

Analyzing the Impact of the Medicare Coverage Gap on Counseling Professionals: Results of a National Study

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The authors surveyed 6,550 members of the American Counseling Association regarding the current impact of Medicare policy on counseling professionals. More than half of respondents (54.8%) had been directly affected by Medicare reimbursement barriers, including 70.0% of practicing counselors. Statistical analyses indicated significant associations between years in the profession, direct experience with the Medicare coverage gap, and participation in professional advocacy related to Medicare. Implications for counselors, counselor educators, and counseling scholarship are discussed.

Keywords: Medicare, professional issues, older adults, gerontological counseling, disability

Currently, Medicare is the primary insurance provider for approximately 60 million Americans (Kaiser Family Foundation, 2019), and that figure is expected to reach 80 million by 2030 (Medicare Payment Advisory Commission, 2015). With regard to the provision of psychotherapy services, Medicare recognizes psychiatrists, psychologists, clinical social workers, and psychiatric nurses as eligible providers. Notably, this excludes licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs), who collectively make up close to half of the total number of master's-level mental health professionals nationwide (American Counseling Association [ACA], n.d.).

The list of eligible providers was last updated in 1989, when clinical social workers were added and restrictions were removed on services provided by psychologists (H.R. Rep. No. 101-386, 1989). During the 30-year period since the provider list was last updated, the mental health landscape has changed markedly. Counseling licensure exists in all 50 states, there is a well-established accreditation process to which many counselor training programs ascribe, and the ratio of counselors to other mental health provider types has increased. Concurrently, there has been a sharp increase in Medicare enrollment that has accompanied population-level demographic changes (i.e., 10,000 people turning 65 each day; Short, 2016), as well as a growing awareness that Medicare beneficiaries (i.e., people over 65 years old and younger

people with permanent disabilities) experience restricted access to mental health care due to a lack of professionals who are available to work with individuals who are Medicare insured (Institute of Medicine, 2012), particularly in rural areas (Larson, Patterson, Garberson, & Andrilla, 2016; Stewart, Jameson, & Curtin, 2015).

The Needs of Medicare-Insured Individuals

There is a great deal of research suggesting that individuals who are Medicare insured are in need of mental health care. Approximately 10% of men and 15% of women over age 65 experience depressive symptoms, and these symptoms are often correlated with greater functional disability, higher rates of physical illness, and increased risk of dementia (Federal Interagency Forum on Aging Related Statistics, 2016). Among younger beneficiaries, Medicare insures individuals who live with disabilities, including the 37% of all beneficiaries with a disability who have a mental disorder (Center for Medicare Advocacy, n.d.), individuals with chronic physical conditions such as arthritis or musculoskeletal disorders, and beneficiaries living with HIV/AIDS (Claypool, Crowley, & LaManna, 2015). In fact, Medicare is the second largest source of funding for HIV/AIDS care (Kaiser Family Foundation, 2015). Professional advocacy groups have

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described the numerous mental health needs of Medicare-insured individuals (Medicare Mental Health Workforce Coalition, 2019), including the fact that Medicare is the largest single payer for opioid hospitalizations (Song, 2017).

Other scholars have noted that the Medicare coverage gap (MCG) may be particularly detrimental to Medicare beneficiaries who live in rural localities. This is because there are fewer mental health providers in rural areas, and those providers are more commonly LPCs and LMFTs (Christenson & Crane, 2004; Larson et al., 2016). This means that Medicare beneficiaries in these areas may be particularly burdened by current policy. In a qualitative study of the experiences of Medicare-ineligible mental health providers, we found that practicing counselors were aware of the discrepancy of mental health resources between rural and nonrural localities (Fullen, Wiley, & Morgan, 2019), and multiple interviewees mentioned that Medicare beneficiaries are at risk of under-treatment or hospitalization due to the MCG.

■ Medicare Advocacy

Because of the aforementioned circumstances, Medicare reimbursement of counselors has become one of the counseling profession's top priorities (Field, 2017; Fullen, 2016). Professional organizations that represent counselors began formally lobbying Congress over 15 years ago, and legislation to add LPCs and LMFTs to the list of eligible Medicare providers has passed in both the House and Senate, albeit not in the same congressional cycle (Field, 2017). One example of the prioritization of Medicare reimbursement to the counseling profession is the frequent reference to the issue in *Counseling Today*, the professional trade magazine published by ACA. A recent scan of *Counseling Today* issues located 19 references to the Medicare issue dating back to 2006 (Fullen, Lawson, & Sharma, 2020). Although this observation is anecdotal, it speaks to the profession's awareness that the MCG is relevant to the future viability of the profession, not to mention its detrimental impact on Medicare-insured individuals.

Counselors have a long history of engagement with social policy and legislative advocacy (Kiselica & Robinson, 2001), and social justice has been described as an essential characteristic of what it means to be a counselor (Chang, Crethar, & Ratts, 2010). In more recent years, a great deal of attention has been paid to cultivating social justice advocacy within counselor training curricula, with expressed goals such as identifying how exemplar counselor advocates develop (Swartz, Limberg, & Gold, 2018) and creating new models for how advocacy identity might be synthesized with counselor and scholar identities (Ratts & Greenleaf, 2018). The growth of the social justice advocacy movement within the counseling profession has clear implications for the issue of Medicare reimbursement for counselors. The MCG restricts

access to mental health services for a particular part of the population: those who have Medicare insurance. As such, it could be argued that the policy unduly limits the accessibility of counseling services to people over age 65 and to younger people with permanent disabilities.

