CENTRAL STATE UNIVERSITY

MACC

mhac Mental Health & Addiction Advocacy Coalition

OHIO UNIVERSITY

Behavioral Health in Ohio

Improving Data, Moving Toward Racial & Ethnic Equity

Report 2:

Opportunities for the Workforce

FEBRUARY 2023

Table of Contents

"This report offers our first big picture look at the racial and ethnic composition of Ohio's behavioral health workforce."

— JOAN ENGLUND, EXECUTIVE DIRECTOR MHAC

About the Partners Conducting this Research

Central State University (CSU), an 1890 Land-Grant institution, prepares students with diverse backgrounds and experiences for leadership, research and service. The University fosters academic excellence within a nurturing environment and provides a strong liberal arts foundation leading to professional careers and advanced studies. Central State University aspires to be a premier institution of excellence in teaching and learning that embraces diversity and produces graduates with the knowledge, skills, and dispositions to make valuable contributions in a global society.

centralstate.edu

Multiethnic Advocates for Cultural Competence (MACC) is Ohio's leading voice for cultural competence, and we've held this distinction for nearly 20 years. Our mission is to help organizations embrace, achieve, and benefit from diversity and equity. We are the premier statewide organization offering cultural competence education and training for behavioral health and healthcare systems, non-profit organizations, educational institutions, businesses and any organizations interested in creating equity and addressing disparity. We believe discrimination in any form harms people, communities, and the economy. MACC supports organizations in getting to win-wins gaining understanding and skills in cultural competence to increase employee engagement and satisfaction, increase equity in upward mobility, improve service delivery and outcomes, increase the bottom line and impede attrition all while receiving a return on investment that is measurable.

maccinc.net

The Mental Health & Addiction Advocacy Coalition (MHAC) is comprised of over 130 member organizations statewide, including: health and human service agencies; the faith based community; Alcohol, Drug Addiction, Mental Health and Recovery Services Boards; advocacy organizations; courts; major medical institutions; the corporate arena; and behavioral health agencies serving children and adults. The MHAC's mission is to foster education and awareness of mental health and addiction issues while advocating for public policies and strategies that support effective, well-funded services, systems, and supports for those in need, resulting in stronger Ohio communities.

The MHAC would like to thank its generous philanthropic supporters including: Abington Foundation, Bruening Foundation, The Cleveland Foundation, Community West Foundation, The Char and Chuck Fowler Family Foundation, The George Gund Foundation, Interact for Health, The McGregor Foundation, Network for Good, The Nord Family Foundation, Peg's Foundation, Woodruff Foundation (and its funders who have asked to remain anonymous).

mhaadvocacy.org

Ohio University (OU) is the oldest public university in the state of Ohio, with a total enrollment of over 28,000 students across the state and online. Ohio University is also the state's leading producer of health professionals with the largest medical school in the state and among the top ten largest colleges of health professions nationally. The University holds as its central purpose the intellectual and personal development of its students. Distinguished by its rich history, diverse campus, international community, and beautiful Appalachian setting, Ohio University is known as well for its outstanding faculty of accomplished teachers whose research and creative activity advance knowledge across many disciplines.

ohio.edu

CSU, MACC, MHAC, and OU would like to thank the funders who provided dedicated funding to support this project including: bi3, CareSource, The George Gund Foundation, HealthPath Foundation, Interact for Health, Ohio State Bar Foundation.

Introduction: Race, Ethnicity, and Ohio's Behavioral Health Workforce

This second installment in the report series entitled Behavioral Health in Ohio: Improving Data, Moving Toward Racial & Ethnic Equity seeks to identify opportunities to develop the behavioral health workforce so that it can best serve the state's marginalized racial and ethnic groups. The data analysis presented in this report provides detailed breakdowns of the racial, ethnic, and gender identities of behavioral health providers by licensure type as well as their geographic locations. With this analysis, stakeholders interested in the behavioral health workforce's capacity to serve marginalized racial and ethnic groups have essential baseline data to inform planning, policy, and funding decisions. As with other reports in this series, the data presented are a first step towards understanding the opportunities for workforce development and support and are meant to spark additional questions and research into the arena of behavioral health for minoritized racial and ethnic populations.

In addition to the data analyses provided in this report, there are other factors to consider when seeking to improve the workforce's capacity to serve racial and ethnic marginalized groups. Although this report does not contain specific analysis of all issues related to the behavioral health workforce, it is important to recognize the components of the system that should be considered when seeking to improve services. The behavioral health workforce system components include, but are not limited to, access to education, training for future and current professionals, pay that is equitable to other health professions, work-life balance, opportunities for career advancement, and a sense of fulfillment from working in the field. Within each of these areas, cultural competency emphasizing true inclusion of marginalized racial and ethnic groups must be a priority. Achieving cultural competency requires people of color (POC) to be at decision-making tables and in leadership positions. The ideas, suggestions, and needs of POC must be at the center of all initiatives if meaningful change for marginalized groups is to be achieved. Foregrounding POC in workforce development is essential for identifying and implementing impactful initiatives that can meet the growing needs for behavioral health services.

The Ohio Department of Mental Health & Addiction Services (OhioMHAS) reports that the demand for behavioral health services increased by an average of 29% per year between 2013 and 2019.[1] Shortages in Ohio's behavioral health workforce are a longstanding problem and have been exacerbated by the COVID-19 pandemic.[2] A 2016 report published by the Health Resources and Services Administration (HRSA) identified worker shortages as a key challenge for meeting the nationwide demand for behavioral health services.[3] As of September 2022, only 30% of Ohioans within HRSA's Mental Health Care Health Professional Shortage Areas have had their behavioral health needs met.[4] All Ohioans are impacted by these unmet needs, but not in equal measure; differing circumstances within the state have concentrated shortages in some regions more than others.[1] This report provides a clearer picture of the accessibility of racially and ethnically concordant care for marginalized populations through its original analysis of the workforce in terms of racial and ethnic composition and analysis of the location of providers of color relative to the location of marginalized populations.

Although various federal and state entities collect data about race and ethnicity and the people who provide and receive behavioral health services (i.e., HRSA), there has been no systematic effort to analyze whether Ohio's behavioral health providers are racially and ethnically representative of the populations they serve. Working towards filling this gap, the present report provides an Ohio-specific analysis of the racial and ethnic composition of the behavioral health workforce. In addition to this analysis, this report assesses the

current workforce's ability to meet the need for Adult Care Facility (ACF) services, which offers a non-clinical, protective level of care for elders and/or individuals with serious mental illness. The data analysis in this report are guided by the following research questions:

- What is the racial and ethnic breakdown of providers within each behavioral health discipline?
- Are the racial and ethnic demographics of providers proportional to Ohio's population demographics?
- Are providers of color accessible in geographic areas where there is a higher concentration of people of color?

Why this Study is Important

Besides employing strategies that improve health outcomes and reduce health disparities among marginalized Ohioans being the right thing to do, advancing equity—just and fair inclusion—is important to a prosperous Ohio. Research proves that inequality and racial discrimination hinder growth, prosperity, and economic mobility, while diversity and inclusion fuel innovation and business success.[5] Good physical and behavioral health are essential inputs into a productive economy, helping create educated, productive workers. Poor behavioral health is associated with worse educational outcomes. Mental health diagnoses such as attention deficit hyperactivity disorder (ADHD) are associated with lower school attendance, lower test scores, and higher dropout rates.[6,7] Research also shows teens and adults with mental illness and substance use disorders are less likely to participate in the labor force.[5] Mental health disorders such as depression, schizophrenia, and bipolar disorder carry significant earnings losses.[5] These negative outcomes, among others, may further lead to deaths of despair.[8] These deaths from drugs, alcohol, and suicide—caused by pain, economic distress, and mental health difficulties—more than doubled between the 1960s and 2017 and have continued to rise.[8]

An important strategy for improving behavioral health outcomes in marginalized populations is to expand and increase racial, ethnic, and gender representation in the behavioral health workforce.[9] Research shows that having access to someone who shares the same gender, race, or ethnicity as the client can reduce some of the barriers that prevent people from seeking help.[9,10] When a patient and provider share the same racial or ethnic demographics (i.e., racial concordance), patient behavioral health outcomes improve as do overall health outcomes.[9]

Increasing suicide rates are a stark example for the need to improve behavioral health outcomes for marginalized racial and ethnic populations. Overall, the groups experiencing the highest increases in suicide death rates over the last decade, both in Ohio and nationally, include people of color, younger people, those living in rural areas, and men.[11] In Ohio and nationally, Black men have experienced the highest increases in suicide death rates over the last decade.[12] For non-Hispanic Black Ohioans, there was an 87.3% increase in deaths from suicide between 2010 to 2020.[12]

There are many points to intervene before the irreversible outcome of suicide, but studies show that medical mistreatment of numerically minority groups creates a reluctance to seek services.[13] A key example of mistreatment is shared by Olbert and colleagues and the renowned psychiatrist, Jonathan Metzl, who report that non-Hispanic Black males have historically been over diagnosed with psychotic disorders and under diagnosed with mood disorders.[14,15] Following the over-diagnosis of Black men with psychotic disorders has been the overuse of severe forms of psychiatric treatment such as physical and chemical restraint.[16] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), diversifying the workforce so that people of color receive care from a racially and ethnically concordant provider is a promising strategy to improve the likelihood that people seek and receive appropriate treatment.[17]

As Ohio seeks to improve behavioral health outcomes for marginalized racial and ethnic groups, assessing the workforce composition is a vital first step. However, enumerating the problem is not enough

to significantly improve behavioral health care for marginalized racial and ethnic groups. Addressing the lack of diversity in Ohio's workforce requires action from multiple sectors, particularly higher education and state and local initiatives for workforce development.

Existing Initiatives to Increase Racial and Ethnic Diversity in the Behavioral Health Workforce

Student Recruitment, Retention, and Graduation

There are several initiatives in Ohio striving to improve recruitment, retention, and graduation of students from marginalized groups into behavioral health careers. For example, Central State University is engaged with the Association of Social Work Boards (ASWB) regarding an analysis of pass rates for its social work licensing exam. The analysis conducted in 2022 found that marginalized racial and ethnic groups have lower pass rates than White test takers.[18] As part of a commitment to improving diversity, equity, and inclusion in the social work field, ASWB uses data such as the exam pass rate broken down by race and ethnicity to measure the performance of their initiatives. According to the ASWB analysis, White test takers had a pass rate of 83.9%, whereas Black test takers only had a pass rate of 45%.[18] Because of the disparity revealed by the analysis, ASWB is taking concrete actions to improve the test, such as conducting focus groups and interviews with social workers from marginalized groups that will inform how problems are identified as well as potential solutions. Other initiatives include some higher education institutions, such as Miami University and University of Cincinnati, offering their students in their social work programs additional tutoring and other exam preparation services.

Behavioral Health Support Specialists

Another strategy being implemented with promising results is growing the Behavioral Health Support Specialist (BHSS) segment of the behavioral health workforce. The BHSS program reports a significant increase in racial and ethnic diversity in the workforce. BHSSs are defined as non-clinical behavioral health workers who contribute to teams that administer comprehensive patient care and who play important roles in delivering behavioral health services that support licensed professionals. These positions include peer supporters such as peer support workers, peer recovery coaches, and peer recovery support specialists; community health workers; and paraprofessionals such as behavioral health technicians, unlicensed (non-licensed clinical social workers) substance use counselors/counselor assistants, or qualified behavioral health specialists workers, and patient navigators.[19] In 2008, a care delivery program in England that increased the number of BHSSs demonstrated improved patient outcomes and reduced cost of care while growing the workforce, especially in rural and under-resourced areas, trained the workforce to use evidence-based strategies, and significantly reduced wait lists. Using a similar model, in Ohio, OhioMHAS opened the statewide Child and Adolescent Behavioral Health Center of Excellence at Case Western Reserve University's Center for Innovation Practices in 2021. Part of the Center's responsibility is to expand service and care coordination capacity for children with complex needs and their families, support home-and community-based services, and build the continuum of care.[20]

Culturally and Linguistically Appropriate Services (CLAS) Training

CLAS or Culturally and Linguistically Appropriate Services training is a widely known and respected training program created by the U.S. Office of Minority Health (OMH). The CLAS standards provide a framework for addressing barriers to health equity in three areas: organizational, structural, and clinical.[21] Importantly, CLAS trainings are essential for increasing the cultural competency of existing behavioral health workers–both for White and Black, Indigenous, and People of Color (BIPOC) groups. The 15 standards that make up CLAS are outlined in Appendix A of this report. Currently, OhioMHAS fully supports and funds CLAS training, illustrating their commitment and leadership to cultural competency. ■

Practitioners Included in the Analysis

Table 1 provides a summary of practitioner types examined in this report and the response rates for race and ethnicity for each professional type. Data were obtained from each discipline's regulatory body (e.g., licensing board or state agency). Please note that this list is not exhaustive; it should not be inferred that these are the only professions or people contributing to behavioral health support and care in Ohio.

TABLE 1: Types of Professional Credentials in Ohio's Behavioral Health Services Examined in this Report

TITLE	TITLE / ABBREVIATION	LEVEL OF EDUCATION & SUPERVISION REQUIRED
Ohio Counselor, Social Worker & Marriage and Family Therapist Board **100% of licensees self-reported race; 98.99% self-reported ethnicity**		
Independent Marriage and Family Therapist	IMFT	master's + 2 years clinical supervision post master's as a MFT
Marriage and Family Therapist	MFT	master's
Licensed Independent Social Worker	LISW	master's + 2 years of clinical supervision post master's
Licensed Social Worker	LSW	bachelor's
Registered Social Work Assistant	SWA	associate's
Licensed Professional Clinical Counselor	LPCC	master's + 2 years of clinical supervision post master's
Licensed Professional Counselor	LPC	master's
Ohio State Medical Board **96.36% of licensees self-reported race; separate ethnicity data not provided**		
Physicians	MD or DO	Completion of bachelor's + medical/osteopathic school and residency
Ohio Board of Psychology **98.98% of licensees self-reported race; 98.82% self-reported ethnicity**		
Psychologist	PhD or PsyD	doctorate

Continued

TABLE 1 continued

TITLE	TITLE / ABBREVIATION	LEVEL OF EDUCATION & SUPERVISION REQUIRED
Ohio Chemical Dependency Professionals Board **99.4% of licensees self-reported race; 93.26% self-reported ethnicity**		
Licensed Independent Chemical Dependency Counselor – Clinical Supervisor	LICDC-CS	master's + 1 year clinical supervision as a LICDC
Licensed Independent Chemical Dependency Counselor	LICDC	master's in behavioral science
Licensed Chemical Dependency Counselor III	LCDC III / Counselor III	bachelor's in behavioral science
Licensed Chemical Dependency Counselor II	LCDC II / Counselor II	qualified associate's, or bachelor's in behavioral science
Chemical Dependency Counselor Assistant	CDCA	high school or GED + must be supervised
Chemical Dependency Counselor Assistant-Preliminary	CDCA-PRE	high school or GED
Ohio Certified Prevention Consultant	OCPC	bachelor's
Ohio Certified Prevention Specialist	OCPS	associate's
Ohio Certified Prevention Specialist Assistant	OCPSA	high school or GED
State of Ohio Board of Pharmacy **97.79% of licensees self-reported race; separate ethnicity data not collected**		
Pharmacist	PharmD or PhD	doctorate/ Pharm D (5 years)
Pharmacy Tech		Various; see pharmacy.ohio.org
Ohio Board of Nursing 99.99% of licensees self-reported race; separate ethnicity data not collected		
Advanced Practice Registered Nurse/Nurse Practitioner	APRN	master's or doctorate
Registered Nurse	RN	bachelor's
Licensed Practical Nurse	LPN	associate's
Ohio Department of Mental Health & Addiction Services **100% of certified individuals self-reported race; separate ethnicity data not collected**		
Peer Supporter		high school or GED

Findings: Racial & Ethnic Composition of Ohio's Behavioral Health Workforce Relative to Population Demographics

Understanding the Data

The data in this report were supplied by a variety of boards that license professionals (i.e., Medical Board, Nursing Board) as well as practitioners allied with behavioral health (i.e., Peer Support Specialist and Prevention Professionals). Each data source reports information somewhat differently and Table 2 outlines some of these differences for a quick reference. However, additional explanation may help clarify what the data are reporting.

