INDIANA UNIVERSITY
SCHOOL OF MEDICINE
Bowen Center for Health Workforce Research and Policy

The mental health workforce is comprised of a collection of providers including physicians, registered nurses, and licensed mental health professionals. Since these multiple professions are regulated by differing licensing boards, supply data is collected through various survey tools during different licensure renewal intervals.

The Bowen Center collects data on the supply and practice characteristics of each of these professionals. This data is then compiled together in order to provide a comprehensive look at the health workforce that provides mental health and behavioral health services. As such, all surveys for these professions are included in this document.

1110 W. Michigan Street Long Hall, #200 Indianapolis, IN 46202 (317) 278-4818 (317) 274-4444 (fax) family.medicine.iu.edu/hws

2015 Addiction Counselor and Clinical Addiction Counselor Re-Licensure Survey Instrument

1. Sex
    a. RADIO BUTTONS
    b. Male
    c. Female

2. Ethnicity: Are you Hispanic or Latino?
    a. RADIO BUTTONS
    b. Yes
    c. No

3. Race (Check all that apply.)
    a. CHECK BOXES
    b. American Indian or Alaska Native
    c. Black or African American
    d. White
    e. Asian
    f. Native Hawaiian or Other Pacific Islander

4. What type of degree/credential qualified you for your first addiction counselor or clinical addiction counselor license?
    a. DROP DOWN LIST
    b. High school diploma/GED
    c. Associate degree
    d. Bachelor's degree – addiction counseling, addiction therapy, or related area
    e. Bachelor's degree – other
    f. Master's degree – addiction counseling, addiction therapy, or related area
    g. Master's degree – other
    h. Doctoral degree – addiction counseling, addiction therapy, or related area
    i. Doctoral degree – other

5. Where did you complete the degree first qualified you for your license?
    a. DROP DOWN LIST
    b. Indiana
    c. Michigan
    d. Illinois
    e. Kentucky
    f. Ohio
    g. Another State (not listed)
    h. Another Country (not U.S.)

6. What is your highest level of education?
    a. DROP-DOWN LIST OR RADIO BUTTONS
    b. Baccalaureate degree – counseling or related field
    c. Baccalaureate degree – other field
    d. Master's degree – counseling or related field
    e. Master's degree – other field
    f. Doctoral degree – counseling or related field
    g. Doctoral degree – other field

7. Please mark all counseling certifications you currently hold.
    a. CHECK BOXES
    b. Certified Alcohol and Drug Counselor (CADC)
    c. Certified Advanced Alcohol and Drug Counselor (CAADC)
    d. Certified Clinical Supervisor (CCS)
    e. Certified Prevention Specialist (CPS)
    f. Certified Criminal Justice Addictions Professional (CCJP)
    g. Certified Co-Occurring Disorders Professional (CCDP)
    h. Certified Co-Occurring Disorders Professional Diplomate (CCDPD)
    i. National Certified Counselor (NCC)
    j. National Certified Addiction Counselor I
    k. National Certified Addiction Counselor II
    l. Master Addictions Counselor (MAC)
    m. Certified Clinical Mental Health Counselor (CCMHC)
    n. National Certified School Counselor (NCSC)
    o. None
    p. Other

8. What is your employment status?
    a. RADIO BUTTONS
    b. Actively working in a substance abuse/addiction counseling position that <u>requires</u> a substance abuse/addiction counseling license/certification
    c. Actively working in a substance abuse/addiction counseling position that <u>does not require</u> a substance abuse/addiction counseling license/certification
    d. Actively working in a field other than substance abuse/addiction counseling
    e. Not currently working
    f. Retired

9. What best describes your employment plans for the next 12 months?
    a. DROP DOWN LIST
    b. Increase hours
    c. Decrease hours
    d. Seek non-clinical job
    e. Retire
    f. No change
    g. Seek career advancement
    h. Move to a different career
    i. Unknown

10. Please indicate which languages you are able to use to communicate with your patients.
    a. CHECK BOXES
    b. English
    c. Spanish
    d. Other

11. What is the street address of your principal practice location?
    a. TEXT-BOX

12. In what city is your principal practice location?
    a. TEXT-BOX

13. In what state is your principal practice location? Please indicate state using 2-letter postal abbreviation.
    a. DROP-DOWN LIST OF STATES (2LETTER ABV.)