Notwithstanding the counseling profession's commitment to social justice advocacy, there are indications that this commitment has not been fully actualized in regard to the MCG. Consider the counseling literature, where social justice advocacy has been named a priority (Chang et al., 2010). Aside from Medicare references in *Counseling Today*, however, there have been very few allusions to the issue within the scholarly literature in spite of over 15 years of advocacy (for exceptions, see Field, 2017; Fullen, 2016; Reiner, Dobmeier, & Hernández, 2013). Similarly, although the profession has been in agreement about the need to change Medicare policy for this length of time, there have not been corresponding efforts to collect data about the prevalence of Medicare beneficiaries who are turned away due to their insurance coverage, the impact on counseling professionals, and the resulting levels of advocacy engagement in which counseling professionals have participated. Despite Kiselica and Robinson's (2001) recommendation that "counselors . . . use their assessment and research skills to evaluate their advocacy initiatives" (p. 393), there are currently no empirical studies that probe the prevalence or impact of the MCG on counseling professionals.

■ The Current Study

To address this gap in the literature, we sought to collect data that would provide the counseling profession with baseline information regarding the prevalence and impact of the MCG. By asking counselors directly about their experiences with the MCG, we intended to begin a professional dialogue about the impact of Medicare's mental health provider policy. Because of the prioritization of Medicare reimbursement among counseling professional organizations (Medicare Mental Health Workforce Coalition, 2019), we also intended to ascertain how direct experience with the MCG informs participation in grassroots advocacy related to Medicare reimbursement for counselors. Therefore, to generate additional dialogue as a profession about the MCG and its impact on counseling professionals and their communities, we posed the following research questions:

Research Question 1: In regard to Medicare, how many counseling professionals have turned away or referred clients, or used a sliding scale to serve clients due to reimbursement barriers?

Research Question 2: Is there a difference among types of counseling professionals (i.e., practicing counselors, counselor educators, master's-level students, doctoral students) when it comes to experience with the MCG?

Research Question 3: Are practicing counselors more likely to have direct experience with the MCG the longer they are members of the profession?

Research Question 4: Does direct experience with the MCG influence participation in Medicare-related professional advocacy?

Method

The data used to answer our research questions were drawn from a larger survey of ACA members. In light of the lack of baseline knowledge about the current impact of the MCG, the survey method was deemed appropriate because of the need to directly access counseling professionals' experiences (Young, 2010). Prior to developing a questionnaire, we attained permission from ACA to develop and conduct a survey of its members, with a specific focus on the issue of Medicare reimbursement for counselors. The full survey was intended to better ascertain the impact of Medicare ineligibility on the counseling profession, current engagement in professional advocacy, and other key issues that might illuminate how to improve Medicare reimbursement advocacy going forward. The full survey contained the following: (a) personal (e.g., age, sex, race/ethnicity) and professional (e.g., years in profession, professional status, specialization, training accreditation) demographic information; (b) exploratory items regarding the prevalence of turning away or referring Medicare-insured individuals; (c) qualitative descriptions of what occurs when Medicare-insured individuals seek services from counseling professionals; (d) current level of advocacy participation on key issues, including Medicare reimbursement of counselors; (e) a validated measure of members' engagement in social advocacy (Nilsson, Marszalek, Linnemeyer, Bahner, & Misialek, 2011); (f) a validated measure of attitudes about aging (Levy, Kasl, & Gill, 2004); (g) an original assessment of factual knowledge about Medicare policy and professional advocacy; and (h) opinions about who is responsible for Medicare advocacy (Reiner et al., 2013).

Prior to disseminating the survey, we made several efforts to assess the comprehensibility of the items. A pilot version was disseminated to a group of graduate students and LPCs affiliated with our institution. We solicited feedback and amended items that were deemed unclear. We also provided a copy of the full survey to ACA for its review. Upon approval of the full survey by an appropriate ACA designate, temporary access to a membership list was provided and authorized for use for the survey. The survey and ensuing research were approved via exempt status by the Western Institutional Review Board.

Participants

The survey was sent to 51,221 ACA members via Qualtrics beginning in August 2018; 629 emails were returned as

undeliverable, resulting in a sampling frame of 50,592 (see Figure 1). Survey invitations were sent on three separate occasions over a period of approximately 5 weeks. No participant incentives were provided. In total, 6,550 (12.95%) responses were returned, although the number of responses provided to specific survey items varied. To put the sample size and response rate into context, a recent systematic review published by the *Journal of Counseling & Development* (Poynton, DeFouw, & Morizio, 2019) indicates that there have been 45 studies of counseling professional association members that used online recruitment measures. Sample sizes for these studies ranged from 13 to 2,092, and response rates ranged from 1.5% to 54.0% ($M = 20.1%$, $SD = 12.7%$; Poynton et al., 2019).

For the current study, participants were screened based on whether they clearly responded "yes," "none," or "not sure" to a series of questions about whether they have been directly affected by the MCG. Although an "other" category was provided for the purpose of better understanding the intricacies of the MCG, visual inspection of these responses indicated a wide range of possibilities (i.e., "All my work is pro bono," "My clinic services are funded by a grant," "I have not worked with clients beyond internship yet"), which made interpretation difficult. Therefore, 465 "other" responses were excluded from the current analysis. Additionally, 15 participants did not respond to these items and were excluded. Therefore, a total of 480 (7.33%) responses were excluded from the present analysis, resulting in 6,070 (92.67%) remaining responses (see Figure 1).