Requirements for Reporting Race and Ethnicity:
Requiring a response to the race and ethnicity questions should be the standard for data collection (for detailed guidance, see the recommendations). However, as Table 2 shows, not all professional types have 100% reporting for race, an indication that this is likely not currently a required or forced choice question.

Separate Variables for Race and Ethnicity:
The instruments used in this analysis collected racial and/or ethnic data for respondents in two ways. Most instruments ask two questions: one for race and a separate question for ethnicity. However, some groups use an instrument (i.e., Peer Supporters) that does not ask a separate question about provider ethnicity. Data collected from sources that do not have separate variables for race and ethnicity are not as accurate, complete, or useful as those that have separate variables.

Racial Category Labels and Other:
In this report, the racial and/or ethnic categories used are White, Black, Hispanic, and Other. These labels were chosen because they align with the U.S. Census categories. Readers may note the absence of Asian as a racial category. This is not because Asian was excluded from analysis, but because of the small number of individuals reporting Asian as their race. The Asian population is captured in the Other category, as are all individuals who did not identify as White alone, Black alone, or Hispanic alone. This includes multi-racial individuals or those reporting Hispanic ethnicity and White race, for example.

ZIP vs. County Level Data:
Table 2 reports whether the data source provides ZIP Code or county-level data. Where available, this report uses ZIP Code data to map where providers are located because of its greater geographic specificity and relevance to audiences such as policymakers.

Office vs. Home Residence Location:
Table 2 reports whether provider location data refer to their home, office, or in some instances, both home and office. In some cases, this information is unknown. This data point is relevant because practitioners may live in one location, but provide their services in another location. Refer to Table 2 when interpreting the maps of provider location to know whether the data is for home, office, both, or unknown.

Most Likely to Provide Behavioral Health Services:
Some practitioner types, such as MDs and nurses, provide a wide array of services, not all of which are behavioral-health related. The data analysis accounted for this by including specialties most likely to provide behavioral health services. Still, it is necessary to interpret these data with the fact in mind that not all providers are specialists in behavioral health.

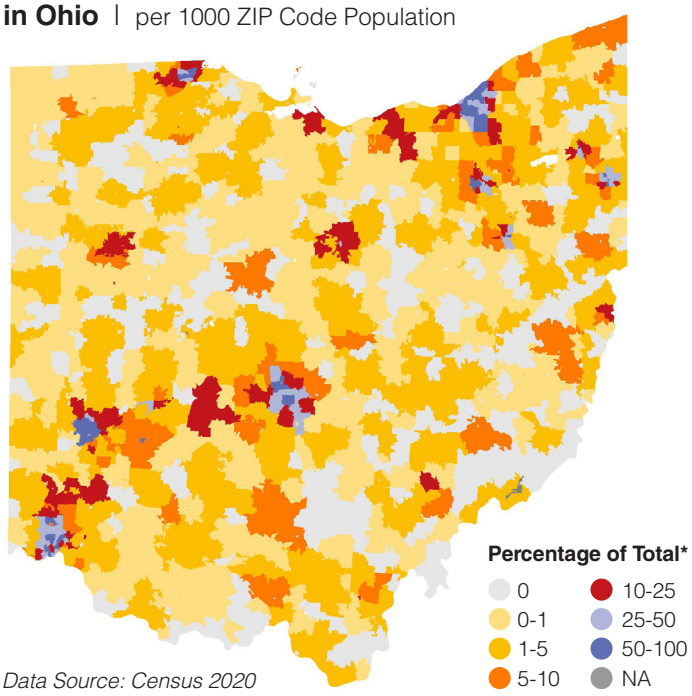
TABLE 2: Summary of Data Sources

DATA SOURCE NAME	SEPARATE VARIABLES FOR RACE/ ETHNICITY?	% OF DATA THAT INCLUDES RACE	% OF DATA THAT INCLUDES ETHNICITY	ZIP OR COUNTY LEVEL DATA?	HOME OR OFFICE LOCATION USED	LANGUAGES SERVICE PROVIDERS SPEAK	% WHITE ALONE	% BLACK ALONE	% HISPANIC ALONE	% OTHER	% OF ZIP CODES THAT DO NOT HAVE THESE PROFESSIONALS
Counselor, Social Worker & Marriage & Family Therapist Board	Yes	100	98.99	ZIP	Home	Missing Data: 76.43% English: 99.83% Spanish: 1.83% Other: <1%	80.64	11.39	2.32	7.97	 15.87%
Medical Board	Yes	100	99.99	ZIP	Both	N/A	66.41	4.86	3.02	28.73	 45.55%
Psychology Board	Yes	98.98	98.82	ZIP	N/A	Missing Data: 89.97% English: 100% Spanish: 2.88% Other: <1%	86.95	4.68	2.54	8.38	 64.08%
Chemical Dependency Board	Yes	99.4	93.26	ZIP	N/A	Missing Data: 61.70% English: 99.81% Spanish: 0.79% Other: <1%	70.99	21.57	2.09	7.44	 26.65%
Prevention Professionals	Yes	99.8	89.38	County	N/A	Missing Data: 53.75% English: 100% Spanish: 1% Other: 2.68%	70.27	23.00	2.19	4.69	N/A
Ohio Board of Pharmacy	No	97.79	N/A	ZIP	Home	N/A	87.20	3.50	0.51	8.78	 31.08%
Nursing Board	No	99.99	N/A	ZIP	Office	N/A	85.57	9.49	1.44	3.50	 15.13%
OhioMHAS - Peer Support Specialists	No	100	N/A	ZIP	N/A	N/A	67.90	25.68	2.33	4.09	N/A
Ohio Resident Demographics							77.0	12.5	4.4	1.9	

Assessing Disparities in the Behavioral Health Care Workforce

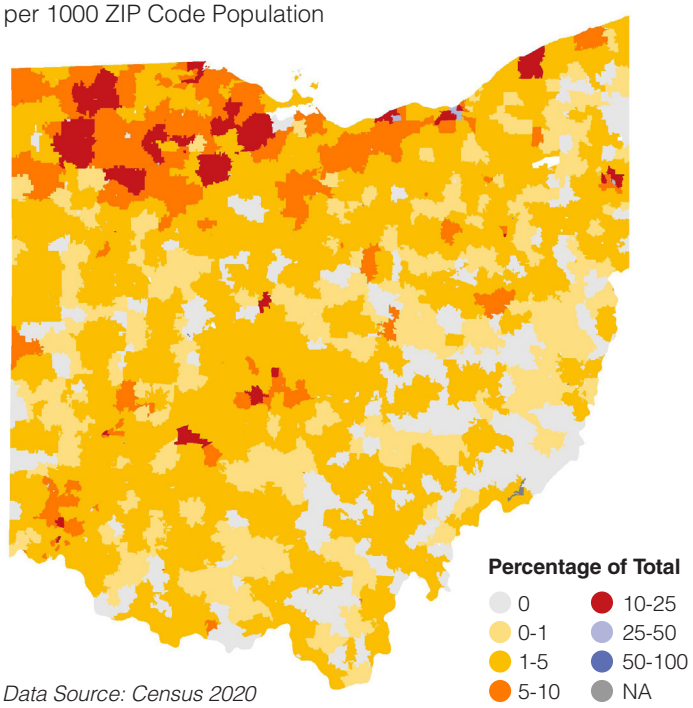
Available data from professional licensing boards show workforce disparities that vary across different regions of Ohio and specific professions. Disparities in the behavioral health workforce are measured in two ways: 1) the percent of behavioral health providers that are either Black or Hispanic and whether this percentage is similar to the overall percentage of Black and Hispanic residents in Ohio; and 2) whether there is geographic overlap in provider availability and residents of color given important evidence that racial and ethnic concordance between providers and patients leads to improved health care outcomes. Figures 1 and 2 are maps demonstrating racial and ethnic diversity across the state by ZIP Code (Figures 1-2). These maps serve as helpful reference points for overall racial and ethnic distribution of Ohioans across the state. When compared with maps of the available behavioral health workforce, they also provide an assessment of behavioral health care professional availability across the state and whether the workforce matches the race and ethnicity of residents.

FIGURE 1: Black or African American Population in Ohio | per 1000 ZIP Code Population



Data Source: Census 2020

FIGURE 2: Hispanic Population in Ohio
per 1000 ZIP Code Population



Data Source: Census 2020

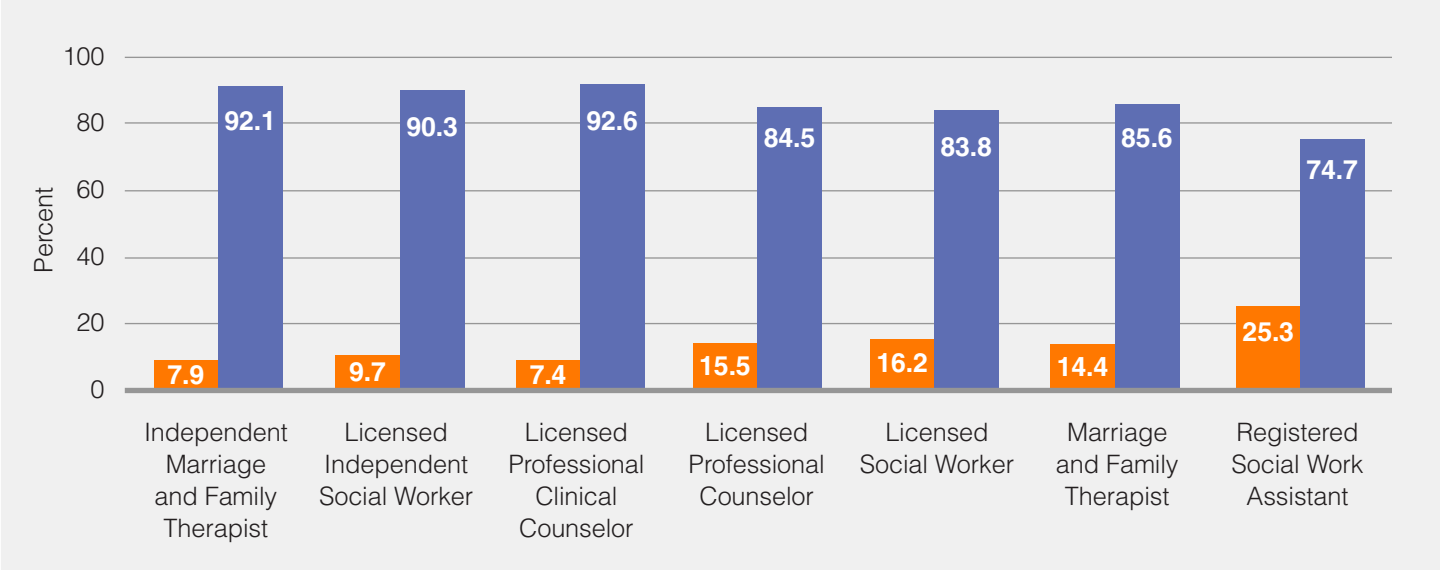
*** Whole numbers are used in the map legends for ease of reading. The discrete numbers are found by applying this scale:**

0 = rate 0 < rate ≤ 1 1 < rate ≤ 5 5 < rate ≤ 10 10 < rate

Counselors and Social Workers

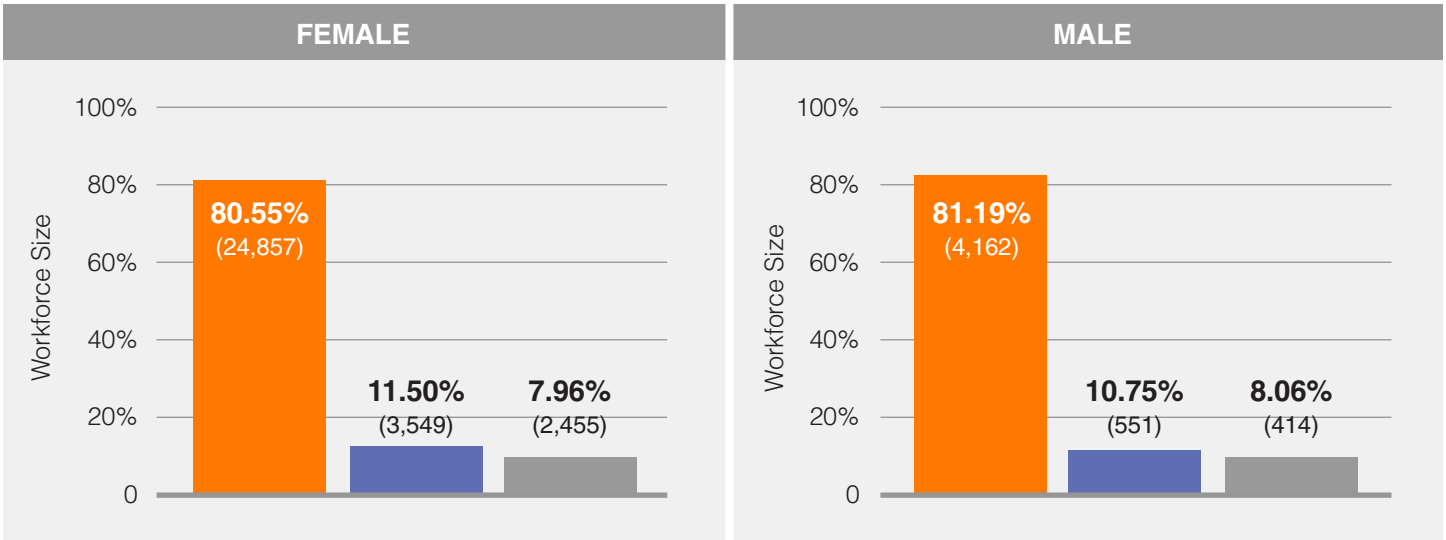
Counselors and Social Workers' (CSWs) demographics, overall, do not align proportionately with the racial diversity of Ohio's population. Among social workers (SWs), education requirements impact the racial makeup of licensure type. With Black providers make up only 7.9% of the highest level of licensure, (licensed independent social workers, LISW), but 25.3% in the lowest level of licensure, (registered social work assistants, SWA). Considering all licensure types within CSWs, White people make up proportionally more of the profession (80.87%) than Ohio's White population (77%) and Black CSWs (11.25%) number fewer than the Black population (12.5%) (Figure 4).