14. What is the 5-digit ZIP code of your principal practice location?
    a. TEXT-BOX

15. How many hours do you spend in direct patient care at your principal practice location?
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week

16. Which best describes the type of setting that most closely corresponds to your principal <u>direct patient care</u> practice location(s):
    a. DROP DOWN LIST
    b. Specialized substance abuse outpatient treatment facility
    c. Community health center
    d. Community Mental Health Center/Mental health clinic
    e. Methadone clinic
    f. Primary or specialist medical care
    g. Child welfare
    h. Criminal justice
    i. Hospital
    j. Federal Government hospital
    k. Non-federal hospital: Inpatient
    l. Non-federal hospital: General Medical
    m. Non-federal hospital: Psychiatric
    n. Non-federal hospital: Other – e.g. nursing home unit
    o. Private practice
    p. Rehabilitation
    q. Detox
    r. Residential setting
    s. Recovery support services
    t. School health service
    u. Faith-based setting
    v. Other

17. What is the street address of your secondary practice location? If you do not have a secondary practice site, please skip this question.
    a. TEXT-BOX

18. In what city is your secondary practice location? If you do not have a secondary practice site, please skip this question.
    a. TEXT-BOX

19. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If you do not have a secondary practice site, please skip this question.
    a. DROP-DOWN LIST OF STATES (2 LETTER ABV.)

20. What is the 5-digit ZIP code of your secondary practice location? If you do not have a secondary practice site, please skip this question.
    a. TEXT-BOX

21. How many hours do you spend in direct patient care per week at your secondary practice location? If you do not have a secondary practice site, please skip this question.
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week

22. Which best describes the type of setting that most closely corresponds to your secondary <u>direct patient care</u> practice location(s): (If you do not have a secondary practice site, please skip this question.)
    a. Specialized substance abuse outpatient treatment facility
    b. Community health center
    c. Mental health clinic
    d. Methadone clinic
    e. Primary or specialist medical care
    f. Child welfare
    g. Criminal justice
    h. Hospital
    i. Federal Government hospital
    j. Non-federal hospital: Inpatient
    k. Non-federal hospital: General Medical
    l. Non-federal hospital: Psychiatric
    m. Non-federal hospital: Other – e.g. nursing home unit
    n. Private practice
    o. Rehabilitation
    p. Detox
    q. Residential setting
    r. Recovery support services
    s. School health service
    t. Faith-based setting
    u. Other

2015 Physician Licensure Survey Instrument

1. What is your racial background? Please select all that apply.
    - DROP-DOWN LIST OR RADIO BUTTONS
        - White
        - American Indian or Alaska Native
        - Native Hawaiian/Pacific Islander
        - Black or African American
        - Asian
        - Other

2. What is your ethnicity?
    - DROP-DOWN LIST OR RADIO BUTTONS
        - Hispanic or Latino
        - Not Hispanic or Latino

3. Where did you complete your medical degree?
    - DROP-DOWN LIST OR RADIO BUTTONS
        - Indiana
        - Michigan
        - Illinois
        - Kentucky
        - Ohio
        - Another State (not listed)
        - Another County (not US)

4. Where did you complete your residency training?
    - DROP-DOWN LIST OR RADIO BUTTONS
        - Indiana
        - Michigan
        - Illinois
        - Kentucky
        - Ohio
        - Another State (not listed)
        - Another County (not US)

5. What is your employment status?
    - DROP-DOWN LIST OR RADIO BUTTONS
        - Actively working in a position that requires a medical license
        - Actively working in a field other than medicine
        - Not currently working
        - Retired

6. Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.