We calculated descriptive statistics pertaining to demographic variables for the sample of 6,070 participants whose responses were eligible for analysis (see Table 1). When possible, we compared our sample's demographics with the demographic information of the full ACA membership list as of September 2018 that was provided by ACA (R. Sites, personal communication, October 10, 2018). Compared with the full membership of ACA, our sample had a slightly higher proportion of female respondents (79.9% vs. 74.3%) and was more racially and ethnically diverse than the full ACA membership (24.5% vs. 17.5% non-White), with a greater composition of respondents who identify as Hispanic/Latinx (4.9% vs. 3.3%), multiracial (2.9% vs. 1.4%), and African American (10.9% vs. 8.1%). Although professional demographic data published by ACA are somewhat limited in scope, we were able to make rough comparisons based on estimates of professional type. For example, our sample differed in terms of the number of students responding (28.8% in our sample vs. 38.9% ACA student members). Additionally, the 6.0% of our sample identifying as counselor educators appears to be in line with recent estimates of ACA membership (6.6% according to May 2019 ACA membership data; September 2018 data were inconclusive). These comparisons imply that

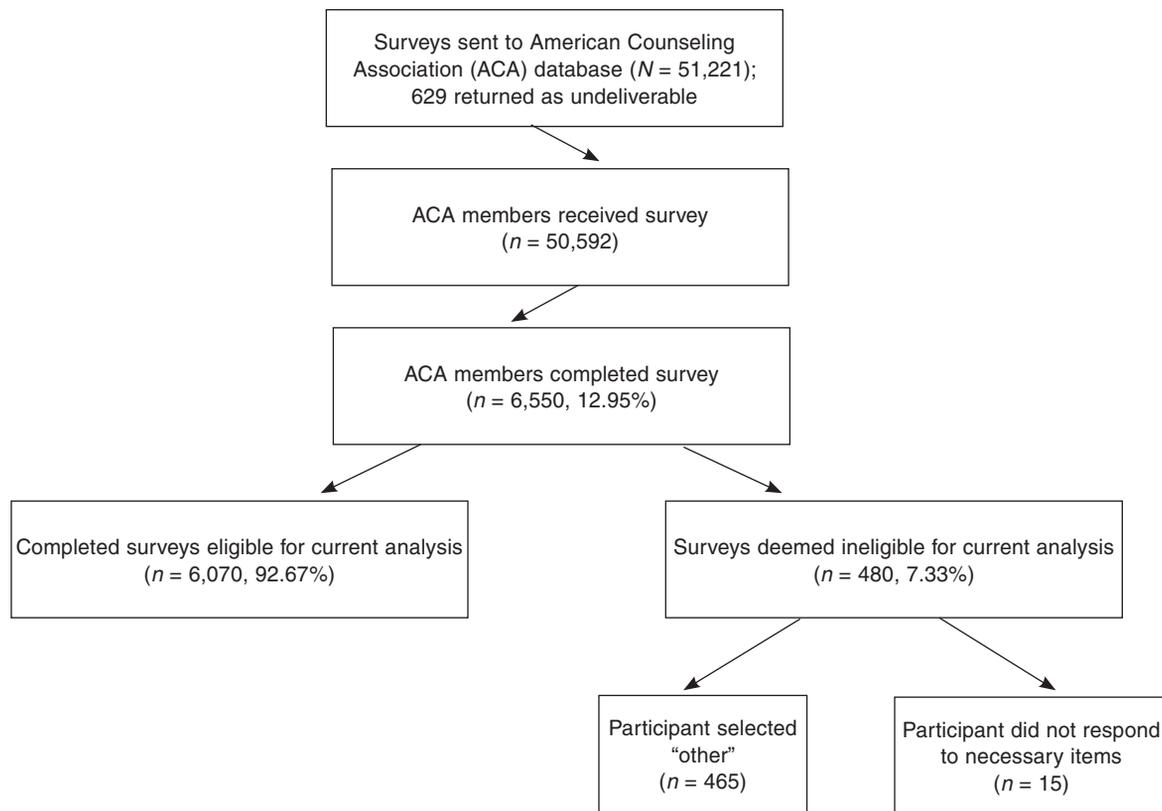


FIGURE 1
Recruitment for Medicare Advocacy Study

our sample may include a higher proportion of practicing counselors, although this is difficult to confirm based on how ACA organizes its membership.

Procedure

In the current study, several of the questions were culled from the larger survey to elucidate current experiences among counseling professionals regarding the MCG. First, to address the lack of existing data on how many counseling professionals are directly affected by the MCG, we asked participants, “Have you ever had to deny/refer potential or existing clients because of a lack of Medicare reimbursement?” (see Table 2). Respondents could answer affirmatively by selecting one of three primary categories related to the MCG, and there were selections for “other,” “none of the above,” and “not sure.” The affirmative response options included (a) turning away potential clients, (b) referring potential or existing clients, and (c) offering pro bono service or using a sliding scale to provide care. We developed the response categories based on sustained engagement in Medicare reimbursement advocacy. Specifically, the categories were informed by personal communication with LPCs

who have described the impact of Medicare ineligibility on current or potential clients, as well direct involvement with historical and ongoing efforts by ACA to lobby for Medicare eligibility. For example, ACA has periodically requested testimonials in which members are asked to describe experiences in which existing clients are no longer eligible because of a shift to Medicare insurance.