FIGURE 3: Ohio Counselors & Social Worker Race and Professional Degree



Analysis provided by Jewel Woods

FIGURE 4: Counselors & Social Workers by Gender & Race | Percentages within each Gender



CSW Licensee Demographic Data

Notably, White male SWs are concentrated in the highest tier of this profession as measured by educational attainment (LISW) with Black male SWs concentrated in the lowest tier of social workers (SWAs) (Figure 4).

There are slightly more male Hispanic CSWs (15.57%) than their male non-Hispanic counterparts (14.21%) (Figure 5). Looking at the intersection of age, race, and ethnicity, non-White social workers are older than their White counterparts suggesting that those who are newer to the profession may less often come from marginalized backgrounds (Figure 6).

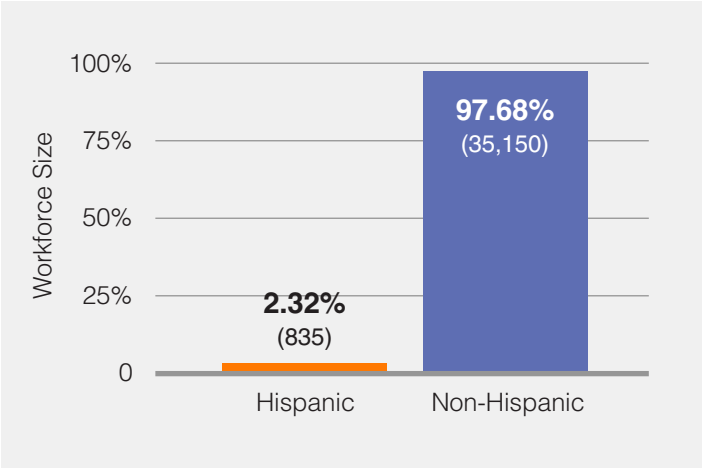
The concentration of CSWs in Ohio was analyzed using a rate per 1,000 residents. Referencing Figures 1 and 2 and comparing them to Figure 7 shows that CSWs are concentrated in urban ZIP Codes across Ohio with important implications for Ohioans living outside of metropolitan areas. Nearly 17% of ZIP Codes across Ohio do not have a single CSW.

Looking specifically at location and the race and ethnicity of professionals in this workforce, the rate of Black CSWs per 1,000 residents is highest in the Cleveland, Columbus, Dayton, Cincinnati, and Toledo metropolitan areas (Figure 8), while the rate of Hispanic CSWs per 100,000 residents is highest in Northwest Ohio (Figure 9). The rate of CSWs who are White is presented in Figure 10 and CSWs in the Other category are shown in Figure 11.

FIGURE 6: Counselors & Social Workers by Age & Race in Ohio | Percentages

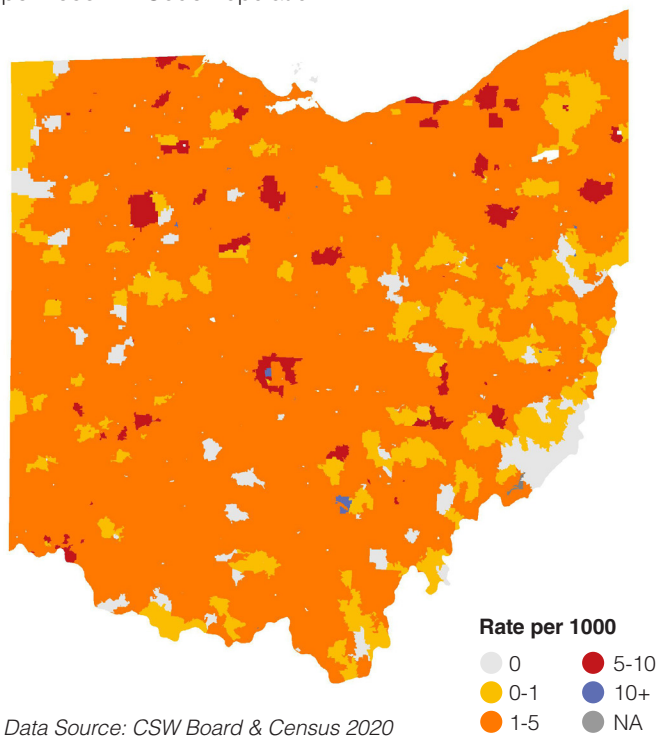
AGE	NON-WHITE	WHITE	TOTAL
18-29	11.9%	14.9%	14.4%
30-40	30.0%	31.6%	31.3%
40-49	22.2%	21.4%	21.5%
50-64	35.9%	32.2%	32.7%
Total	**100.0%**	**100.0%**	**100.0%**

FIGURE 5: Counselors & Social Workers by Ethnicity
Counts and Percentages



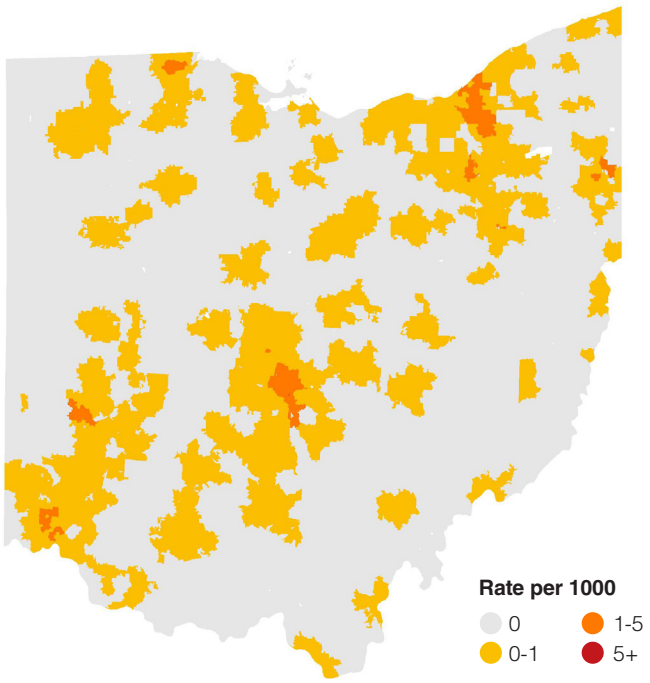
CSW Licensee Demographic Data

FIGURE 7: Counselors & Social Workers (All Races)
per 1000 ZIP Code Population



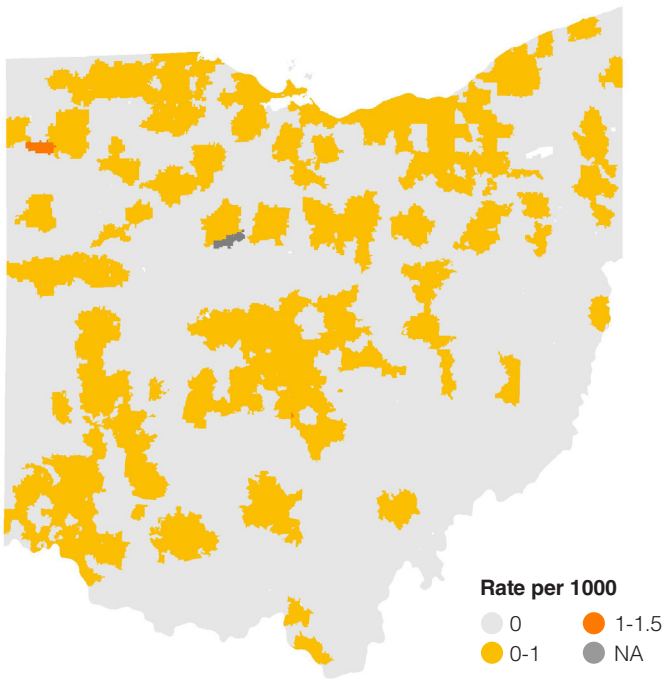
Data Source: CSW Board & Census 2020

FIGURE 8: Black Counselors & Social Workers
per 1000 ZIP Code Population



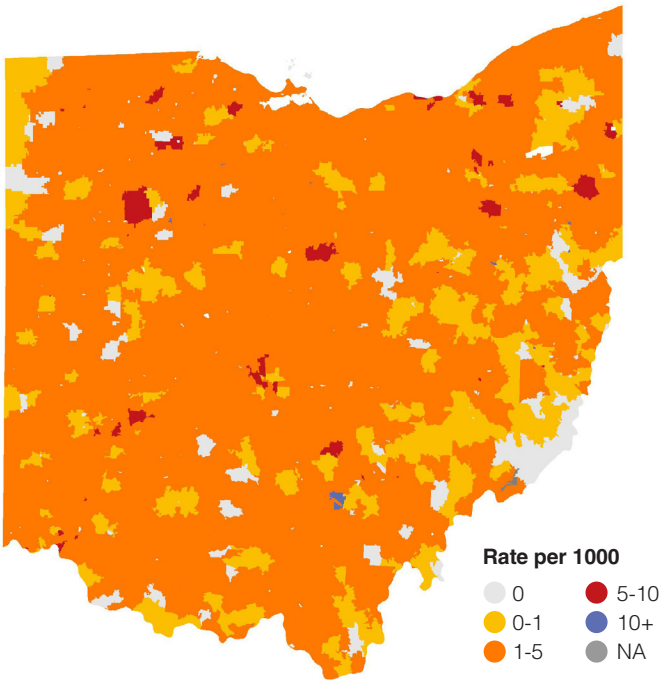
Data Source: CSW Board & Census 2020

FIGURE 9: Hispanic Counselors & Social Workers
per 1000 ZIP Code Population



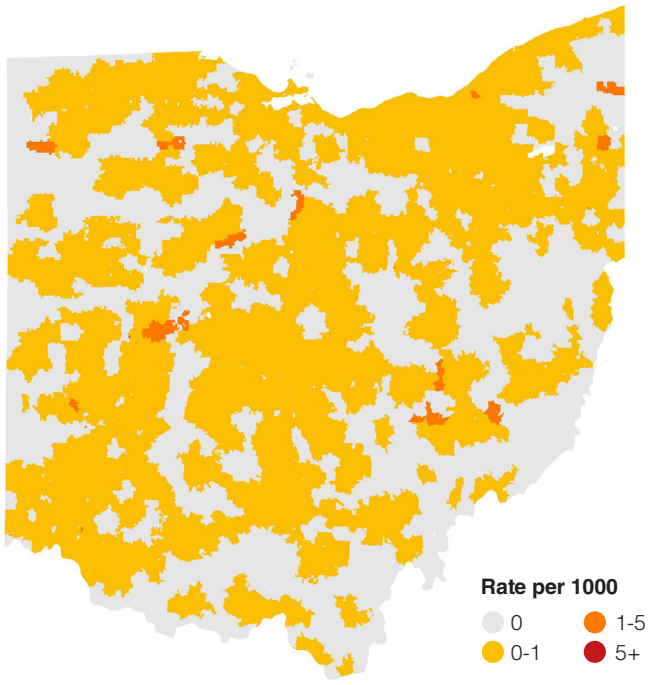
Data Source: CSW Board & Census 2020

FIGURE 10: White Counselors & Social Workers
per 1000 ZIP Code Population



Data Source: CSW Board & Census 2020

FIGURE 11: Other Counselors & Social Workers
per 1000 ZIP Code Population



Data Source: CSW Board & Census 2020

Physicians

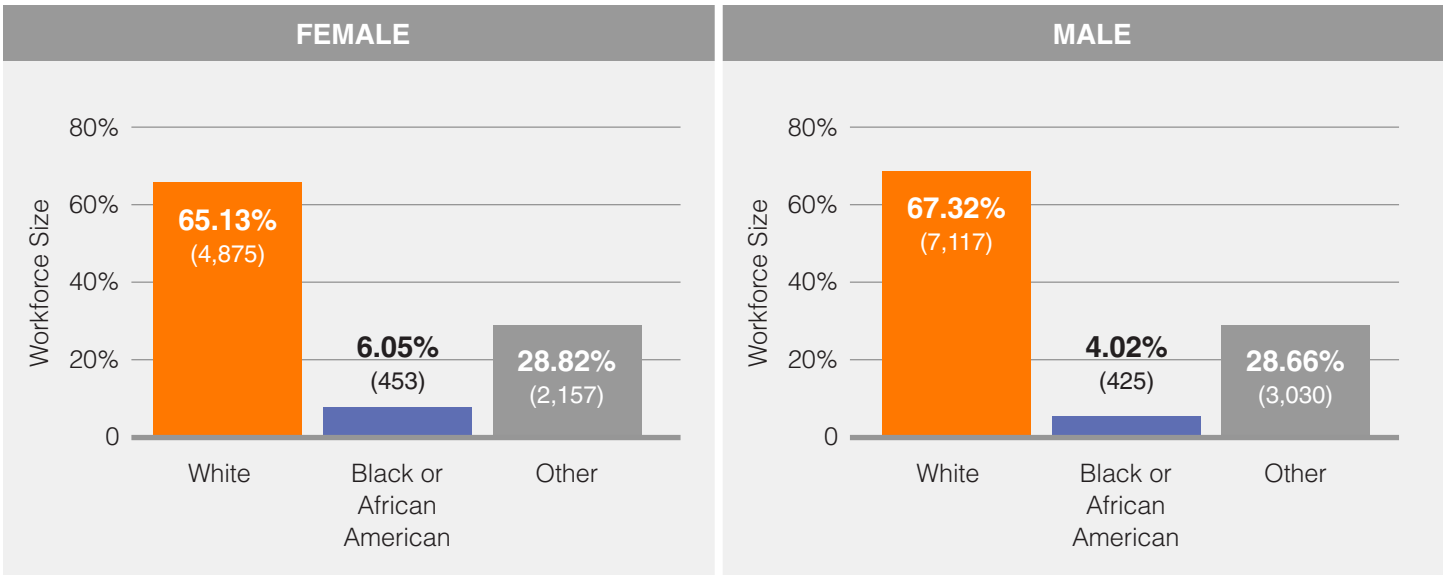
The Ohio State Medical Board regulates physicians holding either an MD or DO degree. This report analyzes only those most likely to provide behavioral health care services, which are physicians with board certification in either pediatrics, obstetrics and gynecology (OBGYN), family medicine, internal medicine, and/or psychiatry. Within this cohort of Medical Board licensees, 100% reported information related to race and 99.99% reported ethnicity.

As previously noted, this report summarizes race information in three categories: Black, White and Other. In conducting the analysis of Medical Board data, all characterizations that were not Black or White were grouped into Other. Of note, the Medical Board has the highest percentage of providers in the Other category (28.73%) while all other professional types in this report have under 9% reported as Other.

Looking at race among the specialties included in this analysis, Black physicians make up just 4.86% of Ohio physicians (Figure 12), even though Black residents make up 12.5% of all Ohioans. At the intersection of gender and race, we find that males are overrepresented among Ohio physicians, similar to national findings. Regarding ethnicity, MDs/DOs that identify as Hispanic represent 3.02% of physicians included in this analysis (Figure 13).