DROP-DOWN LIST

- Adolescent Medicine
- Anesthesiology
- Allergy and Immunology
- Cardiology
- Child Psychiatry
- Colon and Rectal Surgery
- Critical Care Medicine
- Dermatology
- Endocrinology
- Emergency Medicine
- Family Medicine/General Practice
- Gastroenterology
- Geriatric Medicine
- Gynecology Only
- Hematology & Oncology
- Infectious Diseases
- Internal Medicine (General)
- Nephrology
- Neurological surgery
- Neurology
- Obstetrics and Gynecology
- Occupational Medicine
- Ophthalmology
- Orthopedic Surgery
- Other Surgical Specialties
- Otolaryngology
- Pathology
- Pediatrics (General)
- Pediatrics Subspecialties
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Preventive Medicine/Public Health
- Psychiatry
- Pulmonology
- Radiation Oncology
- Radiology
- Rheumatology
- Surgery (General)
- Thoracic Surgery
- Urology
- Vascular Surgery
- Other Specialties

7. What is the street address of your primary practice location?

    TEXT-BOX (64 CHARACTER LIMIT)

8. In what city is your primary practice location?

    TEXT-BOX (64 CHARACTER LIMIT)

9. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation.

    TEXT-BOX (2 CHARACTER LIMIT)

10. What is the 5-digit ZIP code of your primary practice location?

    TEXT-BOX (5 CHARACTER LIMIT)

11. Which of the following categories best describes the practice setting at your primary practice location?

    DROP-DOWN LIST OR RADIO BUTTONS

    - Office/Clinic – Solo Practice
    - Office/Clinic – Partnership
    - Office/Clinic – Single Specialty Group
    - Office/Clinic – Multi Specialty Group
    - Hospital – Inpatient
    - Hospital – Outpatient
    - Hospital – Emergency Department
    - Hospital – Ambulatory Care Center
    - Federal Government Hospital
    - Research Laboratory
    - Medical School
    - Nursing Home or Extended Care Facility
    - Home Health Setting
    - Hospice Care
    - Federal/State/Community Health Center(s)
    - Local Health Department
    - Telemedicine
    - Volunteer in a Free Clinic
    - Other

12. Estimate the average number of hours per week spent in direct patient care at your primary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

0 hours per week
1 – 4 hours per week
5 – 8 hours per week
9 – 12 hours per week
13 – 16 hours per week
17 – 20 hours per week
21 – 24 hours per week
25 – 28 hours per week
29 – 32 hours per week
33 – 36 hours per week
37 – 40 hours per week
41 or more hours per week

13. Estimate the percentage of Indiana Medicaid patients at your primary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

I do not accept Indiana Medicaid
Indiana Medicaid accounts for 0% - 5% of my practice
Indiana Medicaid accounts for 6% - 10% of my practice
Indiana Medicaid accounts for 11% - 20% of my practice
Indiana Medicaid accounts for 21% - 30% of my practice
Indiana Medicaid accounts for 31% - 50% of my practice
Indiana Medicaid accounts for greater than 50% of my practice

14. Estimate the percentage of patients on a sliding fee scale at your primary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

I do not offer a sliding fee scale
Sliding fee patients account for 0% - 5% of my practice
Sliding fee patients account for 6% - 10% of my practice
Sliding fee patients account for 11% - 20% of my practice
Sliding fee patients account for 21% - 30% of my practice
Sliding fee patients account for 31% - 50% of my practice
Sliding fee patients account for greater than 50% of my practice

15. What is the street address of your secondary practice location? Please skip this question if you do not have a secondary practice location.

TEXT-BOX (64 CHARACTER LIMIT)

16. In what city is your secondary practice location? Please skip this question if you do not have a secondary practice location.

TEXT-BOX (64 CHARACTER LIMIT)

17. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a secondary practice location.

TEXT-BOX (2 CHARACTER LIMIT)

18. What is the 5-digit ZIP code of your secondary practice location? Please skip this question if you do not have a secondary practice location.