The categories of “other” and “not sure” were included in the questionnaire to increase the likelihood that respondents would provide valid responses. Participants could select more than one choice, although responses were screened prior to data analysis to ensure that responses did not include both “yes” and “no” responses simultaneously. As a measure of validity, we assessed how many respondents simultaneously answered “yes” and “none,” or “yes” and “not sure.” In total, there were only 14 cases (0.21%) in which “yes” and “none” were selected at the same time, and only 12 cases (0.18%) in which “yes” and “not sure” were selected simultaneously. This indicates that although the items used were exploratory, they appeared to have a high degree of both content and face validity. Regarding “not sure” responses, when only this response was selected (i.e., respondent did not simultaneously



TABLE 1
Descriptive Statistics

Variable	%
Age, in years (<i>N</i> = 5,835)	
<i>M</i>	44.81
<i>SD</i>	14.40
Minimum	21
Maximum	97
Sex (<i>N</i> = 6,066)	
Female	79.9
Male	18.5
Additional categories	1.6
Race (<i>N</i> = 6,055)	
White/Non-Hispanic	76.5
African American	10.9
Asian/Pacific Islander	2.3
American Indian/Native American	0.6
Hispanic/Latinx	4.9
Multiracial	2.9
Additional categories	1.8
Professional status ^a (<i>N</i> = 6,068)	
Practicing counselor	62.9
Counselor educator	6.0
Master's student	25.2
Doctoral student	3.6
Other	2.3
Years in profession ^b (<i>N</i> = 5,339)	
0–1	18.5
2–3	24.6
4–7	20.0
8–14	15.5
15 or more	21.3
Specialization (<i>N</i> = 6,052)	
Addictions	7.0
Career	1.1
Clinical mental health counseling	75.0
College	2.7
Couples and family	6.3
Pastoral	1.2
Rehabilitation	1.8
School	4.7
Primary client age group (<i>N</i> = 6,005)	
0–14 years	13.9
15–24 years	19.6
25–44 years	52.2
45–64 years	12.8
65 and older	1.6
CACREP-accredited program? (<i>N</i> = 6,061)	
Yes	77.1
No	22.9
Member of state counseling association? (<i>N</i> = 6,066)	
Yes	57.4
No	42.6

Note. Percentages may not total 100 because of rounding. CACREP = Council for Accreditation of Counseling and Related Educational Programs.

^aWhich current professional status best describes you? ^bHow many years have you been a member of the counseling profession? [Text box provided; raw data later categorized by research team].

select “yes”), the answer was treated as a non-yes response for subsequent analyses, resulting in a binary variable (i.e., yes vs. none/not sure) that was used to estimate the prevalence of the MCG among ACA members.

TABLE 2

Survey Item Used to Direct Experience With Medicare Ineligibility

Have you ever had to deny/refer potential or existing clients because of a lack of Medicare reimbursement? (<i>Check all that apply</i>)
<input type="checkbox"/> Yes, I have turned away new/potential client(s) due to ineligibility for Medicare reimbursement.
<input type="checkbox"/> Yes, I have referred existing clients due to ineligibility for Medicare reimbursement.
<input type="checkbox"/> I have had to work with a client pro bono or on a sliding scale due to ineligibility for Medicare reimbursement.
<input type="checkbox"/> Other _____
<input type="checkbox"/> None of the above
<input type="checkbox"/> Not sure

The survey also included questions about respondents’ participation in professional advocacy, both by key issue (e.g., Medicare, licensure portability, more funding for school counselors) and by specific type of engagement (e.g., social media, phone call to legislators, in-person meeting with legislators). Specific to our current inquiry, we gleaned data on whether respondents had engaged in Medicare-related advocacy, as well as which forms of engagement they had participated in.

Statistical Method

We conducted statistical analyses using SPSS (Version 25). Quantitative methods, including a combination of frequency counts, chi-square analyses, and odds ratios, were used to answer our research questions. We conducted all analyses with an alpha level of .01 as the benchmark for statistical significance. Statistical assumptions for the chi-square goodness-of-fit test (i.e., independence of observations and expected frequency greater than five in all cells) were satisfied in all cases (Lomax & Hahs-Vaughn, 2012). Effect sizes were calculated using Cramer’s *V*, with an estimation of 0.06, 0.17, and 0.29 as small, medium, and large effect sizes, respectively (when *df* = 3; Cohen, 1988). Raw data were recoded when necessary to answer the research questions. Missing data were handled on a per question basis. In Research Question 2, 140 participants either omitted information related to professional type or provided information that could not easily be coded as one of the four predominant categories (i.e., practicing counselor, counselor educator, master’s student, and doctoral student). Therefore, these responses were excluded because of our concerns about imputing demographic information. In Research Question 3, only data provided by practicing counselors were used (*N* = 3,392). We used this approach because of the greater likelihood that the MCG would affect practicing counselors relative to the full ACA sample, as well as to isolate the impact of years of experience on exposure to the MCG.

A subset ($N = 5,145$) of the larger survey sample was used to answer Research Question 4. This subset consisted of participants who, in addition to providing information about the MCG, also answered a series of questions related to participation in Medicare reimbursement advocacy. Although this subset was smaller than the full sample used to answer Research Question 1 (i.e., $N = 6,070$), the sample was sufficiently large to answer Research Question 4 at the predetermined alpha level. As a point of reference, those who were included in Research Question 4 (by virtue of also answering questions about Medicare reimbursement advocacy) differed slightly from those who did not complete this part of the broader survey ($N = 925$). By comparison, those who were included in Research Question 4 were slightly older (45.31 years vs. 42.04 years) and more likely to identify as White/non-Hispanic (76.9% vs. 72.9%) and male (18.8% vs. 16.6%). They were also more likely to be classified as practicing counselors (63.8% vs. 57.4%) or counselor educators (6.4% vs. 3.7%) and had more experience in the counseling profession (19.1% vs. 16.5% at 15 or more years in the profession).

Results

Prevalence of MCG

Frequency data showed that more than half of the 6,070 respondents (54.8%) had been directly affected by Medicare reimbursement barriers, whereas 45.2% responded that they had not or were unsure. Of those who reported being directly affected by Medicare reimbursement barriers, 36.5% had turned away new or potential clients, 29.1% had referred existing clients, and 31.9% had seen a client pro bono or on a sliding scale due to ineligibility for Medicare reimbursement. When only practicing counselors were examined (e.g., excluding students and counselor educators), there was a noticeable increase in the prevalence of the MCG. Out of 3,392 practicing counselors, 70.0% had been directly affected by Medicare reimbursement barriers, with 50.3% of participants having to turn away new or potential clients, 38.8% referring existing clients, and 39.9% seeing a client pro bono or on a sliding scale (see Table 3).

