have needed but did not receive treatment for mental illness, substance use, and/or substance dependence in 2013.

Exhibit 12: National Supply and Demand, Scenario One (Baseline) and Scenario 2 (Alternative), All Behavioral Health Practitioner Categories, 2013 and 2025

	2025 Projections	2025 Projections Scenario One (Baseline)		2025 Projections Scenario Two (Alternative)	
Practitioner	**Supply**	**Demand**	**Difference[a]**	**Demand**	**Difference[a]**
Psychiatrists	45,210	51,290	-6,080	60,610	-15,400
Behavioral Health Nurse Practitioners	12,960	8,120	4,840	10,160	2,800
Behavioral Health Physician Assistants	1,800	1,350	450	1,690	110
Clinical, Counseling, and School Psychologists	188,930	197,150	-8,220	246,420	-57,490
Substance Abuse and Behavioral Disorder Counselors	105,970	98,040	7,930	122,510	-16,540
Mental Health and Substance Abuse Social Workers	109,220	126,160	-16,940	157,760	-48,540
Mental Health Counselors	145,700	138,170	7,530	172,630	-26,930
School Counselors	243,450	257,190	-13,740	321,500	-78,050
Marriage and Family Therapists	29,780	32,220	-2,440	40,250	-10,470

Notes: All numbers reflect full time equivalents. Numbers may not sum to totals due to rounding. This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.
[a]Difference = (supply – demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Strengths and Limitations

The HWSM used to develop the supply and demand projections presented here relies on a microsimulation approach that replaces the cohort-based workforce models used historically by HRSA and others.[22] A microsimulation approach was chosen for the HWSM because of the

[22] Historically, supply has been modeled using a cohort approach with each cohort typically defined by age, sex, and occupation/specialty. Demand has historically been modeled by deriving provider-to-population ratios based on historical care

flexibility and granularity that this approach provides to simulate potential changes in health care delivery patterns.

It should be reiterated that these projections reflect the HWSM's underlying assumptions about baseline supply and demand,[23] and the findings must be interpreted in the context of those assumptions. For example, under the baseline scenario, the projected surplus of behavioral health NPs reflects the assumption that current supply is approximately equal to current demand (see Exhibit 2). However, if the baseline supply of behavioral health NPs is less than baseline demand, then the projected growth in the number of behavioral health NPs may, in fact, be balanced by the future demand, leading to a possible equilibrium between future NP supply and demand. On the other hand, if the growth in behavioral health NP supply is greater than projected and the increase in future demand is less than projected, the 2025 oversupply may be greater than projected under the baseline scenario.

Similarly, under the alternative scenario, a future shortage of substance abuse and behavioral disorder counselors is projected (Exhibit 11). If the current unmet demand for substance abuse and behavioral disorder counselors is *greater* than the 20 percent assumed for the alternative scenario, the projected shortage may be greater than the estimated 16,530 FTEs. On the other hand, if the current unmet demand for substance abuse and behavioral disorder counselors is *less* than the 20 percent assumed for the alternative scenario, the projected shortage may be less than the estimated 16,530 FTEs.

In constructing the alternative scenario, the assumption of 20 percent unmet demand was applied uniformly across all behavioral health professions. This assumption is consistent with the broad demand for both mental health services and substance use treatment. It also reflects the co-occurrence and complexity of mental health and substance use conditions and the current care models which can involve multiple types of behavioral health care practitioners. However, it is

use and delivery patterns, and then applying these ratios to subsets of the population defined by age group, sex, insurance status, and sometimes race and ethnicity.

[23] Under the baseline scenario, 2013 psychiatrist demand is assumed to exceed 2013 supply by the approximately 2,800 psychiatrists needed to de-designate the HPSAs. Also under this scenario, 2013 supply and demand for other providers was assumed to be in approximate equilibrium. Under the alternative demand scenario, 2013 demand for all providers was increased to reflect the estimated number of persons who needed but did not receive behavioral health care in 2013.

recognized that there are likely differences by profession which are not well-characterized with a uniform allocation.