TEXT-BOX (5 CHARACTER LIMIT)

19. Which of the following categories best describes the practice setting at your secondary practice location? Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

Office/Clinic – Solo Practice
Office/Clinic – Partnership
Office/Clinic – Single Specialty Group
Office/Clinic – Multi Specialty Group
Hospital – Inpatient
Hospital – Outpatient
Hospital – Emergency Department
Hospital – Ambulatory Care Center
Federal Government Hospital
Research Laboratory
Medical School
Nursing Home or Extended Care Facility
Home Health Setting
Hospice Care
Federal/State/Community Health Center(s)
Local Health Department
Telemedicine
Volunteer in a Free Clinic
Other

20. Estimate the average number of hours per week spent in direct patient care at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

0 hours per week
1 – 4 hours per week
5 – 8 hours per week
9 – 12 hours per week
13 – 16 hours per week
17 – 20 hours per week
21 – 24 hours per week
25 – 28 hours per week
29 – 32 hours per week
33 – 36 hours per week
37 – 40 hours per week
41 or more hours per week

21. Estimate the percentage of Indiana Medicaid patients at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

I do not accept Indiana Medicaid
Indiana Medicaid accounts for 0% - 5% of my practice
Indiana Medicaid accounts for 6% - 10% of my practice
Indiana Medicaid accounts for 11% - 20% of my practice
Indiana Medicaid accounts for 21% - 30% of my practice
Indiana Medicaid accounts for 31% - 50% of my practice
Indiana Medicaid accounts for greater than 50% of my practice

22. Estimate the percentage of patients on a sliding fee scale at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

I do not offer a sliding fee scale
Sliding fee patients account for 0% - 5% of my practice
Sliding fee patients account for 6% - 10% of my practice
Sliding fee patients account for 11% - 20% of my practice
Sliding fee patients account for 21% - 30% of my practice
Sliding fee patients account for 31% - 50% of my practice
Sliding fee patients account for greater than 50% of my practice

23. What is the street address of your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (64 CHARACTER LIMIT)

24. In what city is your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (64 CHARACTER LIMIT)

25. In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (2 CHARACTER LIMIT)

26. What is the 5-digit ZIP code of your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (5 CHARACTER LIMIT)

27. Which of the following categories best describes the practice setting at your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

- Office/Clinic – Solo Practice
- Office/Clinic – Partnership
- Office/Clinic – Single Specialty Group
- Office/Clinic – Multi Specialty Group
- Hospital – Inpatient
- Hospital – Outpatient
- Hospital – Emergency Department
- Hospital – Ambulatory Care Center
- Federal Government Hospital
- Research Laboratory
- Medical School
- Nursing Home or Extended Care Facility
- Home Health Setting
- Hospice Care
- Federal/State/Community Health Center(s)
- Local Health Department
- Telemedicine
- Volunteer in a Free Clinic
- Other

28. Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

- 0 hours per week
- 1 – 4 hours per week
- 5 – 8 hours per week
- 9 – 12 hours per week
- 13 – 16 hours per week
- 17 – 20 hours per week
- 21 – 24 hours per week
- 25 – 28 hours per week
- 29 – 32 hours per week
- 33 – 36 hours per week
- 37 – 40 hours per week
- 41 or more hours per week

29. Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

- I do not accept Indiana Medicaid
- Indiana Medicaid accounts for 0% - 5% of my practice
- Indiana Medicaid accounts for 6% - 10% of my practice
- Indiana Medicaid accounts for 11% - 20% of my practice
- Indiana Medicaid accounts for 21% - 30% of my practice
- Indiana Medicaid accounts for 31% - 50% of my practice
- Indiana Medicaid accounts for greater than 50% of my practice

30. Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

- I do not offer a sliding fee scale
- Sliding fee patients account for 0% - 5% of my practice
- Sliding fee patients account for 6% - 10% of my practice
- Sliding fee patients account for 11% - 20% of my practice
- Sliding fee patients account for 21% - 30% of my practice
- Sliding fee patients account for 31% - 50% of my practice
- Sliding fee patients account for greater than 50% of my practice

2015 Registered Nurse Re-Licensure Survey Instrument

1. What is your employment status?
    DROP-DOWN LIST OR RADIO BUTTONS
        Actively employed in nursing full-time
        Actively employed in nursing part-time
        Actively employed in nursing per diem
        Actively employed in a field other than nursing
        Working in nursing only as a volunteer
        Unemployed and seeking work as a nurse
        Unemployed and not seeking work as a nurse
        Retired

2. What is your racial background? Please select all that apply.
    DROP-DOWN LIST OR RADIO BUTTONS
        White
        American Indian or Alaska Native
        Native Hawaiian/Pacific Islander
        Black or African American
        Asian
        Other