Differential Impact

Next, we used chi-square analysis to identify any group differences based on professional status (i.e., practicing counselor, counselor educator, master's student, and doctoral student; see Table 3). This analysis revealed that practicing counselors were considerably more likely to have direct experience with the MCG compared with all other groups. In terms of overall experience with the MCG, the previously referenced 70.0% of practicing counselors had been directly affected by the MCG, whereas only 48.3% of counselor educators, 48.8% of doctoral students, and 20.9% of master's students had such an experience. A chi-square test of goodness-of-fit was performed, which indicated that direct impact of the MCG was not equally distributed across the groups, $\chi^2(3, N = 5,930) = 1,075.06, p < .001$, Cramer's $V = .43$. This is a large effect size.

Analyses for each subtype of direct experience with the MCG were also statistically significant. There was a difference among groups in terms of turning away potential clients, $\chi^2(3, N = 5,930) = 876.93, p < .001$, Cramer's $V = .39$; referring existing clients, $\chi^2(3, N = 5,930) = 507.31, p < .001$, Cramer's $V = .29$; and working with beneficiaries pro bono/via sliding scale, $\chi^2(3, N = 5,930) = 373.23, p < .001$, Cramer's $V = .25$. Each of these effect sizes is in the large or medium-large range.

Impact of Years of Experience

We then examined whether years of experience had an impact on experience with the MCG. A total of 44.5% of practicing counselors with 0 to 1 years of experience reported directly experiencing the impact of the MCG, compared with 56.2% of those with 2 to 3 years of experience and 71.5% of those with 4 to 7 years of experience. Additionally, 80.8% of practicing counselors with 8 to 14 years of experience and 82.1% of those with 15+ years of experience also described direct experience with the MCG. A similar pattern was observed when specific phenomena (i.e., turning away, referring, and treating pro bono/sliding scale) were analyzed. A chi-square test of goodness-of-fit was performed, which indicated that direct impact of the MCG was not equally distributed across the groups, $\chi^2(4, N = 3,392) = 273.12, p < .001$, Cramer's V

TABLE 3

Percentage of American Counseling Association Members Affected by Medicare Coverage Gap, by Professional Type

Experience Level	Total Affected	Turned Away Clients	Referred Existing Clients	Pro Bono/ Sliding Scale
Practicing counselor	70.0	50.3	38.8	39.9
Counselor educator	48.3	24.4	22.7	29.1
Doctoral student	48.8	23.8	23.3	33.3
Master's student	20.9	8.2	8.2	12.7

Note. $N = 5,930$ (missing data consist of 140 respondents who omitted response to professional type item).

= .28. This is considered a medium-large effect size, and it indicates that practicing counselors with more time in the profession are increasingly likely to have direct experience with the MCG (see Table 4).

To further explore this phenomenon, we calculated an odds ratio (OR) that compared ACA members with 3 or fewer years in the profession with those with 4 or more years. The corresponding test once again revealed group differences depending on years in the profession, $\chi^2(1, N = 3,392) = 232.16, p < .001$, Cramer's $V = .26$, OR = 3.28, 95% confidence interval (CI) [2.81, 3.84]. This means that practicing counselors with 4 or more years of experience in the counseling profession are more than three times as likely to experience the MCG than those with 3 or fewer years of experience.

MCG Experience and Medicare Advocacy

Finally, we used chi-square analyses to determine whether experiencing the impact of the MCG was related to participation in professional advocacy. A total of 5,145 respondents answered questions about MCG impact and participation in several forms of engagement related to Medicare advocacy (see Fullen et al., 2020, for a complete description). Across several types of advocacy engagement, there were statistically significant relationships between having been directly affected by the MCG and counseling professionals' participation in Medicare advocacy, meaning that those who had turned away, referred, or treated beneficiaries pro bono/via sliding scale were more likely to participate in each form of Medicare professional advocacy. Respondents who were affected were more likely to advocate by social media, $\chi^2(1, N = 5,145) = 222.99, p < .001$, Cramer's $V = .21$, OR = 2.78, 95% CI [2.42, 3.19]; VoterVoice, $\chi^2(1, N = 5,145) = 268.52, p < .001$, Cramer's $V = .23$, OR = 2.94, 95% CI [2.58, 3.35]; phone call, $\chi^2(1, N = 5,145) = 194.61, p < .001$, Cramer's $V = .19$, OR = 3.97, 95% CI [3.23, 4.88]; and personal letter, $\chi^2(1, N = 5,145) = 222.30, p < .001$, Cramer's $V = .21$, OR = 3.30, 95% CI [2.81, 3.89]. Each of these effect sizes is in the medium range. Furthermore, respondents were also more likely to participate in a local meeting with lawmakers or

their staff, $\chi^2(1, N = 5,145) = 37.70, p < .001$, Cramer's $V = .09$, OR = 2.85, 95% CI [2.81, 3.89], as well as meetings in the state or national capitol, $\chi^2(1, N = 5,145) = 9.41, p < .001$, Cramer's $V = .04$, OR = 1.78, 95% CI [1.23, 2.59], although these effect sizes were much smaller.