In the absence of more specific data, it is not possible at this time to derive more exact estimates of either shortages or surpluses of behavioral health practitioners. While some information on the supply of psychiatrists is available with the mental health HPSAs, other behavioral health professions are not included in the calculation of HPSAs making estimates more difficult. However, as behavioral health workforce data become more robust, it is anticipated that future models will be better able to project supply and demand. For example, better estimates of individuals receiving training in behavioral health professions as well as stronger estimates of individuals' retirements would enhance the models. Additionally, stronger clarity on the roles and functions of behavioral health care providers would enable the models to be expanded beyond the nine behavioral health professions contained in this report. It is anticipated that these models will also be able to more fully characterize behavioral health care delivery through more precise allocation of unmet demand across provider type, more nuanced estimates of the comprehensive care required by individuals with co-occurring behavioral health conditions, and more precise understanding of how behavioral health care treatment and prevention may be effectively provided over each individual's lifetime.

Conclusion

This report is one in a series of HRSA reports on the nation's health care workforce. These reports are intended to help provide an understanding of the current and future workforce supply in the context of a growing and aging population together with evolving models of care.

National demand for the nine categories of behavioral health providers modeled in this report is projected to grow due, in large measure, to the aging and growth of the U.S. population. Under an assumption of approximate baseline equivalence between supply and demand (Scenario One), projections indicate 2025 shortages of 16,940 mental health and substance abuse social workers; 13,740 school counselors; 8,220 clinical, counseling, and school psychologists; 6,080 psychiatrists; and 2,440 marriage and family therapists. Even greater shortages are

projected under an assumption of 20 percent unmet demand at baseline (Scenario Two), with seven of the nine professions having 2025 shortages of more than 10,000 FTEs.

Future demand for behavioral health care providers will be driven by many factors:

- The emphasis on *integrating behavioral health services with primary health care*, together with expanded behavioral health coverage and stronger federal parity protections, suggest there will be considerable growth in demand. Frequently, mental illness and substance use disorders are unrecognized, or, even when recognized, there can be perceived stigmas associated with seeking care. As behavioral health care becomes better integrated with primary care, greater availability of screening and access to treatment may reduce levels of unrecognized illness and stigma, and encourage greater utilization of behavioral health care. Other factors, including improved diagnostics and better treatment and prevention strategies may also lead to greater demand for behavioral health services. Thus, it is anticipated that a number of factors may contribute to a higher demand for behavioral health services going forward. Additionally, integrated behavioral health services are frequently implemented with team-based collaborative care models. In these new models, behavioral health professionals in short supply (e.g., psychiatrists and psychologists) may be utilized more efficiently and in expanded roles thus somewhat mitigating the short supply.[24]
- The projections presented here account for increased utilization of health care services due to expanded insurance coverage and stronger federal parity protections. Because of uncertainties in staffing patterns and the evolving roles of different health professionals on care teams, changes in health care service delivery are not currently incorporated into the model. The alternative scenario may offer some perspective on these future levels of demand.
- *Advances in medicine and technology* could reduce demand for some behavioral health care services by improving patient wellness, but such advances may concurrently lead to increased demand for services by creating more treatment options. For example, electronic health record systems combined with telemedicine could improve access to care and overall

[24] Olfson M. Building the mental health workforce capacity needed to treat adults with serious mental illnesses. Health Affairs. 2016: 35(6): 983-990.

patient health by allowing providers to treat and monitor patients independent of geographic location. Such advances may alleviate the need for providers to be geographically co-located with their patients, but, at the same time, may increase overall demand for care. Additionally, implementation of evidence-based practices may improve efficiency of care, and over time, may reduce overall demand.

- Growing emphasis on behavioral health wellness, prevention of mental and substance use disorders, behavioral care coordination, and behavioral care management may lead to *new and different roles for all behavioral health practitioners* and to expanded roles for some providers (e.g., behavioral health NPs and PAs). These considerations, together with the recruitment and retention challenges that have long constrained the behavioral health care workforce, [25] underscore the need for continued training across all provider types to ensure an agile and responsive behavioral health workforce.

