INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Bowen Center for Health Workforce Research and Policy

2020 Behavioral Health Board Survey Instrument

Administered to: Bachelor Social Workers, Social Workers, Clinical Social Workers, Marriage and Family Therapist Associates, Marriage and Family Therapists, Mental Health Counselor Associates, Mental Health Counselors, Addiction Counselor, Addiction Counselor Associate, Clinical Addiction Counselor Associate

1. Sex
   RADIO BUTTONS
   a. Male
   b. Female

2. What is your race? Mark one or more boxes.
   MULTI CHECK BOX
   a. White
   b. American Indian or Alaska Native
   c. Native Hawaiian or Other Pacific Islander
   d. Black or African American
   e. Asian
   f. Some Other Race

3. Are you of Hispanic or Latino origin?
   RADIO BUTTONS
   a. Yes
   b. No

4. What type of degree/credential qualified you for your first U.S. counselor license?
   DROP DOWN LIST
   a. High school diploma/GED - counseling or related field
   b. High school diploma/GED – other
   c. Vocational/Practical certificate – counseling or related field
   d. Vocational/Practical certificate – other
   e. Associate degree – counseling or related field
   f. Associate degree – other
   g. Bachelor’s degree – counseling or related field
   h. Bachelor’s degree – other
   i. Master’s degree – counseling or related field
   j. Master’s degree – other
   k. Doctoral degree – counseling or related field
   l. Doctoral degree – other

5. Where did you complete the degree that first qualified you for your license?
   DROP DOWN LIST
   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?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. High school diploma/GED - counseling or related field
   b. High school diploma/GED – other
   c. Vocational/Practical certificate – counseling or related field
   d. Vocational/Practical certificate – other
   e. Associate degree – counseling or related field
   f. Associate degree – other
   g. Bachelor's degree – counseling or related field
   h. Bachelor's degree – other
   i. Master's degree – counseling or related field
   j. Master's degree – other
   k. Doctoral degree – counseling or related field
   l. Doctoral degree – other

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

8. What is your employment status?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Actively working in a position that requires this license
   b. Actively working in a related position that does not require this license
   c. Actively working in a field not related to this license
   d. Not currently working
   e. Retired

9. What best describes your employment plans for the next 12 months?
   DROP DOWN LIST
   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

10. If you hold more than one license that is overseen by the Behavioral Health and Human Services Licensing Board, under which license do you primarily practice? If this does not apply, please select "not applicable."
    RADIO BUTTON
    a. Bachelor Social Worker
    b. Social Worker
    c. Clinical Social Worker
    d. Marriage and Family Therapist Associate
    e. Marriage and Family Therapist
    f. Mental Health Counselor Associate
    g. Mental Health Counselor
    h. Addiction Counselor Associate
    i. Addiction Counselor
    j. Clinical Addiction Counselor Associate
    k. Clinical Addiction Counselor
    l. Not applicable

11. Do you use telemedicine to deliver services to patients located in Indiana (telemedicine as defined in Indiana Code 25-1-9.5-6: delivery of health care services using electronic communications and information technology, including: secure videoconferencing; interactive audio-using store and forward technology; or remote patient monitoring technology)?
    RADIO BUTTON
    a. Yes
    b. No

12. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.
    CHECKBOXES
    a. Addiction counseling
    b. Crisis counseling
    c. Dementia/Alzheimer's care
    d. School counseling
    e. None of the above

13. Please indicate the population groups to which you provide services:
    CHECKBOXES
    a. Newborns
    b. Children (ages 2-10)
    c. Adolescents (ages 10-19)
    d. Adults
    e. Geriatrics (ages 65+)
    f. Pregnant women
    g. Inmates
    h. Disabled individuals
    i. Individuals in recovery
    j. None of the above

14. What is the street address of your primary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A"
    TEXT-BOX (64 CHARACTER LIMIT)

15. In what city is your primary practice location? If this does not apply, please indicate "N/A"
    TEXT-BOX (64 CHARACTER LIMIT)

16. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"
    DROP-DOWN LIST
    Please include all states' 2-letter postal abbreviation along with an option for N/A

17. What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"
    TEXT-BOX (5 CHARACTER LIMIT)

18. How many hours do you spend in direct patient care at your principal practice location? If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    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
    m. Not applicable

19. Which best describes the type of setting that most closely corresponds to your principal direct patient care practice location(s). If this does not apply, please select “not applicable.”:
    DROP DOWN LIST
    a. Child Welfare
    b. Community Health Center
    c. Community Health Center/Mental Health Clinic
    d. Criminal Justice
    e. Detox
    f. Faith-Based Setting
    g. Federal Government Hospital
    h. In-Home Setting
    i. Methadone Clinic
    j. Non-Federal Hospital: General Medicine
    k. Non-Federal Hospital: Inpatient
    l. Non-Federal Hospital: Other- e.g. nursing home unit
    m. Non-Federal Hospital: Psychiatric
    n. Primary or Specialist Medical Care
    o. Private Practice
    p. Recovery Support Services
    q. Rehabilitation
    r. Residential Setting
    s. School Health Service
    t. Specialized Substance Abuse Outpatient Treatment Facility
    u. Telemedicine
    v. Other
    w. Not applicable

20. Which best describes the field of practice for your principal practice location? If this does not apply, please select “not applicable.”
    RADIO BUTTONS
    a. Addictions
    b. Administration
    c. Community Development
    d. Developmental and Other Disabilities
    e. Family and Children Services
    f. Gerontological Services
    g. Health and Rehabilitation
    h. Income Maintenance
    i. Information and Retrieval
    j. Juvenile and/or Adult Corrections
    k. Mental Health
    l. Occupational
    m. Violence and Abuse Services
    n. Other
    o. Not applicable

21. What is the street address of your secondary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate “N/A”.
    TEXT-BOX (64 CHARACTER LIMIT)

22. In what city is your secondary practice location? If this does not apply, please indicate “N/A”.
    TEXT-BOX (64 CHARACTER LIMIT)

23. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”
    DROP-DOWN LIST
    Please include all states’ 2-letter postal abbreviation along with an option for N/A

24. What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate “N/A”.
    TEXT-BOX (5 CHARACTER LIMIT)

25. How many hours do you spend in direct patient care per week at your secondary practice location? If this does not apply, please select “not applicable.”
    DROP-DOWN LIST OR RADIO BUTTONS
    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
    m. Not applicable

26. Which best describes the type of setting that most closely corresponds to your secondary direct patient care practice location(s): If this does not apply, please select "not applicable."

DROP-DOWN LIST OR RADIO BUTTONS

a. Child Welfare
b. Community Health Center
c. Community Health Center/Mental Health Clinic
d. Criminal Justice
e. Detox
f. Faith-Based Setting
g. Federal Government Hospital
h. In-Home Setting
i. Methadone Clinic
j. Non-Federal Hospital: General Medicine
k. Non-Federal Hospital: Inpatient
l. Non-Federal Hospital: Other- e.g. nursing home unit
m. Non-Federal Hospital: Psychiatric
n. Primary or Specialist Medical Care
o. Private Practice
p. Recovery Support Services
q. Rehabilitation
r. Residential Setting
s. School Health Service
t. Specialized Substance Abuse Outpatient Treatment Facility
u. Telemedicine
v. Other
w. Not applicable

27. Which best describes the field of practice for your secondary practice location? If this does not apply, please select "not applicable."

RADIO BUTTONS

a. Addictions
b. Administration
c. Community Development
d. Developmental and Other Disabilities
e. Family and Children Services
f. Gerontological Services
g. Health and Rehabilitation
h. Income Maintenance
i. Information and Retrieval
j. Juvenile and/or Adult Corrections
k. Mental Health
l. Occupational
m. Violence and Abuse Services
n. Other
o. Not applicable