Discussion

This study was designed to examine the prevalence and impact of the MCG, its relationship to counselor variables (i.e., years in the profession), and its impact on participation in Medicare-related advocacy. Our investigation yielded several findings that elucidate the current impact of Medicare ineligibility on the counseling profession. With regard to how many counseling professionals have turned away potential clients, referred existing clients, or used pro bono/sliding scale approaches to work with Medicare-insured individuals, our finding that over half (i.e., 54.8%) of all respondents and more than two thirds (i.e., 70.0%) of practicing counselors responded affirmatively is sobering. Although it is not possible to fully generalize these data to the full population of ACA members or non-ACA member counselors, these data suggest that the MCG is affecting a large number of counselors, and by implication, an even larger number of Medicare-insured individuals who are subsequently affected by the MCG. This finding corroborates what has been implied in other studies (e.g., Larson et al., 2016); however, the current study is the first to provide a concrete estimate of how many counseling professionals have directly experienced the impact of Medicare ineligibility.

Broad Impact on the Counseling Profession

Contrary to the notion that Medicare ineligibility only affects a select number of counselors, the prevalence of the MCG impact, coupled with the very small amount of respondents who said they work primarily with people over age 65 (i.e., 1.6%), suggests an impact that is much more broad. The data indicate that the counseling professionals who have been affected by the MCG by and large do not consider their primary client populations to be individuals

TABLE 4
Percentage of Practicing Counselors Affected by the Medicare Coverage Gap, by Years of Experience

Years of Experience	Total Affected	Turned Away Clients	Referred Existing Clients	Pro Bono/ Sliding Scale
0–1 years	44.5	26.1	20.1	19.8
2–3 years	56.2	28.8	27.9	29.3
4–7 years	71.5	46.7	38.3	39.4
8–14 years	80.8	59.4	45.9	45.3
15+ years	82.1	63.9	43.9	45.3

Note. $N = 3,392$ (additional 423 respondents omitted response to years of experience item and were excluded from table).

age 65 and older. Although specific survey items related to practice context were not included, one interpretation of the data is that Medicare beneficiaries are seeking mental health services in community-based settings and private practice, not merely within settings that have been traditionally associated with aging (e.g., assisted living, long-term care facilities, hospice). This is corroborated by additional research; for example, we found in a related, qualitative study that reference to the MCG affecting community-based providers was commonplace (Fullen et al., 2019). The finding is also consistent with the shift in age-based care for more home and community-based services, such that currently, the majority of Medicare beneficiaries live independently in their communities and only a small percentage (i.e., 3%) reside in long-term care facilities (Kaiser Family Foundation, 2019).

Burden on Medicare-Insured Individuals

The data also suggest that current Medicare policy is directly affecting the ability of Medicare-insured individuals to access mental health services across the United States. In contrast to the myth that Medicare beneficiaries are not interested in seeking mental health services, the data indicate that potentially thousands have sought care, only to have these efforts thwarted. Several consequences may ensue when this happens. When potential clients are turned away, they may experience long wait-lists prior to being seen by a Medicare-eligible provider (Fullen et al., 2019), or they may elect not to seek alternative treatment, resulting in no treatment or undertreatment of mental health conditions. These responses to being unable to work with an LPC or LMFT may be detrimental to their mental health, especially given that there are serious consequences to forgoing treatment or undertreating mental health conditions, particularly for people in the Medicare program. For example, comorbidity of depression and chronic disease results in higher health care costs (Unützer et al., 2009). Hospitalization due to untreated mental health conditions creates a burden on both individual beneficiaries and the system on the whole. The reimbursement rate for a single day of inpatient psychiatric hospitalization is equivalent to approximately twelve 45-minute counseling sessions (American Psychological Association, 2015; Centers for Medicare and Medicaid Services, 2019). Removing the possibility of high-quality outpatient care is inefficient due to the likelihood that undertreatment, overtreatment in the form of hospitalization, or no treatment will ensue. Our data suggest that by restricting provider access, the current policy may exacerbate this issue for Medicare beneficiaries who seek out counseling services.

Detrimental Impact on Counseling Professionals

When we consider that 29.1% of total respondents (and 38.8% of practicing counselors) had referred an existing

client because of the MCG, additional detrimental consequences are worthy of consideration. Early withdrawal from mental health treatment is inefficient, and potentially harmful, to both clients and counselors (Barrett et al., 2008). Having to refer an existing client may be particularly problematic given the emphasis that counselors place on the therapeutic alliance. The psychological benefits that are associated with the therapeutic alliance (Wampold, 2015) may be undermined when a provider has to terminate treatment due to a client aging into Medicare coverage or qualifying for permanent disability while in the middle of treatment. In light of shifting population demographics, it is increasingly likely that counselors will experience working with clients who use a non-Medicare form of insurance, only to later have to cease treatment when the clients turn 65 and transition to Medicare.

The preponderance of counseling professionals who indicated that they had worked with Medicare beneficiaries using a sliding scale or pro bono approach was also striking. This finding demonstrates that many counseling professionals are using a form of social justice advocacy at the client level (Ratts & Hutchins, 2009) in an attempt to circumvent the challenges associated with the MCG. The need to extend services despite receiving a reduced fee may be particularly pressing in rural communities due to the dearth of Medicare-eligible providers who are in close proximity to the practicing counselor (Larson et al., 2016). Although this form of client-level social justice advocacy is laudable and necessary (Lopez-Baez & Paylo, 2009), it is important to consider whether it is sustainable in the long term. Drawing on findings from a related study (Fullen et al., 2019), many counseling professionals indicated problems with this approach, such as working for agencies that would not allow them to provide pro bono services; the inability of many clients to pay directly for services, even when they were offered at a sliding-scale rate; and the long-term economic ramifications on their own professional practices due to providing services at reduced fees.