[25] Health Professions and Nursing Education Coalition. 2015. The Need for Title VII and Title VIII Programs: Addressing Provider Shortages and Improving Access to Quality Care. Accessed Nov 17, 2015: https://www.aamc.org/advocacy/hpnec/backgrounder.pdf.

Appendix A: Behavioral Health Provider Overview

This section provides information on the duties, education/training, and licensure/certification for the nine categories of behavioral health providers considered in this brief.

Psychiatrists

Duties: Psychiatrists are physicians who diagnose and treat mental illnesses and substance use disorders through a combination of personal counseling (psychotherapy), psychoanalysis, hospitalization, and medication. Psychotherapy involves discussions with patients about their behavioral patterns and their past experiences, and may include individual, group, and/or family therapy sessions. Psychoanalysis involves long-term psychotherapy and counseling for patients. Psychiatrists may prescribe medications to correct chemical imbalances that cause some mental illnesses.[26, 27]

Education/Training: Becoming a psychiatrist requires the completion of a 4-year residency program after medical school. Psychiatrists may also complete additional specialized fellowship training in sub-specialties such as child and adolescent psychiatry, geriatric psychiatry, and addiction psychiatry.[28]

Licensure/Certification: All states and the District of Columbia require practicing psychiatrists to be licensed. Specific licensing requirements vary by state. To qualify for a license, candidates must graduate from an accredited medical school, complete residency training, and pass both written and practical exams. [29] Psychiatrists may also elect to become board certified,

[26] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Physicians and Surgeons. Accessed 12/1/2015: http://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm.
[27] American Board of Psychiatry and Neurology, Inc. 2015. What is a Board-Certified Psychiatrist? Accessed 12/2/2015: http://www.abpn.com/about/definition-of-a-board-certified-psychiatrist-and-neurologist/.
[28] American Council for Graduate Medical Education. 2015. Psychiatry. Accessed 12/2/2015: https://www.acgme.org/acgmeweb/tabid/147/ProgramandInstitutionalAccreditation/MedicalSpecialties/Psychiatry.aspx.
[29] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Physicians and Surgeons. Accessed 12/1/2015: http://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm.

requiring case management experience as well as additional written and oral examinations beyond those required for state licensure.[30, 31]

Behavioral Health Nurse Practitioners (NPs)

Duties: Behavioral health NPs diagnose and treat acute, episodic, or chronic behavioral health-related illness, independently or as part of a broader health care team. Their duties may include conducting patient assessments as well as ordering, performing, or interpreting diagnostic tests. They may also conduct individual, group, or family counseling sessions. Some states allow behavioral health NPs to prescribe medication under the supervision of a physician.[32, 33]

Education/Training: Behavioral health NPs are considered advanced practice registered nurses. Typically, they have completed a graduate degree (e.g., a Master of Science in Nursing (MSN) or a Doctor of Nursing Practice (DNP)). Behavioral health NPs also obtain additional clinical training beyond the preparation they receive as part of their basic registered nurse (RN) training. This intensive study through both didactic and clinical forums gives behavioural health NPs the skills and competencies necessary to practice in a range of settings.[34]

Licensure/Certification: After earning a graduate degree, behavioral health NPs take an exam to become certified. Credentialing examinations are offered by various organizations, including the American Academy of Nurse Practitioners Certification Program and the American Nurses Credentialing Center. Generally, an NP is licensed by the state in which she or he practices. All states and the District of Columbia issue licenses to NPs, and NPs practice under the rules and regulations of the state in which they are licensed. Laws governing NP licensure and scope of practice vary by state, and range from allowing NPs complete clinical and business autonomy to