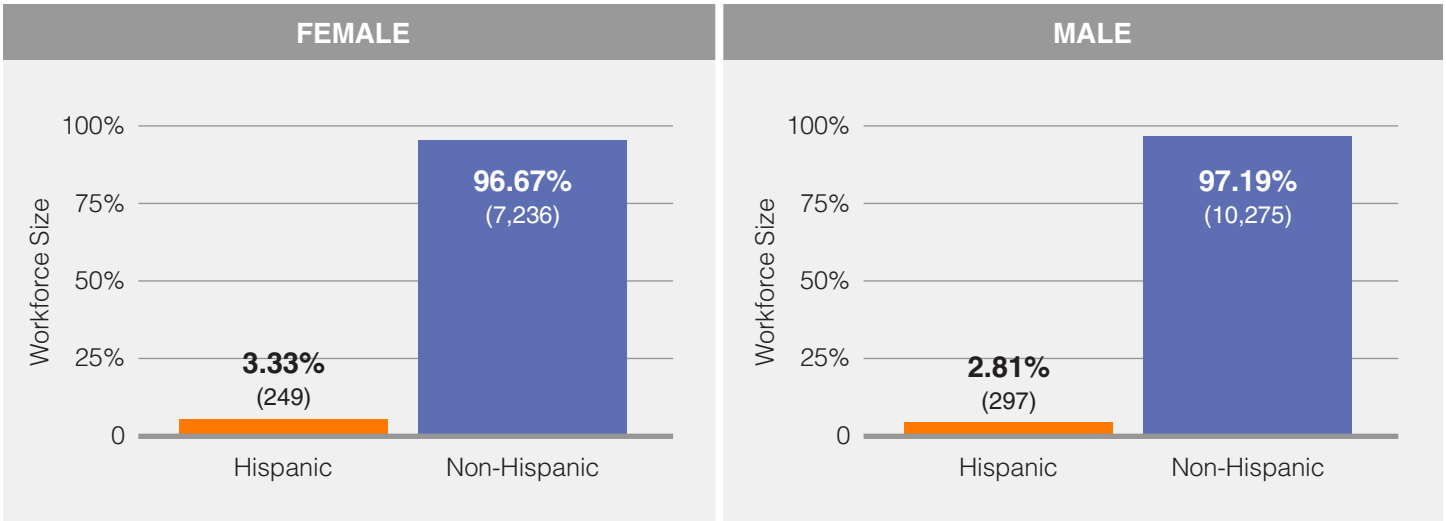
Figure 14 maps the rate of physicians of all races included in this analysis per 1,000 Ohio residents. Figures 15, 16, 17, and 18 provide the geographic distribution of the rate of physicians included in this analysis per 1,000 residents who identify as White, Black, Hispanic, or Other, respectively. Use Figure 1 to compare Figures 15-18 with Ohio's overall population by race to assess whether physicians are located in areas where people of color live. While physicians of all races are more heavily concentrated in Ohio's more populous ZIP Codes, White physicians are found at greater rates throughout the state, demonstrating a lack of diversity in Ohio's behavioral health workforce. Notably, almost half (45.55%) of Ohio ZIP Codes do not have a single licensed physician.

FIGURE 12: Physicians by Race & Gender | Percentages within each Gender



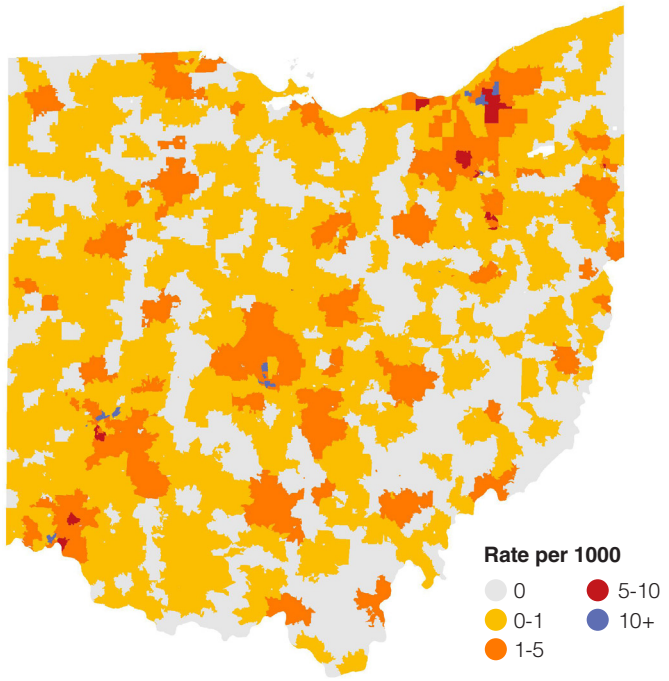
Medical Board Demographic Data

FIGURE 13: Physicians by Hispanic Ethnicity | Counts and Percentages



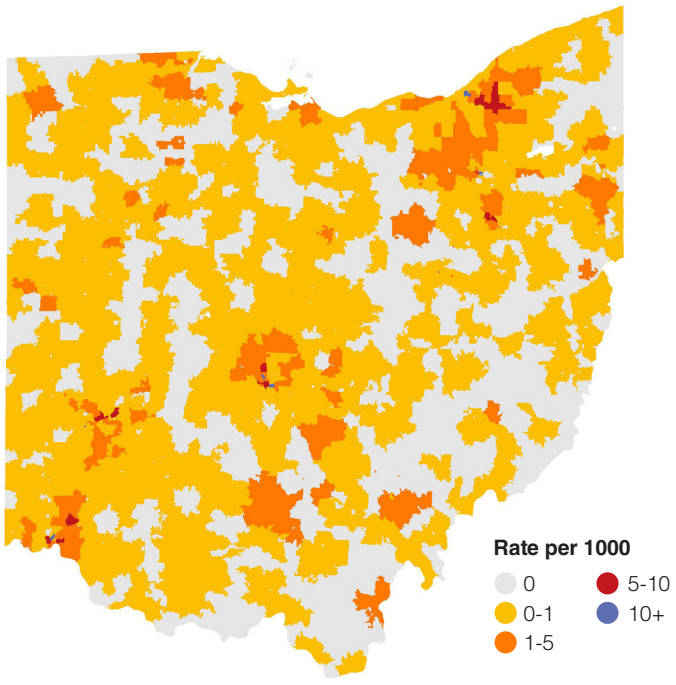
Medical Board Demographic Data

FIGURE 14: Physicians (All Races)
per 1000 ZIP Code Population



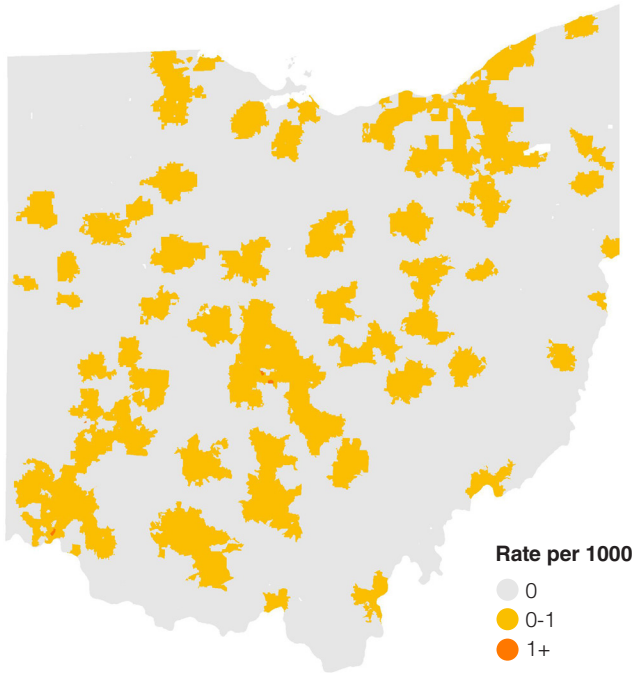
Data Source: Medical Board & Census 2020

FIGURE 15: Physicians (White)
per 1000 ZIP Code Population



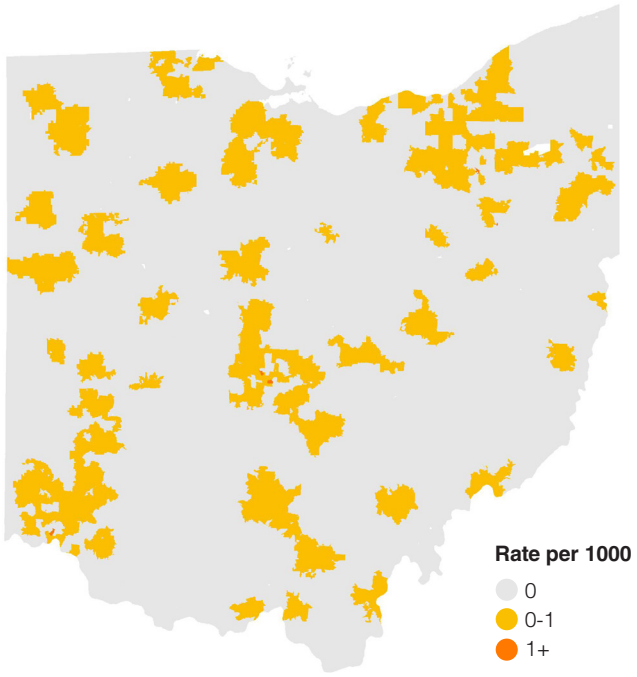
Data Source: Medical Board & Census 2020

FIGURE 16: Physicians (Black)
per 1000 ZIP Code Population



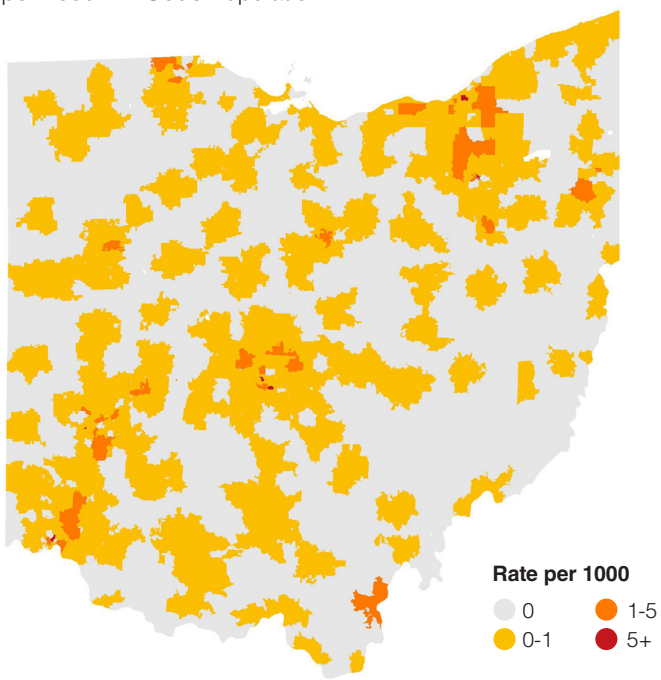
Data Source: Medical Board & Census 2020

FIGURE 17: Physicians (Hispanic)
per 1000 ZIP Code Population



Data Source: Medical Board & Census 2020

FIGURE 18: Physicians (Other)
per 1000 ZIP Code Population



Data Source: Medical Board & Census 2020

"Every Ohioan who needs mental health or substance use support should have access to those services. Currently in Ohio, racial and ethnic minorities are unlikely to find care that offers the best chance for the best possible outcomes. That kind of care means access to providers who look like them and who have a similar cultural background."

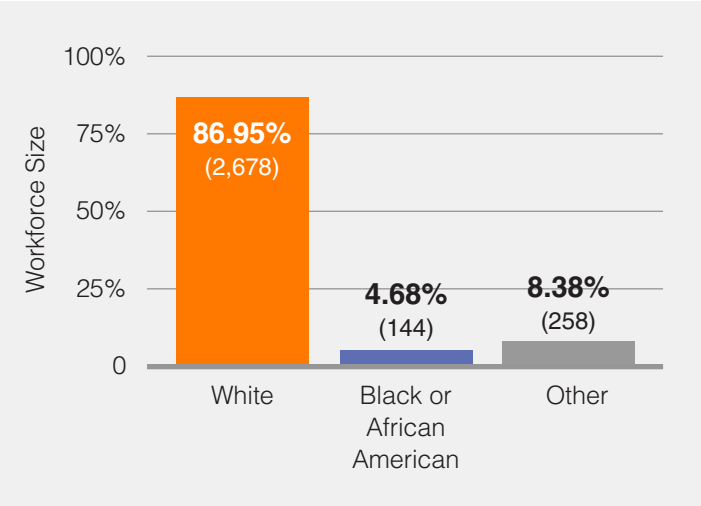
— TRACY MAXWELL HEARD, EXECUTIVE DIRECTOR OF MACC

Psychologists

Psychology professionals included in this analysis that have licensure through the Ohio Board of Psychology are either clinical psychologists or school psychologists. Among this profession, Black psychologists make up 4.68% of all Ohio psychologists and Hispanic psychologists constitute 2.54% (Figures 19 and 20). Psychologists that are not White, Black, or Hispanic make up 8.38% of the profession in Ohio (Figure 19). This somewhat high number of psychology professionals in the Other category points to a need for more detailed information around race and ethnicity, especially for providers outside of the most common racial and ethnic groups. Approximately 65% of psychologists in Ohio are female (Figure 21) and of these providers, approximately 86% are White, 5% are Black, and 9% are classified as Other (Figure 22). There are disproportionately fewer male psychologists identifying as Black or Other in Ohio as compared to their female counterparts (Figure 22).