Our finding that practicing counselors were significantly more likely to have experienced the impact of the MCG suggests that, when it comes to the MCG, the modal experience of practicing counselors differs from that of counselor educators, doctoral students, and master's students. The medium-large effect sizes related to these group differences are compelling, especially in light of the large sample that was used to investigate the MCG's impact. Additionally, our data provide strong evidence for a relatively greater impact of Medicare ineligibility for those who have spent more time in the counseling profession, specifically among practicing counselors. Although it is not surprising that counselors with more years of experience are relatively more likely to encounter problems related to the MCG, the correlation suggests that Medicare ineligibility becomes



increasingly problematic the longer one works in the counseling profession. In total, it appears that practicing counselors have disparate experiences related to the MCG, and these differences may widen as counselors accumulate years in the profession.

Repercussions for Advocacy Engagement

At first glance, our finding that those with direct MCG experience were more likely to participate in Medicare-related advocacy signals at least a correlational relationship between ACA members' personal experiences with Medicare ineligibility and their willingness to participate in advocacy initiatives. This is consistent with theory related to how individuals learn to engage in social justice advocacy. For example, in the social-cognitive model of social justice interest and commitment, Miller and Sendrowitz (2011) highlighted the importance of two key elements that contribute to the formation of social justice advocacy commitment: personal moral imperative and counselor training environment. With regard to personal moral imperative, the authors stated that individuals discover forms of social injustice that provide motivation to think and act as agents of social justice. Drawing on Bandura's (1991) work in social cognitive theory, Miller and Sendrowitz suggested that personal moral imperative, along with training environments that model social justice advocacy, results in the cultivation of social justice interest.

In the language of this model, it is possible that ACA members who directly experience the consequences of the MCG develop a personal moral imperative related to the needs of Medicare-insured individuals. These experiences may activate counseling professionals' interest in Medicare advocacy, including grassroots lobbying efforts. Miller and Sendrowitz (2011) described this as "the process by which individuals discover for themselves certain aspects of social injustice that compel them to action" (p. 160). Although advocacy participation is costly because of the time and attention it requires, counseling professionals who possess firsthand experience with the MCG may be more willing to participate, because of the impact on their livelihood and their concern for clients. Aligned with the aforementioned model, these professionals may then experience greater self-efficacy in regard to social justice advocacy (Miller & Sendrowitz, 2011), positive feedback from legislators in regard to the seriousness of the issue, and increased willingness to stay engaged in an issue as it plays out over the course of months and years.

Impact on Counselor Training

Our data also suggest that counselor educators, as well as graduate students at all levels, were less likely to have direct experience with the MCG, which may suggest a subsequent impact on participation in Medicare-related

advocacy. In a related study (Fullen et al., 2020), we found that master's-level counseling students were significantly less likely to state that Medicare reimbursement negatively affects the profession, and they also were significantly less likely to agree that older adults benefit from counseling services. In addition, we found that these students were significantly less likely to have engaged in any form of Medicare-related advocacy. Therefore, in keeping with Miller and Sendrowitz (2011), it is possible that trainees lack exposure to the MCG, thus limiting their interest in addressing the issue at a time when they are shaping their social justice advocacy identities.

Furthermore, it is necessary to consider the role of counselor educators and other professional leaders when it comes to inspiring social justice advocacy about the MCG within counselor training programs. Miller and Sendrowitz (2011) argued that "program faculty can have a large impact in shaping the environment by modeling, supporting, and facilitating social justice engagement and discussions" (p. 160). Although there have been frequent references to social justice advocacy in the scholarly literature over the last 15 years or more, there has been relatively little scholarly inquiry into the impact of the MCG. It is possible that the frequent allusion to Medicare in practice publications like *Counseling Today*, coupled with the lack of scholarship around this issue, is further evidence of a bifurcation between counselor practice and counselor training.

■ Implications

The results of this study have implications for counseling practice, counselor education, and counseling scholarship. With regard to counseling practice, the prevalence of counseling professionals who have been directly affected by the MCG has major implications for the well-being of clients, the professional viability of licensed counselors, and participation in legislative advocacy related to this issue. As the U.S. population continues to grow older and the number of Medicare beneficiaries grows (Medicare Payment Advisory Commission, 2015), an increasing number of Americans may have difficulty accessing mental health care, due in part to the MCG. Despite scholars calling for more resources for older Americans (Institute of Medicine, 2012), especially those who live in rural areas (Stewart et al., 2015), Medicare beneficiaries will continue to experience systematic barriers to receiving mental health services as long as the current policy is in place.

Implications for Counselors

Consistent with our findings, practicing counselors are most likely to bear the largest brunt of Medicare ineligibility, particularly as the number of Medicare-insured individuals

grows. More so than students or counselor educators, practicing counselors may be forced to make difficult decisions about how to respond when a community member with Medicare insurance contacts them for mental health treatment. Practicing counselors may also have a difficult time finding employment within particular contexts in which Medicare reimbursement makes up a sizable proportion of revenue. Specifically, integrative care contexts such as hospitals, federally qualified health centers, accountable care organizations, or patient-centered medical homes may be less willing to hire licensed counselors knowing that these employees will be unable to be compensated by Medicare (Fullen et al., 2019).

Additionally, the results of our study suggest that practicing counselors, especially those with more years of experience, have a unique responsibility to tell their stories about the MCG to legislators and other key stakeholders. From a systems advocacy perspective, harnessing the experiences of counseling professionals who are willing to speak about their own experiences with the MCG is vital given that legislators are more likely to be compelled to act when they hear from constituents who share direct information about a phenomenon in a manner that requires the constituents' time and energy (Cluverius, 2017). In light of the value of advocacy efforts, counseling professionals who have compelling stories to share will continue to be relied upon when grassroots advocacy is used. Given the double burden facing counselors, in which they have to navigate how to best respond to Medicare beneficiaries who seek treatment *and* tell their MCG stories in a timely fashion to lawmakers, further work is needed to identify how to provide support to this group.