[30] American Board of Physician Specialties. 2015. Board Certification in Psychiatry. Accessed 12/2/2015: http://www.abpsus.org/psychiatry.
[31] American Psychiatric Association. 2015. Maintain Your Certification and Licensure. Accessed 12/2/2015: http://www.psychiatry.org/psychiatrists/education/certification-and-licensure.
[32] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Accessed 12/2/2015: http://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm.
[33] American Psychiatric Nurses Association. 2015. What do Psychiatric-Mental Health Nurses Do? Accessed 12/2/2015: http://www.apna.org/i4a/pages/index.cfm?pageid=3292.
[34] American Association of Nurse Practitioners (AANP). What's an NP? Accessed 10/1/2015: http://www.aanp.org/all-about-nps/what-is-an-np.

requiring that NPs work closely with a physician in performing certain work duties (e.g., prescribing medication).[35]

Behavioral Health Physician Assistants (PAs)

Duties: Behavioral health PAs provide health care services typically performed by a physician, under the supervision of a physician. Their responsibilities may include performing psychiatric evaluations and assessments, ordering and interpreting diagnostic studies, counseling patients, developing and managing treatment plans, and ordering referrals. In some cases, behavioral health PAs may also prescribe medication. [36, 37]

Education/Training: Behavioral health PAs must complete an accredited educational program. These programs typically lead to a master's degree.[38]

Licensure/Certification: Like behavioral health NPs, behavioral health PAs are state licensed and nationally certified. Generally, PAs are required to be licensed by the state in which they practice. All 50 states and the District of Columbia issue PA licenses and allow PAs to prescribe at least some medications.[39] PA certification requires that, following completion of an accredited training program, PAs pass the Physician Assistant National Certifying Examination (PANCE). PANCE, administered by the National Commission on Certification of Physician Assistants, evaluates fundamental medical and surgical comprehension.[40] Candidates who pass the PANCE may use the Physician Assistant-Certified designation.[41]

[35] U.S. National Library of Medicine. MedlinePlus: Nurse Practitioner. Accessed 10/1/2015: http://www.nlm.nih.gov/medlineplus/ency/article/001934.htm.
[36] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Physician Assistants. Accessed 12/3/2015: http://www.bls.gov/ooh/healthcare/physician-assistants.htm.
[37] American Academy of Physician Assistants. 2010. Specialty Practice Issue Brief: Physician Assistants in Psychiatry. Available at: https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=649.
[38] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Physician Assistants. Accessed 12/2/2015: http://www.bls.gov/ooh/healthcare/physician-assistants.htm.
[39] American Academy of Physician Assistants. 2015. PA Prescribing Authority, by State. Accessed 10/1/2015: https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2453.
[40] National Commission on Certification of Physician Assistants. Becoming Certified. Accessed 10/1/2015: http://www.nccpa.net/BecomingCertified.
[41] American Academy of Physician Assistants. Become a PA. Accessed 10/1/2015: https://www.aapa.org/become-a-pa/.

Clinical, Counseling, and School Psychologists

Duties: Clinical, counseling, and school psychologists assess, diagnose and treat mental disorders, learning disabilities, and cognitive, behavioral, and emotional problems. These providers help people deal with a range of problems, from short-term personal issues to severe, chronic conditions. Their work may involve conducting assessments; administering diagnostic tests; working with individuals and groups to help them better understand their condition or situation and to identify resources and strategies for managing their illness or problem; and developing treatment plans involving individual, family, and/or group therapies. Some clinical, counseling, and school psychologists may focus on specific populations such as children or the elderly.[42, 43, 44, 45]

Education/Training: Typically, clinical and counseling psychologists complete a doctoral degree (e.g., a Ph.D. in psychology or a Doctor of Psychology (Psy.D.) degree). School psychologists may also have an advanced degree (e.g., a master's degree or doctoral degree in school psychology).[46]

Licensure/Certification: Licensure laws for clinical, counseling, and school psychologists vary by state and type of position. All states and the District of Columbia require that psychologists who practice independently be licensed. [47] Although not mandatory, many psychologists elect to become board-certified in a specific area (e.g., counseling psychology, school psychology). Board certification typically requires a doctoral degree in psychology as well as completion of additional training, examination, and experience requirements.[48]