3. What is your ethnicity?
    DROP-DOWN LIST OR RADIO BUTTONS
        Hispanic or Latino
        Not Hispanic or Latino

4. What type of nursing degree/credential qualified you for your first US nursing license?
    DROP-DOWN LIST OR RADIO BUTTONS
        Vocational/Practical certificate – nursing
        Diploma – nursing
        Associate degree – nursing
        Baccalaureate degree – nursing
        Master's degree – nursing
        Doctoral degree – nursing

5. What is the name of the school (education program) you graduated from that qualified you for your first US RN license?
    TEXT-BOX (128 CHARACTER LIMIT)

6. In what city was this education program located?
    TEXT-BOX (64 CHARACTER LIMIT)

7. In what state was this education program located? Please indicate the state with its 2-letter postal abbreviation.
    TEXT-BOX (2 CHARACTER LIMIT)

8. What is your highest level of education?

DROP-DOWN LIST OR RADIO BUTTONS

- Vocational/Practical certificate – nursing
- Diploma – nursing
- Associate degree – nursing
- Associate degree – other field
- Baccalaureate degree – nursing
- Baccalaureate degree – other field
- Master's degree – nursing
- Master's degree – other field
- Doctoral degree – nursing
- Doctoral degree – other field

9. What other nursing degrees do you plan to pursue in the next 2 years? Please select all that apply.

DROP-DOWN LIST OR RADIO BUTTONS

- Bachelor's Degree
- Master's Degree
- Doctor of Nursing Practice (DNP)
- PhD
- I do not intend to pursue further nursing education in the next 2 years

10. Please identify the type of setting that most closely corresponds to your primary nursing practice position.

DROP-DOWN LIST OR RADIO BUTTONS

- Hospital
- Nursing Home/Extended Care Facility/Assisted Living Facility
- Home Health
- Correctional Facility
- Academic Setting
- Public Health
- Community Health
- School Health Service
- Occupational Health
- Ambulatory Care Setting
- Insurance Claims/Benefits
- Policy/Planning/Licensing Agency
- Other

11. Please identify the position title that most closely corresponds to your primary nursing practice position.

DROP-DOWN LIST OR RADIO BUTTONS

Consultant/Nurse Researcher
Nurse Executive
Nurse Manager
Nurse Faculty
Advanced Practice Nurse
Staff Nurse
Other – Health Related
Other – Non-Health Related

12. Please identify the employment specialty that most closely corresponds to your primary nursing practice position.

DROP-DOWN LIST OR RADIO BUTTONS

Acute Care/Critical Care
Adult Health/Family Health
Anesthesia
Community
Geriatric/Gerontology
Home Health
Maternal-Child Health
Medical Surgical
Occupational Health
Oncology
Palliative Care
Pediatrics/Neonatal
Public Health
Psychiatric/Mental Health/Substance Abuse
Rehabilitation
School Health
Trauma
Women's Health
Other

13. **If you are licensed as an Advanced Practice Nurse or Nurse Midwife**, indicate the specialty of the physician(s) with whom you have a practice. If you have your own practice, please select the specialty that best describes your practice.

DROP-DOWN LIST OR RADIO BUTTONS

Primary Care Specialties
Internal Medicine Subspecialties
Pediatric Subspecialties
Obstetrics & Gynecology
General Surgery
Surgical Specialties
Psychiatry (Adult and Child)
Anesthesiology, Pathology, Radiology or Emergency Medicine
Other Specialty

14. What is the street address of your primary practice location?
TEXT-BOX (64 CHARACTER LIMIT)

15. In what city is your primary practice location?
TEXT-BOX (64 CHARACTER LIMIT)

16. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation.
TEXT-BOX (2 CHARACTER LIMIT)

17. What is the 5-digit ZIP code of your primary practice location?
TEXT-BOX (5 CHARACTER LIMIT)

18. Estimate the average number of hours per week spent at your primary practice location.
DROP-DOWN LIST OR RADIO BUTTONS
0 hours per week
1 – 4 hours per week
5 – 8 hours per week
9 – 12 hours per week
13 – 16 hours per week
17 – 20 hours per week
21 – 24 hours per week
25 – 28 hours per week
29 – 32 hours per week
33 – 36 hours per week
37 – 40 hours per week
41 or more hours per week