Implications for Counselor Education

Within counselor education, our results could be used to inform strategies to mobilize and maximize advocacy efforts among counseling students and counselor educators. At the student level, it appears that a lack of exposure to the direct effects of the MCG may inhibit engagement with professional advocacy efforts. Strategies to reverse this trend should begin with counselor educators and supervisors because of their influence in the student-professor and supervisee-supervisor relationship (Fullen, 2018). Naming Medicare reimbursement for counselors as one of the more pressing issues facing the profession is a good first step, but it may be necessary for counselor educators to invest time in explaining why current Medicare policy is burdensome to clients and counselors, as well as how beneficiaries are uniquely disadvantaged by current policy. Framing the MCG as a social justice issue may activate interests among counselor trainees and increase

their interest in and commitment to this issue (Miller & Sendrowitz, 2011).

There are many specific domains within the counselor education curriculum where these conversations could emerge. Within a professional orientation course, students might learn about the history of counseling as a profession and how Medicare reimbursement would symbolize full recognition of counseling as a nationally recognized profession. Rather than ending the discussion at this point, counselor educators could illustrate the detrimental impact of the MCG on clients and counselors by using a case study approach. By describing a particular client (real or hypothetical) who has been turned away from services or referred mid-treatment due solely to the type of insurance the client has, counselor educators have the opportunity to generate dialogue about the consequences of current Medicare policy, as well as the connection to broader social justice issues such as access to mental health services. This case could then be revisited in other counselor education classes to reinforce the importance of the policy, such as in courses related to ethics (e.g., Is it ethical to abruptly stop counseling clients when they transition to Medicare?), multicultural counseling (e.g., How does Medicare policy unduly affect older people, people with disabilities, and people living in rural areas?), human growth and development (e.g., How do societal attitudes about aging and mental health influence interest in Medicare's policy?), and addictions (e.g., What do you make of the fact that Medicare is the single largest payer for opioid use hospitalizations?; see Song, 2017). By infusing discussion about this particular issue across several teaching domains, counselor educators could create the sort of counselor training environment that is conducive to promoting professional advocacy on this issue (Miller & Sendrowitz, 2011).

Implications for Counseling Scholarship

Finally, there are implications for counseling scholarship. In light of Kiselica and Robinson's (2001) recommendation that counselors should use their skills in assessment and research to evaluate progress on advocacy, it is concerning that so few scholarly articles about Medicare advocacy have emerged. Although broad efforts to cultivate social justice advocacy skills and dispositions have greatly influenced the counseling profession, more work is needed to apply these skills in a systematic manner that transforms specific public policies. Echoing Lee and Rodgers (2009), several steps are required to influence systemic change, including working alongside stakeholders outside of the profession, communicating with the media, and lobbying policymakers. The counseling profession has spent more than 15 years working on Medicare reimbursement, with

countless phone calls and meetings with legislators, all in the hope of effecting systemic change. What has been missing, however, may be the systematic inquiry that comes with scholarship, such as the collection and analysis of data to indicate progress, precise communication about the problem, and empirically supported work that informs whether advocacy strategies have been successful. Given the slow rate of change in the legislative process, it may be beneficial to examine the current policy's impact in a more systematic manner in the event that policy change is still years away.

■ Limitations and Directions for Future Research

Although this investigation begins to illuminate the prevalence and differential impact of the MCG, several limitations should be considered. First, although the sample size exceeds that of previous studies on counseling professional association members (Poynton et al., 2019), the relatively modest response rate means that results may not accurately generalize to the full population of ACA members. It is possible that individuals who had direct experience with the MCG were more likely to participate than those who had not had that direct experience. Relatedly, not all counselors are members of ACA, which means that our results may not be generalizable to all counseling professionals in the United States who are affected by the MCG. Future research might focus on increasing response rate and ensuring that non-ACA members' experiences are also represented.

Second, there are limitations related to the questionnaire that was used to assess the prevalence of direct experience with the MCG. The primary question used to gauge experience with the MCG was intended to have a high degree of face validity. Nevertheless, it is possible that respondents misinterpreted the selections or that additional response categories should have been included. The low number of clearly invalid scores (e.g., "yes" and "no" simultaneously) and the large effect sizes associated with our data analysis suggest that participants accurately interpreted and responded to the item described in Table 2. However, future research is certainly needed to replicate our findings on the prevalence of the MCG's impact, ideally co-occurring with the development of more psychometrically rigorous tools to assess the prevalence of the MCG.

Finally, although the use of a survey instrument is helpful in exploring an understudied phenomenon (Young, 2010), specific questions were not addressed within the current questionnaire, such as how training (e.g., type of educational track) or practice (e.g., type of counseling practice,

geographical location) variables affected the experience of the MCG. For example, our data do not differentiate the experiences of those who specialize in rehabilitation counseling, addictions counseling, or clinical mental health counseling, nor does our study indicate whether the MCG is more problematic in rural versus nonrural settings as has been suggested by other researchers (Larson et al., 2016). Future research that examines how these contextual variables affect experience with the MCG is needed.

■ Conclusion

The prevalence of counselors who have been affected by current Medicare policy suggests that Medicare beneficiaries are systematically restricted from access to mental health services. Given the growing number of Medicare beneficiaries, there is reason to believe that this problem will continue to worsen until the policy is changed. In light of the fact that more than half of our respondents reported direct experience with the MCG, there is a need for greater awareness of the prevalence and scope of the problem, as well as additional research to illuminate the impact of Medicare ineligibility on counseling professionals and their clients.

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