[42] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Psychologists. Accessed 12/3/2015: http://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm.
[43] American Psychological Association. 2015. What do Practicing Psychologists Do? Accessed 12/2/2015: http://www.apa.org/helpcenter/about-psychologists.aspx.
[44] American Psychological Association. 2015. What is a Psychologist? Accessed 12/2/2015: http://www.apa.org/topics/index.aspx.
[45] American Psychological Association. 2015. Practicing Psychologists. Accessed 12/2/2015: http://www.apa.org/support/practice.aspx?item=1.
[46] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Psychologists. Accessed 12/3/2015: http://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm.
[47] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Psychologists. Accessed 12/3/2015: http://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm.
[48] American Board of Professional Psychology. Why Specialize? Accessed 12/3/2015: http://www.abpp.org/i4a/pages/index.cfm?pageid=3290.

Substance Abuse and Behavioral Disorder Counselors (Addiction Counselors)

Duties: Substance abuse and behavioral disorder counselors (also called addiction counselors) provide treatment and support to people who suffer from addiction to alcohol and other drugs, eating disorders, or other behavioral problems. Their duties may include conducting mental and physical health assessments; developing treatment goals and plans; reviewing and recommending treatment options; helping people to develop the skills and strategies necessary for recovery; making referrals for resources and services; and conducing outreach to help people identify and better understand substance abuse and behavioral disorders.[49]

Education/Training: Educational requirements for mental health and substance abuse counselors vary, depending on type of work, practice setting, state regulations, and level of responsibility. These requirements may range from a high school diploma to a master's degree. Workers with only a high school diploma may be required complete a period of on-the-job training.[50]

Licensure/Certification: Generally, substance abuse and behavioral disorder counselors in private practice are licensed by the state in which they practice, with all states and the District of Columbia requiring a master's degree, 2,000 to 4,000 hours of supervised clinical experience, and a passing grade on a state-recognized exam. Licensure requirements for substance abuse and behavioral disorder counselors not in private practice vary by state. Not all states require a specific degree, but many states do require counselors to pass an exam. Like other provider types, substance abuse and behavioral disorder counselors may obtain national certification.[51, 52]

[49] US Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Substance Abuse and Behavioral Disorder Counselors. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm.
[50] US Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Substance Abuse and Behavioral Disorder Counselors. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm.
[51] US Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Substance Abuse and Behavioral Disorder Counselors. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm.
[52] National Board for Certified Counselors. 2015. Understanding National Certification and State Licensure. Accessed 12/3/2015: http://www.nbcc.org/Certification/CertificationorLicensure.

Mental Health and Substance Abuse Social Workers

Duties: Mental health and substance abuse social workers assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs. These providers may conduct individual and/or group therapy. Their duties may also include crisis intervention, case management, client advocacy, prevention, education, and outreach.[53, 54]

Education/Training: At a minimum, most mental health and substance abuse social worker positions require at least a bachelor's degree in social work or a related discipline (e.g., psychology or sociology). Many positions require graduate-level training (e.g., a master's degree in social work). Typically, both bachelor's and master's degree programs in social work include an internship, practicum, or other supervised learning opportunity.[55]

Licensure/Certification: Although requirements vary by state, all states and the District of Columbia have some type of licensure or certification requirement for mental health and substance abuse social workers. Generally, clinical social workers must be licensed, which requires at least a master's degree in social work, extensive supervised clinical experience, and a passing grade on a state licensure exam. In addition, nonclinical social workers may also be required to obtain a state license. [56, 57, 58]

[53] U.S. Department of Labor, Bureau of Labor Statistics. 2010. Standard Occupation Classification: 21-2013 – Substance Abuse and Mental Health Social Workers. Accessed 12/3/2015: http://www.bls.gov/soc/2010/soc211023.htm.
[54] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Social Workers, Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/social-workers.htm.
[55] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Social Workers, Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/social-workers.htm.
[56] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Social Workers, Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/social-workers.htm.
[57] Association of Social Work Boards. 2013. The Role of ASWB. Accessed 12/3/2015: https://www.aswb.org/public/.
[58] SocialWorkLicensure.Org. 2015. Social Work License Requirements. Accessed 12/3/2015: http://www.socialworklicensure.org/articles/social-work-license-requirements.html.