19. What is the street address of your secondary practice location? Please skip this question if you do not have a secondary practice location.
TEXT-BOX (64 CHARACTER LIMIT)

20. In what city is your secondary practice location? Please skip this question if you do not have a secondary practice location.
TEXT-BOX (64 CHARACTER LIMIT)

21. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a secondary practice location.
TEXT-BOX (2 CHARACTER LIMIT)

22. What is the 5-digit ZIP code of your secondary practice location? Please skip this question if you do not have a secondary practice location.
TEXT-BOX (5 CHARACTER LIMIT)

23. Estimate the average number of hours per week spent at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS

0 hours per week
1 – 4 hours per week
5 – 8 hours per week
9 – 12 hours per week
13 – 16 hours per week
17 – 20 hours per week
21 – 24 hours per week
25 – 28 hours per week
29 – 32 hours per week
33 – 36 hours per week
37 – 40 hours per week
41 or more hours per week

24. In how many **paid positions** in nursing are you currently employed?

DROP-DOWN LIST OR RADIO BUTTONS

1 position
2 positions
3 positions
4 or more positions

2015 Licensed Professional Counselors Re-Licensure Survey Instrument (Including Social Worker, Clinical Social Worker, Marriage & Family Therapist, Marriage & Family Associate, Mental Health Counselor, Mental Health Associate)

1. Sex
    a. Male
    b. Female

2. What is your racial background? Please select all that apply.
    a. American Indian or Alaska Native
    b. Black or African American
    c. White
    d. Asian
    e. Native Hawaiian or Other Pacific Islander

3. Ethnicity: Are you Hispanic or Latino?
    a. Yes
    b. No

4. What type of counseling degree/credential qualified you for your first U.S. counseling license?
    a. DROP-DOWN LIST OR RADIO BUTTONS
    b. Vocational/Practical certificate – counseling or related field
    c. Diploma – counseling or related field
    d. Associate degree – counseling or related field
    e. Baccalaureate degree – counseling or related field
    f. Master's degree – counseling or related field
    g. Doctoral degree – counseling or related field

5. Where did you complete your initial counseling degree?
    a. Indiana
    b. Michigan
    c. Illinois
    d. Kentucky
    e. Ohio
    f. Another State (not listed)
    g. Another Country (not U.S.)

6. What is your highest level of education?
    a. DROP-DOWN LIST OR RADIO BUTTONS
    b. Baccalaureate degree – counseling or related field
    c. Baccalaureate degree – other field
    d. Master's degree – counseling or related field
    e. Master's degree – other field
    f. Doctoral degree – counseling or related field
    g. Doctoral degree – other field

7. Please mark all counseling certifications you currently hold (please select all that apply).
    a. National Certified Counselor (NCC)
    b. Approved Clinical Supervisor (ACS)
    c. Other

8. What is your employment status?
    a. Actively working in a counseling position that requires a counseling license
    b. Actively working in a counseling position that does not require a counseling license
    c. Actively working in a field other than counseling
    d. Not currently working
    e. Retired

9. Please indicate which languages you are able to use to communicate with your patients.
    a. CHECK BOXES
    b. English
    c. Spanish

10. What are your employment plans for the next 12 months?
    a. Increase hours in patient care
    b. Decrease hours in patient care
    c. Seek employment in a field outside of patient care
    d. Leave direct patient care to complete further training
    e. Leave direct patient care for family reasons/commitments
    f. Leave direct patient care due to physical demands
    g. Leave direct patient care due to stress/burnout
    h. Retire
    i. Continue as you are

11. What is the street address of your primary practice location?
    a. TEXT-BOX

12. In what city is your principal practice location?
    a. TEXT-BOX

13. In what state is your principal practice location? Please indicate state using 2-letter postal abbreviation.
    a. DROP-DOWN LIST OF STATES (2LETTER ABV.)