FIGURE 19: Psychology Workforce by Race

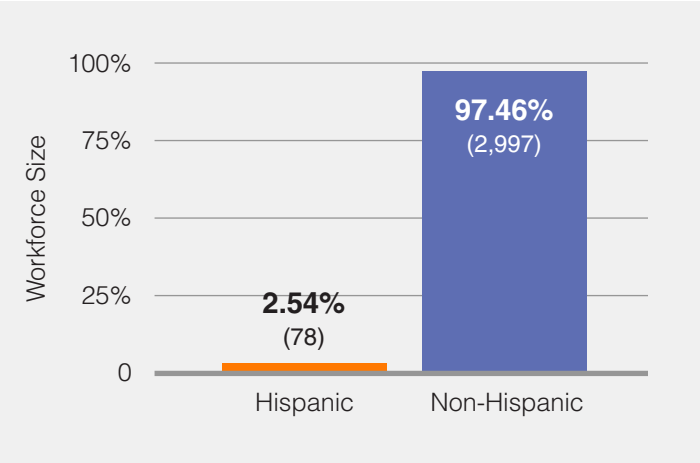
Counts and Percentages



Psychology Board Demographic Data

FIGURE 20: Psychology Workforce by Ethnicity

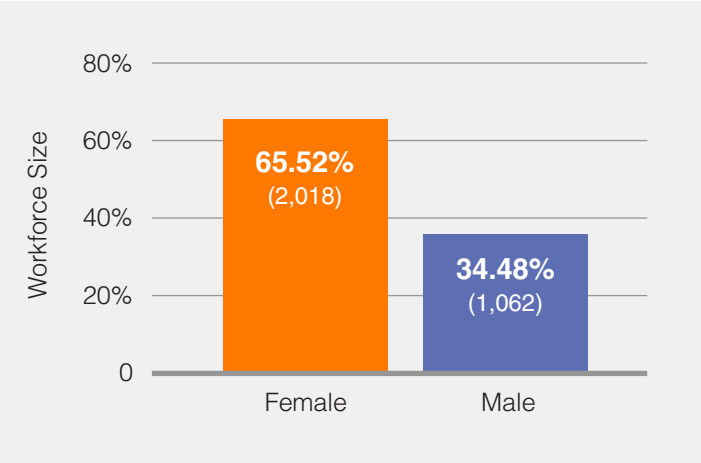
Counts and Percentages



Psychology Board Demographic Data

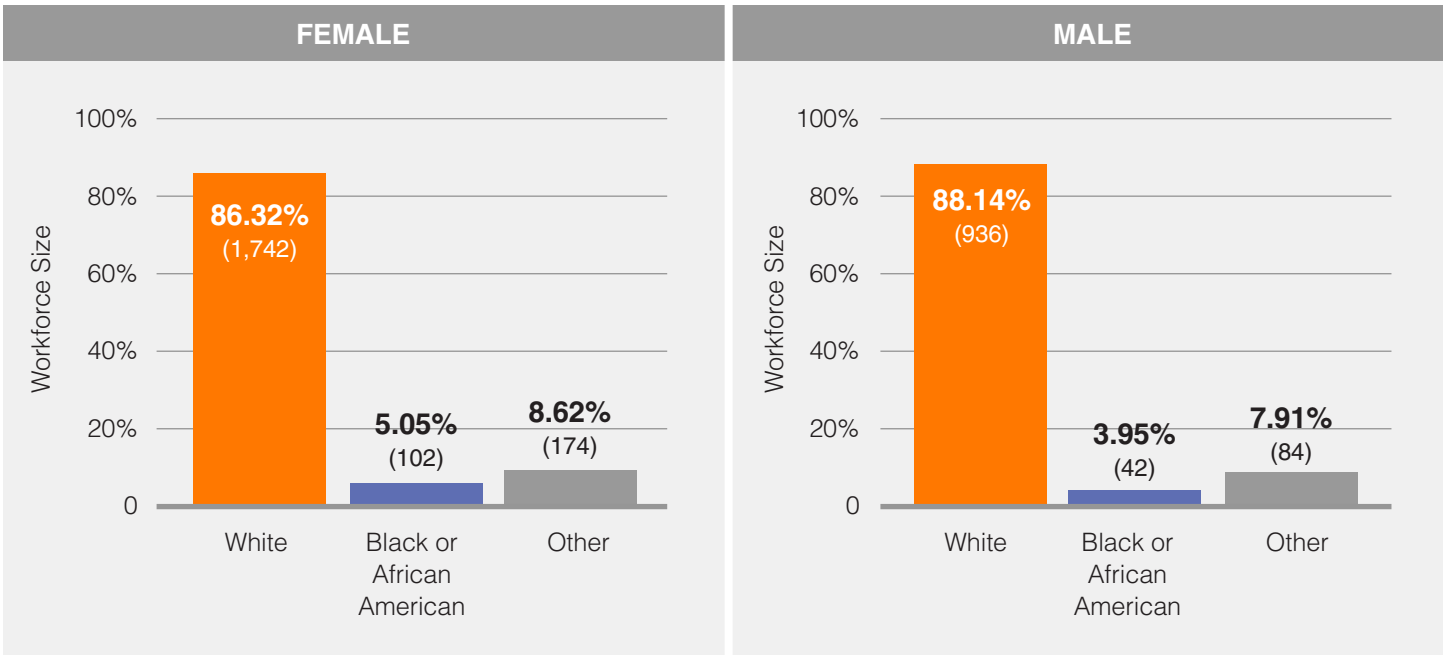
FIGURE 21: Psychology Workforce by Gender

Counts and Percentages



Psychology Board Demographic Data

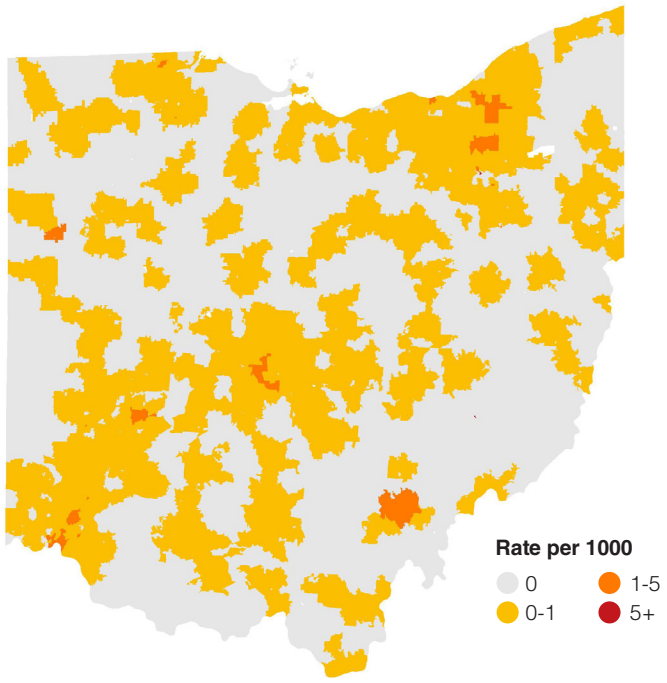
FIGURE 22: Psychology Workforce by Gender & Race | Percentages within each Gender



Psychology Board Demographic Data

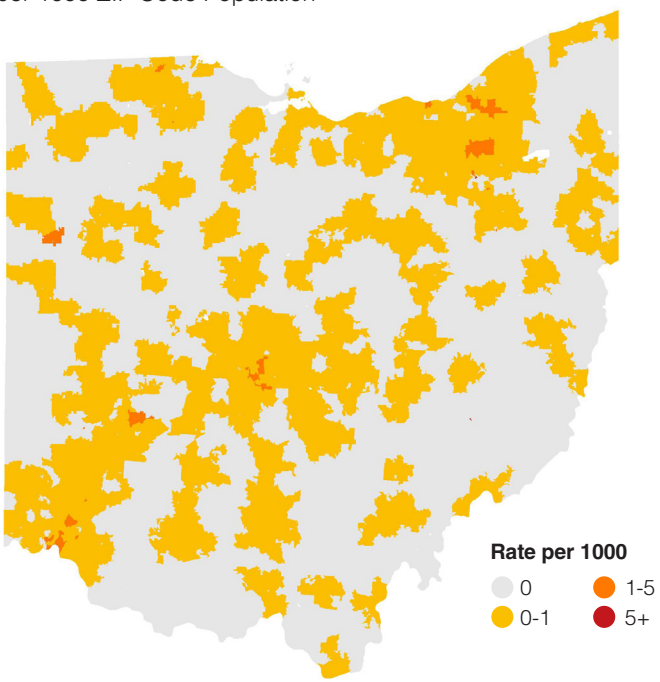
A geographic representation of psychologists across Ohio demonstrates that these professionals are concentrated in major metropolitan areas and university towns, leaving 767 of 1,197 ZIP Codes without a single psychologist (Figure 23). Figures 24-27 respectively offer the number of White, Black, Other, and Hispanic psychologists per 1,000 residents by ZIP Code. In communities outside of major metropolitan areas in Ohio, psychologists are more likely to be White, which has important implications for access to a diverse behavioral health workforce for people of color who live in sparsely populated areas.

FIGURE 23: Psychology Workforce (All Races)
per 1000 ZIP Code Population



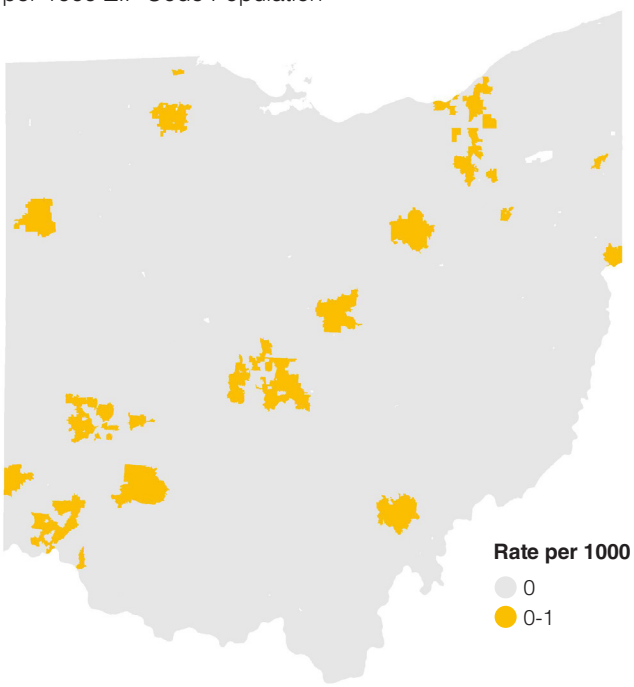
Data Source: Psychology Board & Census 2020

FIGURE 24: White Psychology Workforce
per 1000 ZIP Code Population



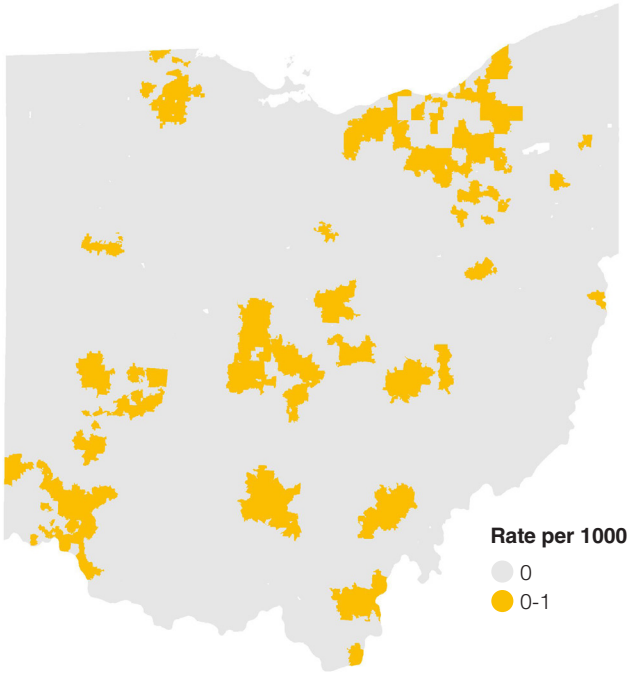
Data Source: Psychology Board & Census 2020

FIGURE 25: Black Psychology Workforce
per 1000 ZIP Code Population



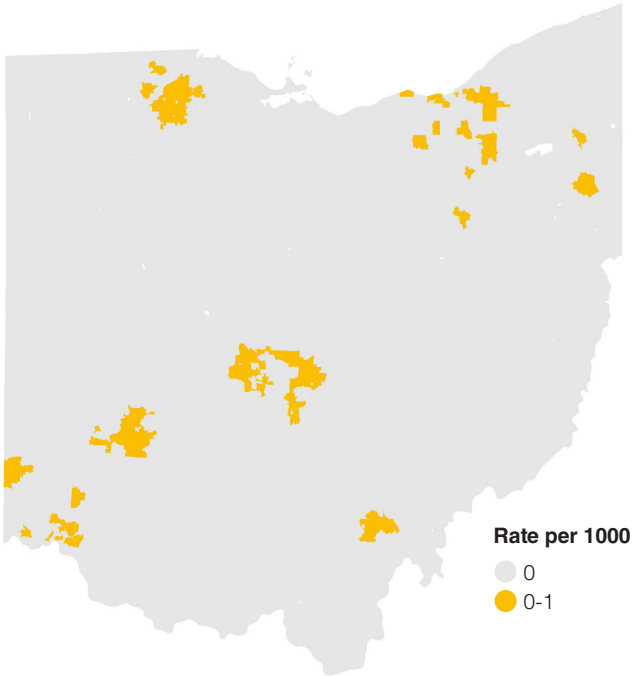
Data Source: Psychology Board & Census 2020

FIGURE 26: Psychology Workforce (Other Races)
per 1000 ZIP Code Population



Data Source: Psychology Board & Census 2020

FIGURE 27: Hispanic Psychology Workforce
per 1000 ZIP Code Population



Data Source: Psychology Board & Census 2020

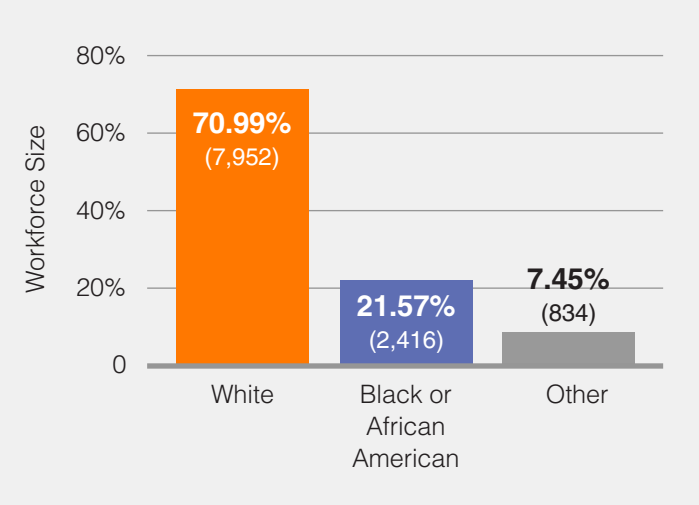
Chemical Dependency Professionals

The Chemical Dependency Professionals (CDP) Board licensees include a spectrum of treatment and prevention providers. Treatment providers include chemical dependency counselor assistants-preliminary (CDCA-PRE), chemical dependency counselor assistants (CDCA), two levels of licensed chemical dependency counselors (LCDC II, III), licensed independent chemical dependency counselors (LICDC). The prevention credentials regulated by the CDP Board include registered applicants (RA), Ohio certified prevention specialists (OCPS), Ohio certified prevention specialist assistants (OCPSA), and Ohio certified prevention consultants (OCPC).

Figures 28 - 32 and 43-47 analyze only the treatment professionals credentialed by the CDP Board. Note that Figures 33-42 look at the characteristics of specific treatment credentials (i.e., Figure 33 only includes CDCA-PREs). Further, some individuals have more than one treatment credential and could be included in more than one figure, though this only applies to a small number of licensees.

Approximately 22% of CDPs in Ohio identify as Black, while 7.5 % identify as Other (Figure 28). Just over 2% of CDCs identify as Hispanic (Figure 29). Nearly 72% of CDCs are female (Figure 30). Male CDCs more commonly identify as Black or Hispanic as compared to female CDCs (Figures 31, 32).