Mental Health Counselors

Duties: Mental health counselors help people deal with anxiety, depression, grief, low self-esteem, stress, and suicidal impulses. They may also help with mental and emotional health issues and with relationship problems, and may provide treatment to individuals, couples, families, and groups. Some mental health counselors may work with a specific population such as children, college students, or the elderly.[59]

Education/Training: Mental health counselors typically have a master's degree in psychology, social work, counseling, or a related field. Following completion of their degree, counselors may also receive a period of supervised training and experience to prepare them for licensure.[60]

Licensure/Certification: Generally, mental health counselors must be licensed by the state in which they practice. All states and the District of Columbia offer licensure, which typically requires counselors to have some combination of graduate education and supervised counseling experience, as well as a passing grade on a state-recognized exam.[61, 62]

[59] U.S., Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Mental Health Counselors and Marriage and Family Therapists. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.htm.
[60] U.S., Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Mental Health Counselors and Marriage and Family Therapists. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.htm.
[61] U.S., Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Mental Health Counselors and Marriage and Family Therapists. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.htm.
[62] National Board for Certified Counselors. 2015. Understanding National Certification and State Licensure. Accessed 12/3/2015: http://www.nbcc.org/Certification/CertificationorLicensure.

School Counselors

Duties: School counselors help students develop social skills and succeed in school. In this role, school counselors can assist students in understanding and overcoming social or developmental problems through individual or group counseling. School counselors may also create and deliver classroom training on bullying, substance abuse, and other behavioral health topics; help to connect students and their parents to needed behavioral health resources outside of the school setting; and work with teachers and other faculty to ensure that school curricula address students' behavioral health needs.[63, 64]

Education/Training: School counselors typically need to have a master's degree in school counseling or in a related field. Graduate programs in school counseling typically include coursework in both education and counseling. These programs frequently require that students complete an internship or practicum to gain experience.[65, 66]

Licensure/Certification: School counselors working in public schools must have a state-issued credential. Depending on the state, this credential may be termed a license, a certification, or an endorsement. Licensure or certification typically requires a master's degree in school counseling as well as completion of an internship or practicum. Some states may also require students to have classroom teaching experience or to hold a teaching license prior to being credentialed. Some states may also allow full-time teaching experience to be substituted for the internship requirement.[67, 68]

[63] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, School and Career Counselors. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/school-and-career-counselors.htm (visited October 31, 2015).
[64] American School Counselor Association (ASCA). 2008. Who Are School Counselors*?* Available at: https://www.schoolcounselor.org/asca/media/asca/home/WhoAreSchoolCounselors.pdf
[65] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, School and Career Counselors. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/school-and-career-counselors.htm.
[66] American School Counselor Association (ASCA). 2008. Who Are School Counselors*?* Available at: https://www.schoolcounselor.org/asca/media/asca/home/WhoAreSchoolCounselors.pdf
[67] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, School and Career Counselors. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/school-and-career-counselors.htm.
[68] American School Counselor Association (ASCA). 2015. State Certification Requirements. Accessed 12/3/2015: https://www.schoolcounselor.org/school-counselors-members/careers-roles/state-certification-requirements.