14. What is the 5-digit ZIP code of your principal practice location?
    a. TEXT-BOX

15. How many hours do you spend in direct patient care at your principal practice location?
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week

16. Which best describes the type of setting that most closely corresponds to your principal practice location(s):
    a. Ambulatory Care Facility – Community health center
    b. Ambulatory Care Facility – Community Mental Health Center/Mental health clinic
    c. Ambulatory Care Facility – Methadone clinic
    d. Ambulatory Care Facility – Primary or specialist medical care
    e. Ambulatory Care Facility – Specialized substance abuse treatment facility
    f. Child welfare
    g. Criminal justice
    h. Hospital – Federal Government hospital
    i. Hospital – Non-federal hospital: General Medical
    j. Hospital – Non-federal hospital: Psychiatric
    k. Hospital – Non-federal hospital: Other – e.g. nursing home unit
    l. Private practice
    m. Rehabilitation
    n. Residential setting
    o. School health service
    p. In-home setting
    q. Other

17. What is the street address of your secondary practice location? If you do not have a secondary practice location, please skip this question.
    a. TEXT-BOX

18. In what city is your secondary practice location? If you do not have a secondary practice location, please skip this question.
    a. TEXT-BOX

19. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If you do not have a secondary practice location, please skip this question.
    a. DROP-DOWN LIST OF STATES (2LETTER ABV.)

20. What is the 5-digit ZIP code of your secondary practice location? If you do not have a secondary practice location, please skip this question.
    a. TEXT-BOX

21. How many hours do you spend in direct care at your secondary practice location? If you do not have a secondary practice location, please skip this question.
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week

22. Which best describes the type of setting that most closely corresponds to your secondary practice location(s): (If you do not have a secondary practice site, please skip this question.)
    a. Ambulatory Care Facility – Community health center
    b. Ambulatory Care Facility – Community Mental Health Center/Mental health clinic
    c. Ambulatory Care Facility – Methadone clinic
    d. Ambulatory Care Facility – Primary or specialist medical care
    e. Ambulatory Care Facility – Specialized substance abuse treatment facility
    f. Child welfare
    g. Criminal justice
    h. Hospital – Federal Government hospital
    i. Hospital – Non-federal hospital: General Medical
    j. Hospital – Non-federal hospital: Psychiatric
    k. Hospital – Non-federal hospital: Other – e.g. nursing home unit
    l. Private practice
    m. Rehabilitation
    n. Residential setting
    o. School health service
    p. In-home setting
    q. Other

2016 Psychologist Re-Licensure Survey Instrument

1. Sex
   Dropdown List
   a. Male
   b. Female

2. Ethnicity: Are you Hispanic or Latino?
   Yes/No Dropdown
   a. Yes
   b. No

3. Race (Check all that apply.)
   Multi Checkbox
   a. American Indian or Alaska Native
   b. Black or African American
   c. White
   d. Asian
   e. Native Hawaiian or Other Pacific Islander

4. Where did you complete the psychology degree/credential that qualified you for your first U.S. psychologist license?
   Dropdown List
   a. Indiana
   b. Michigan
   c. Illinois
   d. Kentucky
   e. Ohio
   f. Another State (not listed)
   g. Another Country (not U.S.)

5. What type of psychology degree/credential qualified you for your first U.S. psychologist license?
   Dropdown List
   a. Bachelor's degree
   b. Master's degree
   c. Doctoral degree
   d. Military training certification
   e. Other

6. What year did you complete the psychology education that first qualified you for your U.S. psychologist license? Please indicate using the four digit year.
   TEXT BOX

7. What is your highest earned degree/credential in psychology?
   Dropdown List
   a. Master's degree (MA, MS, MED)
   b. Specialist degree/Certificate of Advanced Graduate Study (e.g., EdS, PsyS, SSP, CAGS)
   c. PhD
   d. PsyD
   e. Other

8. What is your employment status?
   Dropdown List
   a. Actively working in the field of psychology
   b. Actively working in a field other than psychology
   c. Unemployed but seeking work in psychology
   d. Unemployed, not seeking work in psychology
   e. Retired

9. How many weeks did you work in psychology in the past year? Please approximate and enter a number 1 through 52 (no decimals).
   Text box