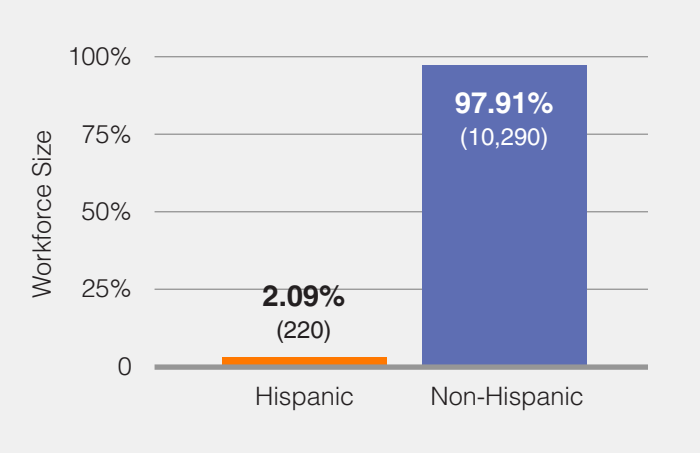
FIGURE 28: Chemical Dependency Professional Workforce by Race | Counts and Percentages



CDP Board Demographic Data

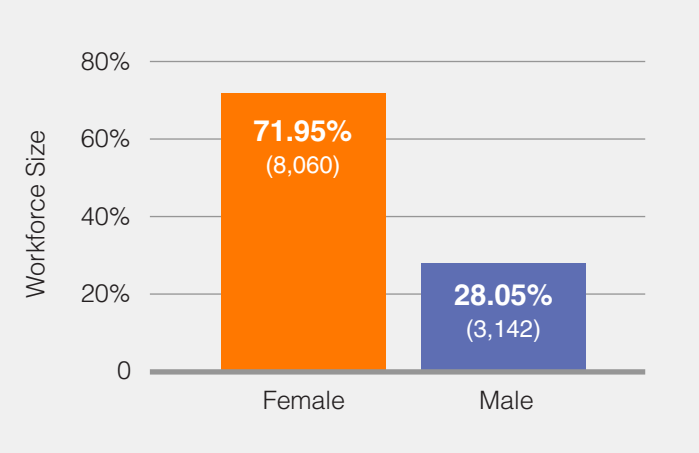
FIGURE 29: Chemical Dependency Professional Workforce by Hispanic Ethnicity

Counts and Percentages



CDP Board Demographic Data

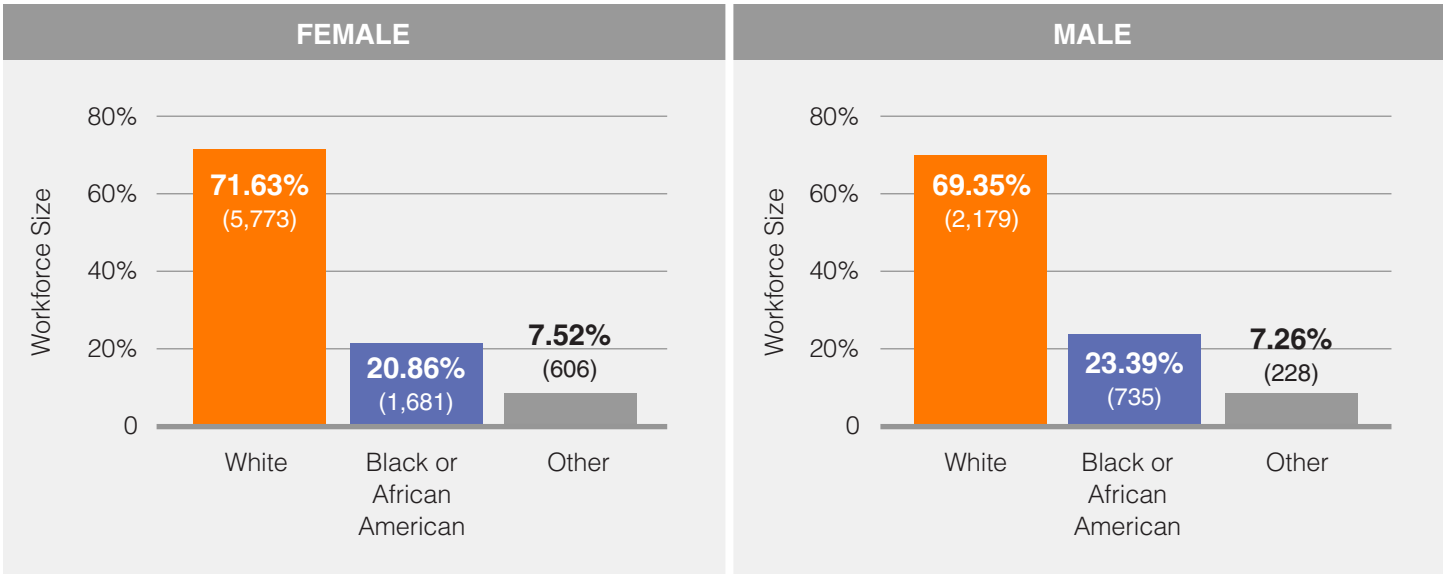
FIGURE 30: Chemical Dependency Professional Workforce by Gender | Counts and Percentages



CDP Board Demographic Data

Looking more closely at different types of Chemical Dependency Counselors (CDCs), Black CDCs are disproportionately more likely to be CDCA-PREs or CDCAs as compared to other licensure types. As educational requirements increase for each level of CDC, Black professionals are increasingly underrepresented as compared to their White counterparts (Figures 33-42).

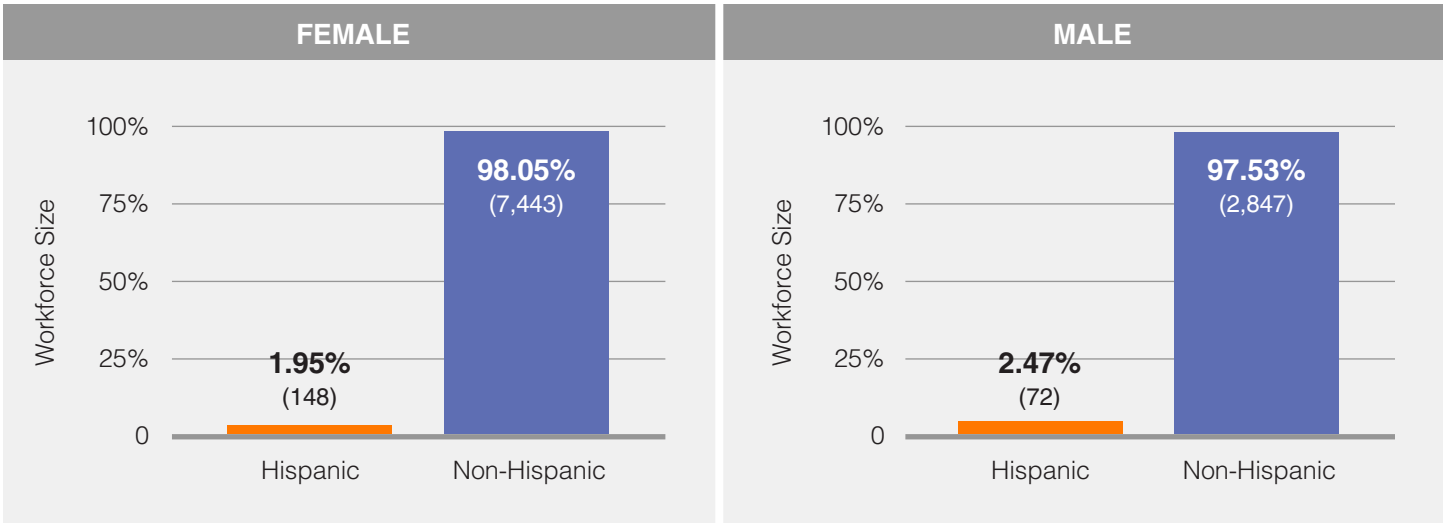
FIGURE 31: Chemical Dependency Professional Workforce by Gender & Race | Percentages within each Gender



CDP Board Demographic Data

FIGURE 32:

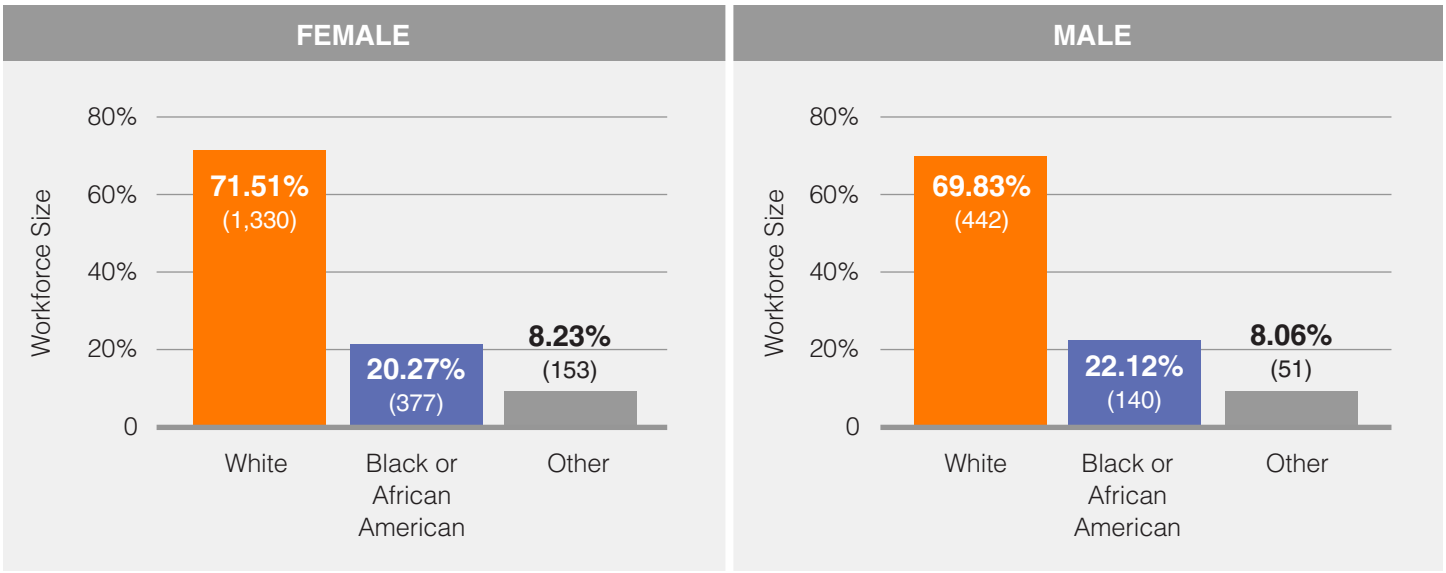
Chemical Dependency Professional Workforce by Hispanic Ethnicity & Gender | Counts and Percentages



CDP Board Demographic Data

FIGURE 33: Chemical Dependency Counselor Assistant Preliminary by Gender & Race

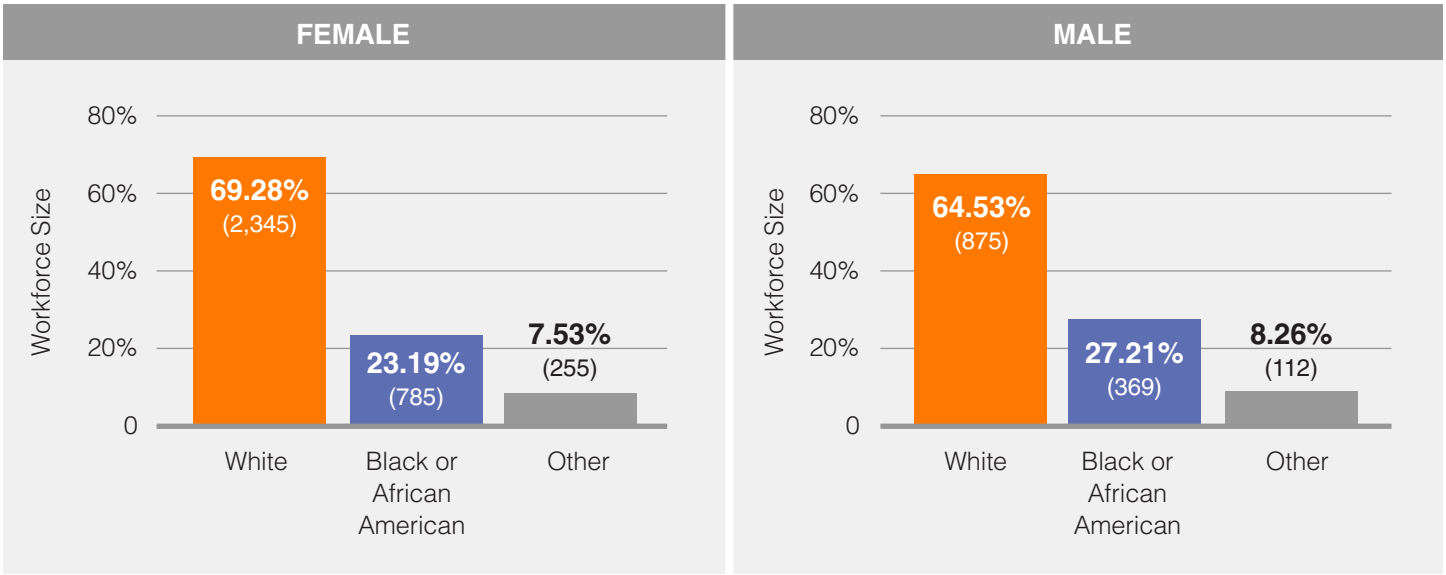
Percentages within each Gender



CDP Board Demographic Data

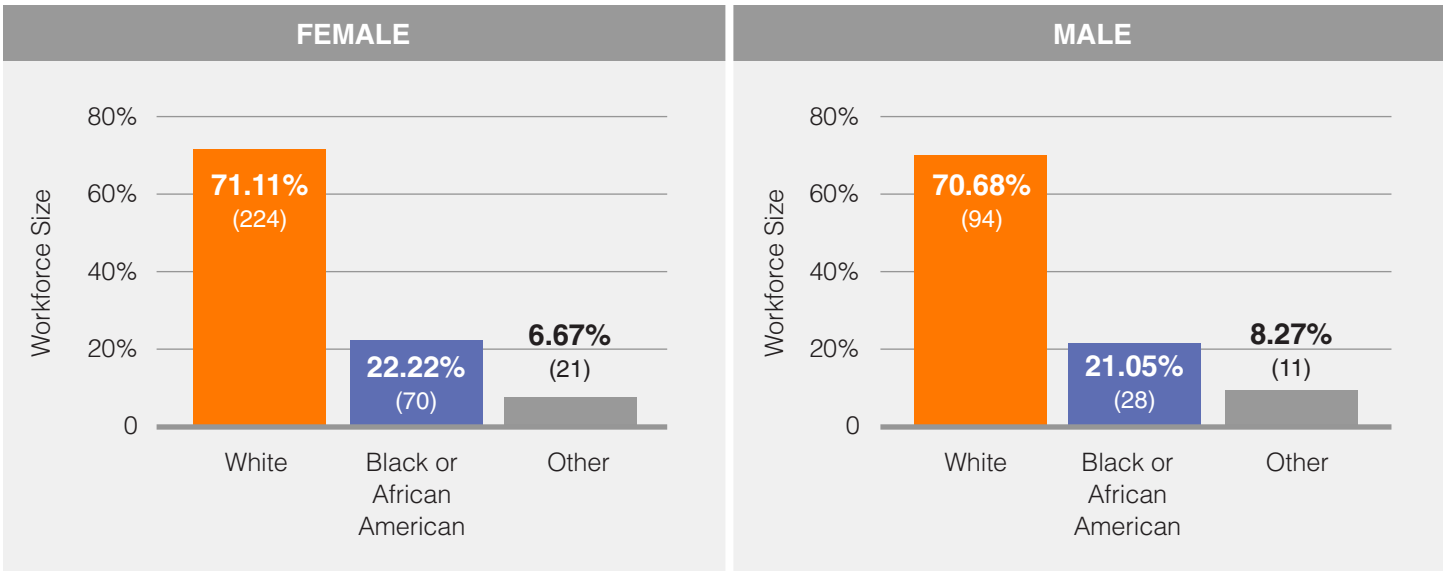
FIGURE 34:

Chemical Dependency Counselor Assistant by Gender & Race | Percentages within each Gender



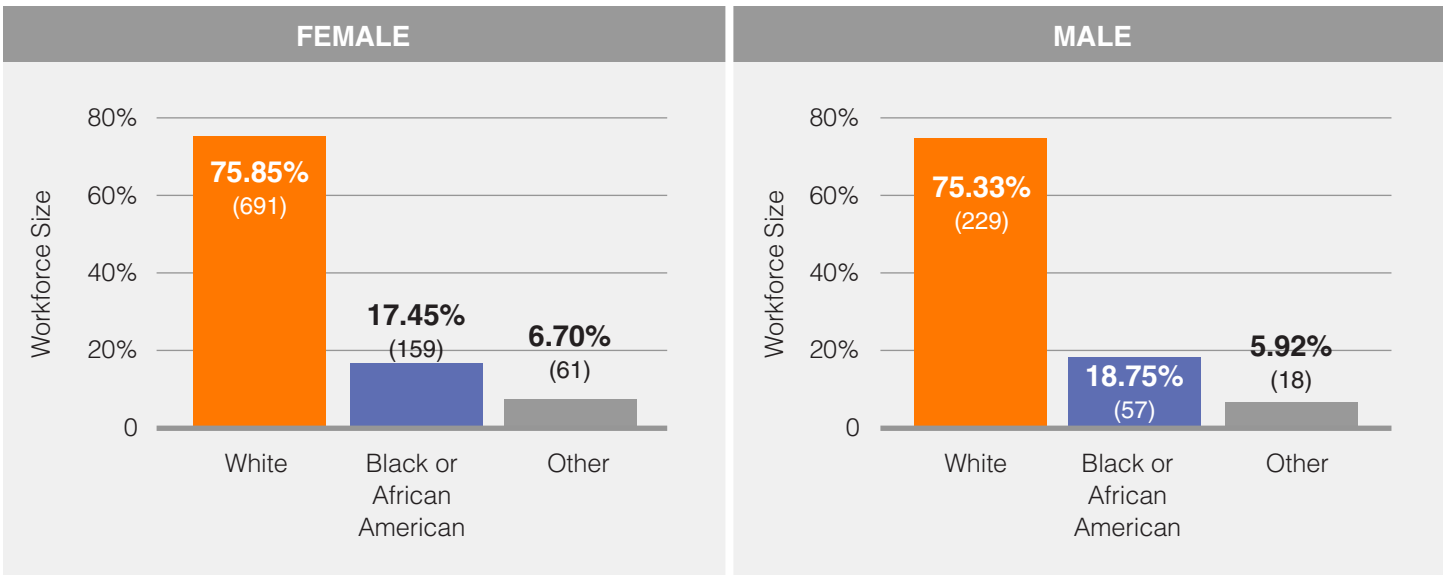
CDP Board Demographic Data

FIGURE 35: Licensed Chemical Dependency Counselor II by Gender & Race | Percentages within each Gender



CDP Board Demographic Data

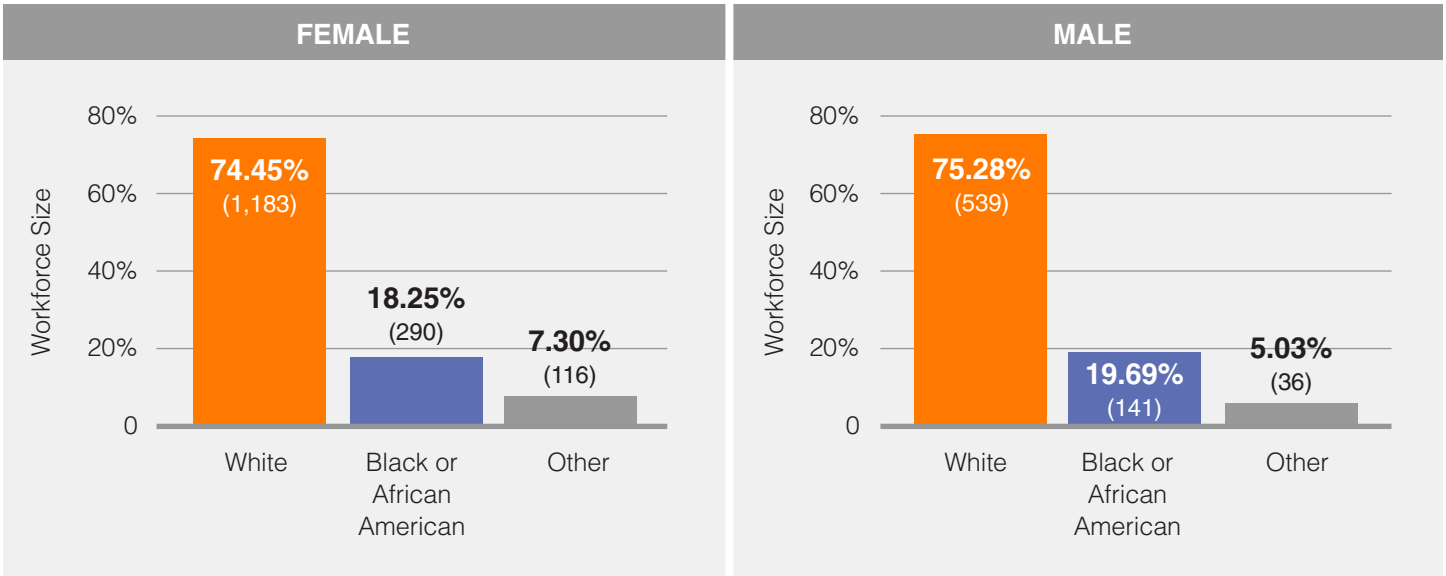
FIGURE 36: Licensed Chemical Dependency Counselor III by Gender & Race | Percentages within each Gender



CDP Board Demographic Data

FIGURE 37:

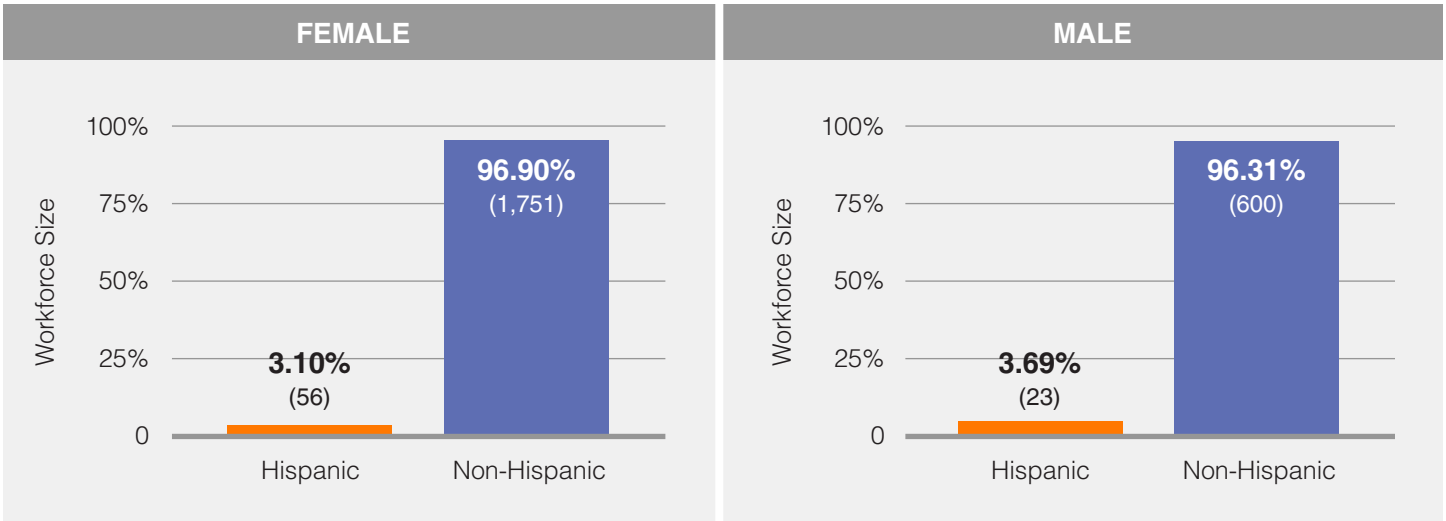
Licensed Independent Chemical Dependency Counselor by Gender & Race | Percentages within each Gender



CDP Board Demographic Data

FIGURE 38: Chemical Dependency Professional Assistant Preliminary by Hispanic Ethnicity & Gender

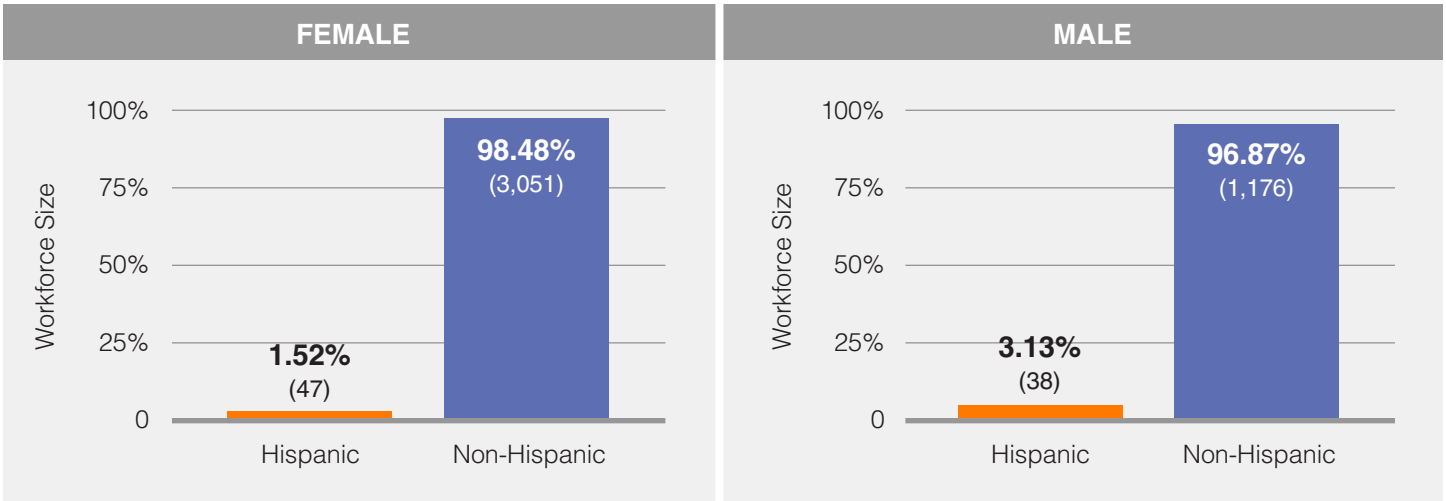
Counts and Percentages



CDP Board Demographic Data

FIGURE 39:

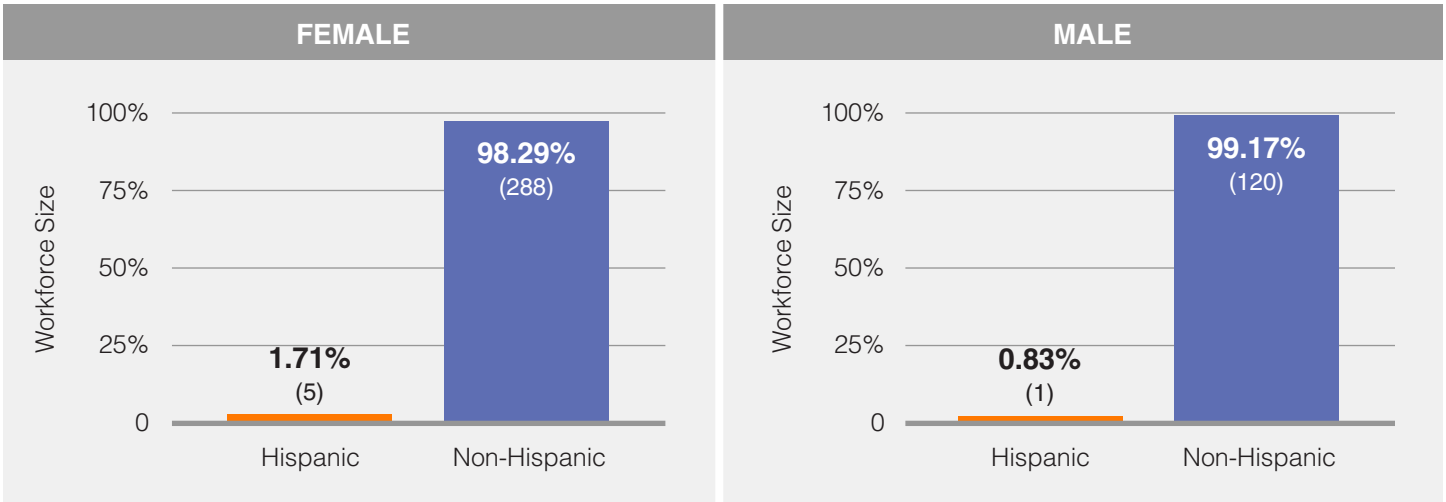
Chemical Dependency Professional Assistant by Hispanic Ethnicity & Gender | Counts and Percentages



CDP Board Demographic Data

FIGURE 40: Licensed Chemical Dependency Professional Counselor II by Hispanic Ethnicity & Gender