Marriage and Family Therapists

Duties: Marriage and family therapists work individuals, couples, and families to diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Even when working directly with an individual, marriage and family therapists bring a family-centered perspective to addressing issues such as low self-esteem, stress, and substance use.[69, 70, 71]

Education/Training: Marriage and family therapists typically have a master's degree in psychology, social work, counseling, marriage and family therapy, or a related field. Marriage and family therapy programs teach students about how marriages, families and relationships function and how they can affect behavioral health.[72]

Licensure/Certification: Generally, marriage and family therapists are required to be licensed in order to practice. Licensure requires a master's degree, a period of supervised experience, and a passing grade on a state-recognized exam.[73, 74]

[69] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, 2014-15 Edition, Mental Health Counselors and Marriage and Family Therapists. Accessed 12/3/2015: http://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.htm.

[70] U.S. Department of Labor, Bureau of Labor Statistics. 2010. Standard Occupation Classification: 21-1013, Marriage and Family Therapists. Accessed 12/3/2015: http://www.bls.gov/soc/2010/soc211013.htm.

[71] American Association of Marriage and Family Therapy. 2015. What is Marriage and Family Therapy? Accessed 12/3/2015: http://www.aamft.org/iMIS15/AAMFT/Content/LEARN_About_MFTs/default.aspx?/imis15/AAMFT/Content/About_AAMFT/Qualifications.aspx .

[72] U.S. Department of Labor, Bureau of Labor Statistics. 2010. Standard Occupation Classification: 21-1013, Marriage and Family Therapists. Accessed 12/3/2015: http://www.bls.gov/soc/2010/soc211013.htm.

[73] U.S. Department of Labor, Bureau of Labor Statistics. 2010. Standard Occupation Classification: 21-1013, Marriage and Family Therapists. Accessed 12/3/2015: http://www.bls.gov/soc/2010/soc211013.htm.

[74] Association of Marital and Family Therapy Regulatory Boards. 2015. State Board Listing. Accessed 12/3/2015: https://www.amftrb.org/stateboards.cfm.

About the Model

The results reported in this brief come from HRSA's Health Workforce Simulation Model (HWSM), an integrated health professions projection model that estimates current and future supply and demand for health care providers.

The supply component of the HWSM simulates workforce decisions for each provider type based on his or her demographics and profession, along with the characteristics of the local or national economy and the labor market. The starting supply plus new additions to the workforce minus attrition provide an end-of-year supply projection, which then becomes the starting supply estimate for the subsequent year. This cycle is repeated through 2025. Supply data come from multiple sources: American Medical Association (AMA) Master File for psychiatrists; the National Commission on Certification of Physician Assistants (NCCPA) Master File for physician assistants; the National Sample Survey of Nurse Practitioners and National Plan and Provider Enumeration System (NPPES) for nurse practitioners; the American Community Survey (ACS) for demographics of counselors, social workers, and therapists.

Demand projections for health care services in different care settings are produced by applying regression equations for individuals' health care use on the projected population. The current staffing patterns by care setting are then applied to forecast the future demand for behavioral health practitioners. The population database used to estimate demand consists of records of individual characteristics of a representative sample of the entire U.S. population derived from the ACS, the National Nursing Home Survey, and the Behavioral Risk Factor Surveillance System. Using the Census Bureau's projected population and the Urban Institute's state-level estimates of the impact of the Affordable Care Act on insurance coverage,[1, 2] the HWSM simulates future populations with expected demographic, socioeconomic, health status, health risk, and insurance status.

The HWSM makes projections at the state level which are then aggregated to regional and national levels. A detailed description of the HWSM can be found in the accompanying technical documentation available at http://bhw.hrsa.gov/healthworkforce/index.html.

[1] Holahan, J. & Blumberg, L. 2010. How would states be affected by health reform? Timely analysis of immediate health policy issues. Accessed 10/1/2015: http://www.urban.org/UploadedPDF/412015_affected_by_health_reform.pdf.

[2] Holahan, J. 2014. The launch of the Affordable Care Act in selected states: Coverage expansion and uninsurance. Washington, DC: The Urban Institute. Accessed 10/1/2015: http://www.urban.org/uploadedPDF/413036-the-launch-of-the-Affordable-Care-Act-in-selected-states-coverage-expansion-and-uninsurance.pdf.