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A Workforce Minimum Data Set for Marriage and Family Therapists

Jessica Buche, MPH, MA, Angela J. Beck, PhD, MPH, Phillip M. Singer, MHSA, Roger D. Smith, JD

BACKGROUND

Marriage and Family Therapists (MFT) are among the core professional occupations in behavioral health. A 2016 Congressional Research Service report estimates over 62,000 MFTs practicing in the United States.[1] Aside from the standardized education and training requirements, few characteristics are known about MFTs, such as demographic composition, practice characteristics, job functions, and settings where they are delivering behavioral health services.

In 2016, the Behavioral Health Workforce Research Center (BHWRC) developed a Minimum Data Set (MDS) for the behavioral health workforce to support standardized data collection of worker characteristics.[2] In 2017, the BHWRC customized the MDS to collect MFT workforce data. The purpose of this study is two-fold. First, through partnership with the American Association for Marriage and Family Therapy (AAMFT), a membership organization for MFTs, this pilot study was developed to test the effectiveness of the MDS as a data collection tool for this segment of the behavioral health workforce. Second, we sought to understand the feasibility of reaching a survey population through AAMFT to obtain worker data.

METHODS

To tailor the MDS to MFTs, the research team limited the online survey questions to only include themes and data elements that pertained specifically to the MFT workforce (Table 1). Upon completing the survey, respondents were prompted to answer several feedback questions to gauge feasibility of the instrument to collect national workforce data for this professional population. BHWRC partner Consortium members provided feedback on the modified MFT MDS tool.

An individual-level sampling plan was developed jointly with AAMFT for this pilot study using the approximately 12,000 MFTs holding Clinical Fellow AAMFT membership. An age-stratified, randomized sample of 5,000 members were drawn from

CONCLUSIONS AND POLICY IMPLICATIONS

Overall, most participants indicated that they were comfortable reporting the information solicited in the MDS. Participants were most comfortable reporting workforce data to AAMFT, their state licensing board, and university researchers. Some respondents felt comfortable providing the information to a federal government agency. This indicates that several avenues may be an effective means of collecting workforce information.

Questions pertaining to respondents' demographic information were most frequently skipped. Additionally, 20% of respondents preferred not to provide their National Provider Identification (NPI) number. Respondents raised concerns about potential job consequences if demographic and NPI data were linked to other survey responses, highlighting the need for the survey to better articulate the purpose of collecting this type of information, as well as confidentiality procedures.

The MDS was distributed to MFTs with clinical membership designation at the AAMFT. Although response rate for this study was approximately 11%, AAMFT can be an important partner in survey dissemination and study promotion. This dissemination method should be considered as one of several ways to reach practicing MFTs for data collection, along with licensing boards and other partners.

[1] Heisler, E. and Bagalman, E. The Mental Health Workforce: A Primer. (2016) Congressional Research Service. Retrieved from: https://fas.org/sgp/crs/misc/R43255.pdf
[2] University of Michigan Behavioral Health Workforce Research Center. A minimum data set for the behavioral health workforce. 2016. http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/02/FA1_MDS_Full-Report.pdf

an available sampling frame of the 11,976 members. Four age strata were chosen, consistent with Census categories: 18-23, 24-44, 45-64, and 65+ years old.

AAMFT leadership distributed a recruitment email in July 2017 to the randomized sample of 5,000 MFTs, explaining AAMFT's partnership with the BHWRC and the specifics of the research project, inviting participation in the study, and providing potential participants the option to be excluded from the research. Of those invited to participate in the survey, 125 opted out, leaving a sample of 4,875 MFTs. Reminder emails were sent periodically by the BHWRC and the AAMFT leadership. Participants were offered the opportunity to enter a random drawing for one of five $25 MasterCard gift cards as an incentive.

Table 1. Summary of Minimum Data Set Data Elements for Marriage and Family Therapists

MDS Theme	Data Elements	
Demographics	• Name • Age • Race/ethnicity • Sex and gender	• Sexual orientation • Place of birth and residence • Military/veteran status • Language skills
Licensure and Certification	• Type of job-related licenses held • Type of job-related certificates held	• National Provider Identification number • State identification/registration number
Education and Training	• Degrees obtained and years of completion • Field of study/specialty	• Completion of other educational programs (e.g. internships) • Current enrollment in degree program
Occupation and Area of Practice	• Primary occupation	• Area of practice
Practice Characteristics and Settings	• Employment status • Number of current employment positions • Number of hours and weeks worked per year • Employment arrangement	• Use of telehealth • Employer practice setting • Hours per week spent on activities (e.g. clinical supervision, diagnosis) • Clinical or patient care provision • Employment plans

KEY FINDINGS

Professional Overview

A total of 538 MFTs with clinical membership with AAMFT responded to the pilot survey (11% response rate). Most respondents identified their profession as MFT (91%). When asked to select all primary areas of practice that apply to their profession, responses included mental health therapy (417/1575, 26%), couple's therapy (405/1575, 26%), child and adolescent therapy (290/1575, 18%), addiction/substance use disorder therapy (134/1575, 9%) military/veteran therapy (94/1575, 6%), medical therapy (56/1575, 4%), social services therapy (34/1575, 2%), or "other" (108/1575, 7%). Related to practice setting, most respondents (252/393, 64%) provide MFT services in a private practice setting, 8% (33/393) in an educational setting, 8% (30/393) in an ambulatory care or clinic setting, 5% (18/393) in a social services or correctional facilities setting, and 2% (9/393) in a hospital setting.

Participants were asked to select all licenses that they currently hold. A total of 77% (504/657) of survey participants currently hold an MFT license and 23% (153/657) hold another mental health professional license such as licensed professional counselor, social worker, psychologist, and mental health counselor. When asked to select all completed levels of education, half of respondents (293/589; 50%) hold an MFT master's degree; 11% (67/589) hold an MFT doctoral degree. There is diversity in the educational background of the respondents: 4% (21/589) hold a master's or doctoral degree in social work, 22% (132/589) and 13% (76/589) hold master's degrees and doctoral degrees, respectively, in another field such as psychology, nursing, counseling, divinity, and business administration. Only 5% (21/453) of those surveyed are currently enrolled in a formal education program that is leading to an academic degree.

Minimum Data Set Feedback

Overall, participants were able to complete the survey questions, with a 55% completion rate. Nearly all participants indicated that they would feel comfortable reporting the information solicited in the MDS. Participants indicated that they felt most comfortable reporting workforce data to AAMFT, their state licensing board, and university researchers. Questions pertaining to respondents' demographics was the most frequently skipped section of the survey. For example, one-third of participants opted out of providing their legal name, date of birth, and zip code and more than 20% of respondents did not provide information about race/ethnicity, gender identity, residency status, and military status. In addition to skipping demographic sections, 20% (107/538) did not indicate whether they have a National Provider Identification (NPI) number and of those who indicated that they have an NPI number, 16% (143/342) preferred not to provide it. In qualitative follow-up respondents indicated that they would be more willing to provide NPI and demographic data if they knew this information would not be directly linked to their other responses or would not jeopardize their job in any capacity. This pilot study was helpful in determining the feasibility of collecting data for workforce planning purposes from this key segment of the behavioral health workforce.

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