10. What are your employment plans for the next 12 months?
    Dropdown List
    a. Increase hours in the field of psychology
    b. Decrease hours in the field of psychology
    c. Increase hours in direct patient care
    d. Decrease hours in direct patient care
    e. Leave employment in the field of psychology
    f. No planned change

11. Please indicate in which major activity you spend the majority of your time:
    Dropdown List
    a. Administration Management
    b. Direct Client Care/Healthcare Services
    c. Clinical Supervision
    d. Clinical/Community Consultation & Prevention
    e. Other Human Services (e.g. forensics, consulting)
    f. Non-clinical Consultation
    g. Teaching/Education/Research
    h. Other

12. What is the street address of your primary practice location?
    TEXT-BOX

13. In what city is your primary practice location?
    TEXT-BOX

14. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation.
    DROP-DOWN LIST OF STATES (2LETTER ABV.)

15. What is the 5-digit ZIP code of your primary practice location?
    TEXT-BOX

16. What is your primary specialty area of practice at your primary practice location?
    Dropdown List
    a. Clinical Child & Adolescent Psychology
    b. Clinical Health Psychology
    c. Clinical Neuropsychology
    d. Clinical Psychology
    e. Cognitive Behavioral Psychology
    f. Counseling Psychology
    g. Couple & Family Psychology
    h. Forensic Psychology
    i. Group Psychology
    j. Organizational & Business Consulting Psychology
    k. Police & Public Safety Psychology
    l. Professional Geropsychology
    m. Psychoanalytic Psychology
    n. Rehabilitation Psychology
    o. Other

17. How many hours do you spend in direct care per week at primary practice location?
    Dropdown List
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week

18. Please identify the type of setting that most closely corresponds to your primary practice location.
    Dropdown List
    a. Federal government hospital
    b. Non-federal hospital: General medical
    c. Non-federal hospital: Psychiatric
    d. Community health center
    e. Mental health clinic
    f. Primary or specialist medical care
    g. Child welfare facility
    h. College/University Counseling/Health Center
    i. Correctional Facility
    j. Criminal Justice Facility
    k. Hospice
    l. Independent group practice
    m. Independent solo practice
    n. Long-term care facility (e.g. nursing home, assisted living)
    o. Organization/Business setting
    p. Rehabilitation
    q. Residential setting
    r. School-based mental health service
    s. Veterans Facility
    t. Other

19. What is the street address of your secondary practice location? Please skip this question if you do not have a secondary practice location.
    TEXT-BOX

20. In what city is your secondary practice location? Please skip this question if you do not have a secondary practice location.
    TEXT-BOX

21. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a secondary practice location.
    DROP-DOWN LIST OF STATES

22. What is the 5-digit ZIP code of your secondary practice location? Please skip this question if you do not have a secondary practice location.
    TEXT-BOX

23. What is your primary specialty area of practice at your secondary practice location? Please skip this question if you do not have a secondary practice location.
    Dropdown List
    a. Clinical Child & Adolescent Psychology
    b. Clinical Health Psychology
    c. Clinical Neuropsychology
    d. Clinical Psychology
    e. Cognitive Behavioral Psychology
    f. Counseling Psychology
    g. Couple & Family Psychology
    h. Forensic Psychology
    i. Group Psychology
    j. Organizational & Business Consulting Psychology
    k. Police & Public Safety Psychology
    l. Professional Geropsychology
    m. Psychoanalytic Psychology
    n. Rehabilitation Psychology
    o. Other

24. How many hours do you spend in direct care per week at secondary practice location?
    Dropdown List
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week

25. Please identify the type of setting that most closely corresponds to your secondary practice location.
    Dropdown List
    a. Federal government hospital
    b. Non-federal hospital: General medical
    c. Non-federal hospital: Psychiatric
    d. Community health center
    e. Mental health clinic
    f. Primary or specialist medical care
    g. Child welfare facility
    h. College/University Counseling/Health Center
    i. Correctional Facility
    j. Criminal Justice Facility
    k. Hospice
    l. Independent group practice
    m. Independent solo practice
    n. Long-term care facility (e.g. nursing home, assisted living)
    o. Organization/Business setting
    p. Rehabilitation
    q. Residential setting
    r. School-based mental health service
    s. Veterans Facility
    t. Other