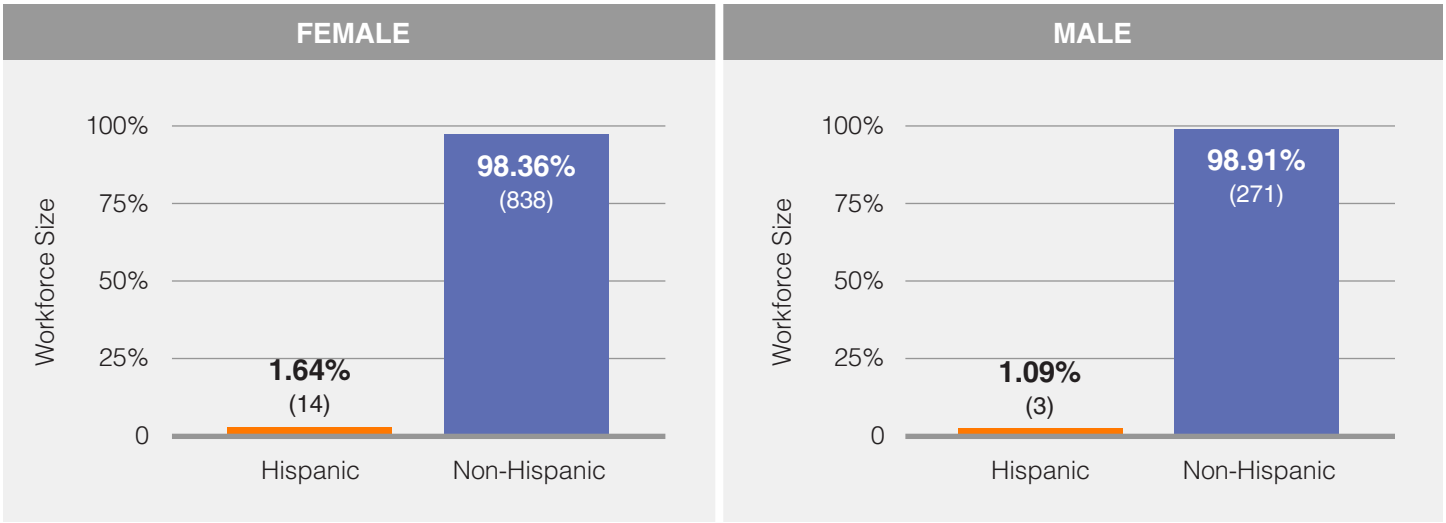
Counts and Percentages



CDP Board Demographic Data

FIGURE 41: Licensed Chemical Dependency Professional Counselor III by Hispanic Ethnicity & Gender

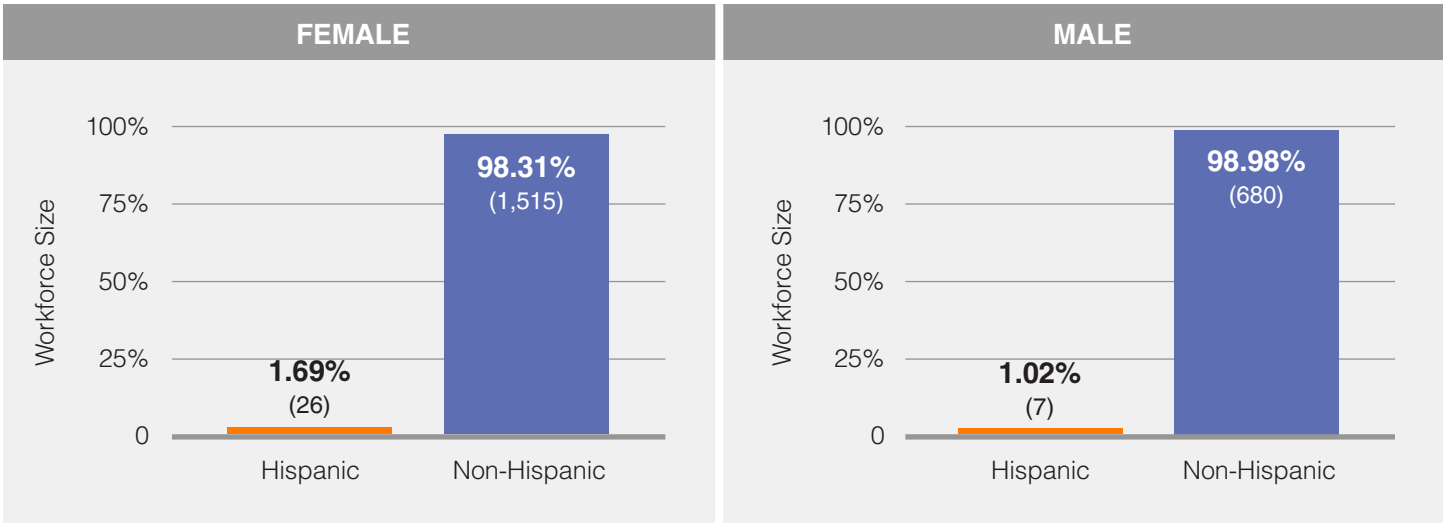
Counts and Percentages



CDP Board Demographic Data

FIGURE 42: Licensed Independent Chemical Dependency Counselor by Hispanic Ethnicity & Gender

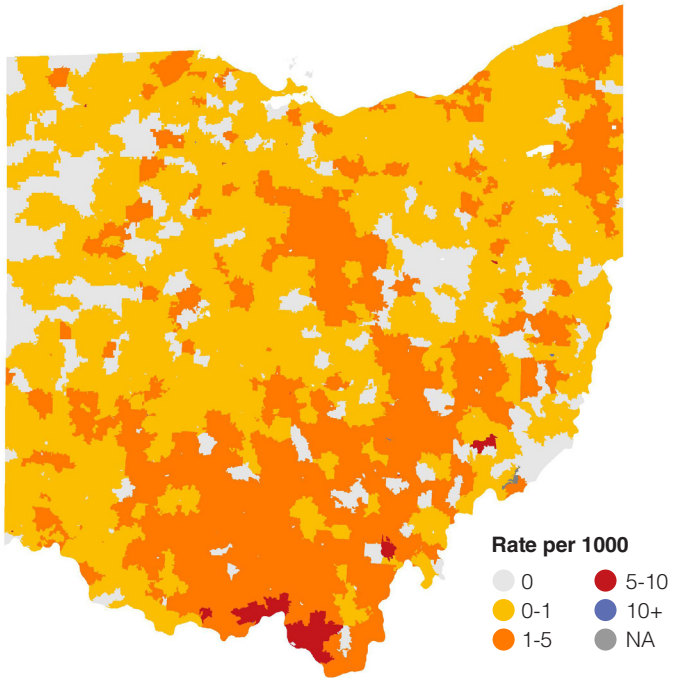
Counts and Percentages



CDP Board Demographic Data

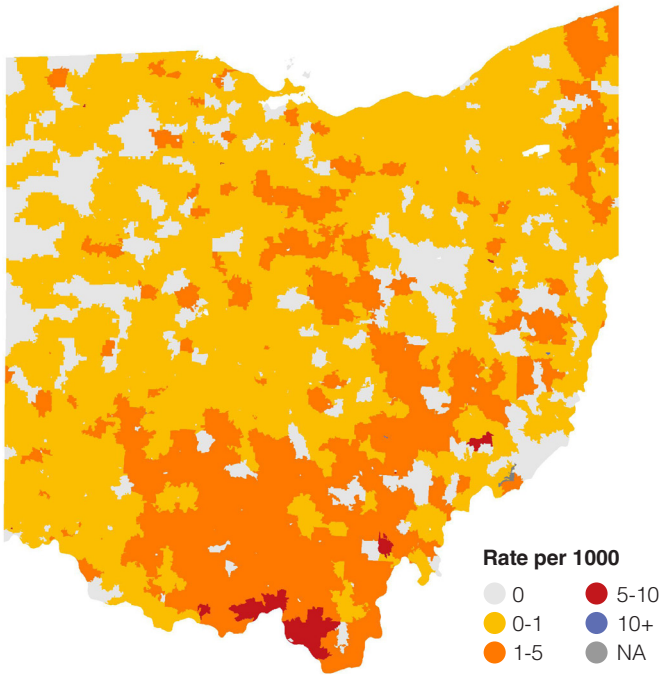
Unlike other behavioral health professionals, CDPs are largely concentrated outside of major metropolitan areas and White CDPs, in particular, are clustered more heavily in the southern part of the state (Figure 43, 44), potentially as a response to the greater overdose mortality rate in Appalachian Ohio.[23] Nearly a quarter of ZIP Codes across the state do not have access to a CDP with large gaps seen in Northern Ohio. Figures 45-47 demonstrate racial and ethnic diversity in the CDP workforce across the state. Black CDPs are more often located in Cleveland, Columbus, and Cincinnati than their White counterparts (Figure 44, 45). Hispanic and CDPs identifying as Other are distributed more evenly across the state and in both urban and rural communities (Figures 46-47).

FIGURE 43: Chemical Dependency Professional Workforce (All Races) | per 1000 ZIP Code Population



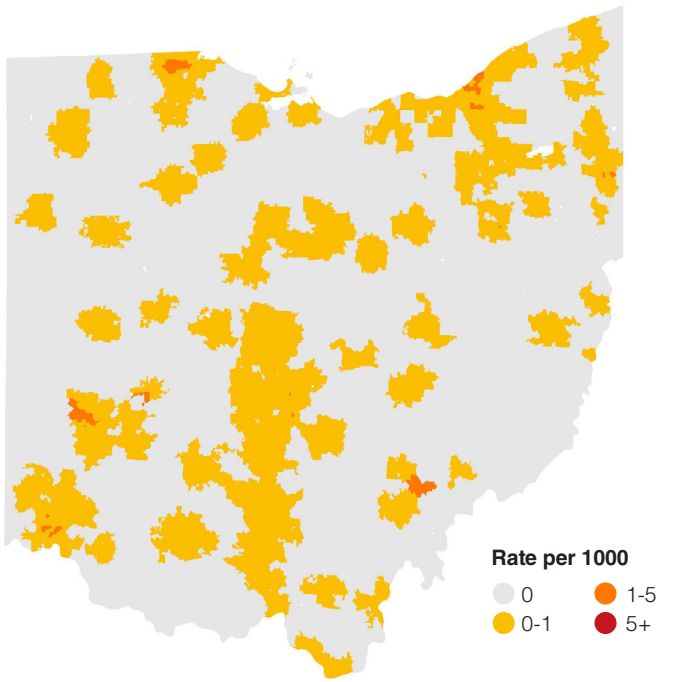
Data Source: CDP Board & Census 2020

FIGURE 44: White Chemical Dependency Professional Workforce | per 1000 ZIP Code Population



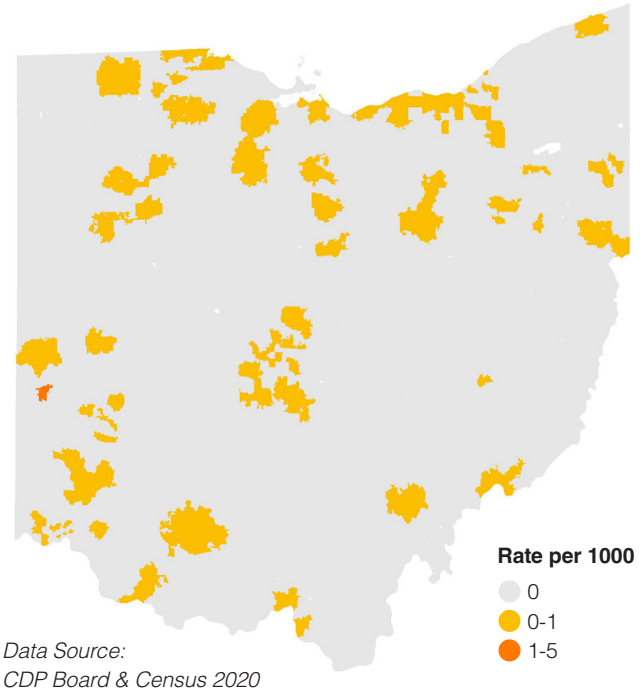
Data Source: CDP Board & Census 2020

FIGURE 45: Black Chemical Dependency Professional Workforce | per 1000 ZIP Code Population



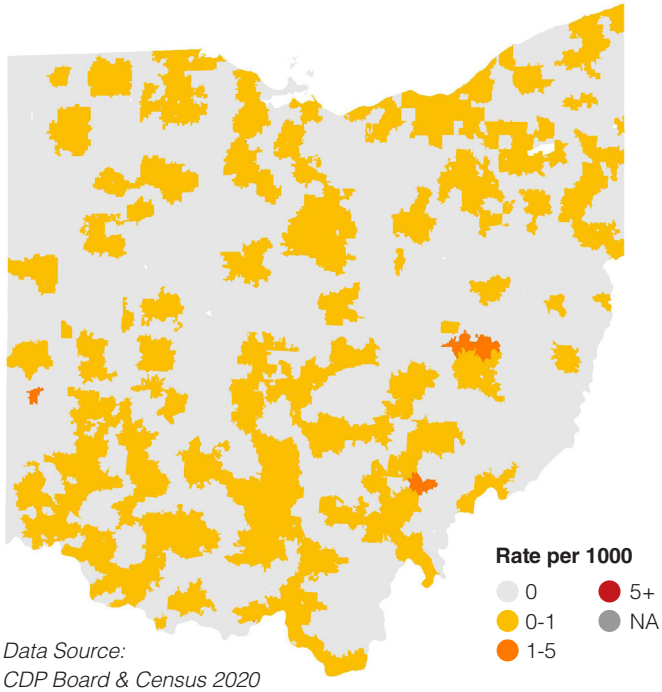
Data Source: CDP Board & Census 2020

FIGURE 46: Hispanic Chemical Dependency Professional Workforce | per 1000 ZIP Code Population



Data Source:
CDP Board & Census 2020

FIGURE 47: Chemical Dependency Professional Workforce (Other Races) | per 1000 ZIP Code Population



Data Source:
CDP Board & Census 2020

Certified Prevention Professionals

Prevention professionals are also credentialed by the CDP Board, but are analyzed separately here to detail the racial, ethnic, and gender demographics of this group. In all, the credential types are: registered applicants (RA), Ohio certified prevention specialists (OCPS), Ohio certified prevention specialist assistants (OCPSA), and Ohio certified prevention consultants (OCPC). Note that data on RAs was not analyzed, though is one of the listed credential types for prevention professionals.

In Ohio there are 641 registered prevention professionals, with OCPSs making up approximately 27%, OCPSAs at 26% and OCPCs at 47% (Figure 48). Approximately 80% are female (Figure 49) and the average age is 48 years old.

Women significantly outnumber men in all prevention professional licensure types. In terms of gender, education, and credentialing requirements, the lowest education requirement, (OCPSA) has more men and women than credential levels with more educational requirements (i.e. OCPS & OCPC) (Figure 49). Among all prevention specialist types, 70% identify as White, 23% identify as Black, and 2.2% identify as Hispanic (Figure 50).

FIGURE 48: Prevention Professionals by Type

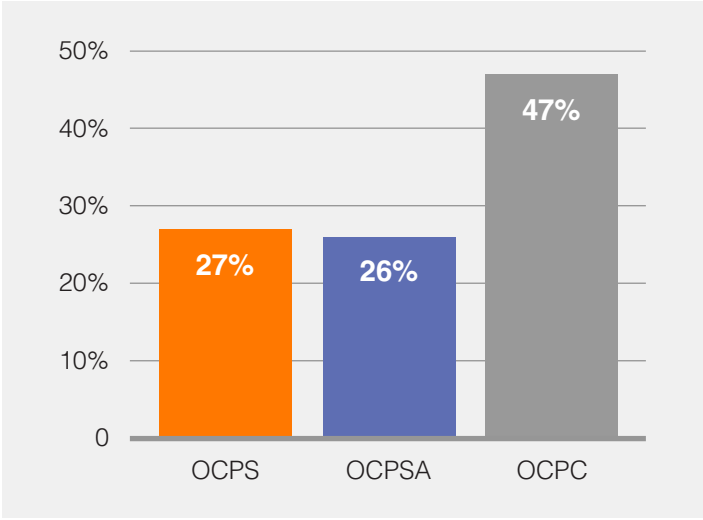


FIGURE 49: Prevention Demographics by Type/Gender
Counts and Percentages

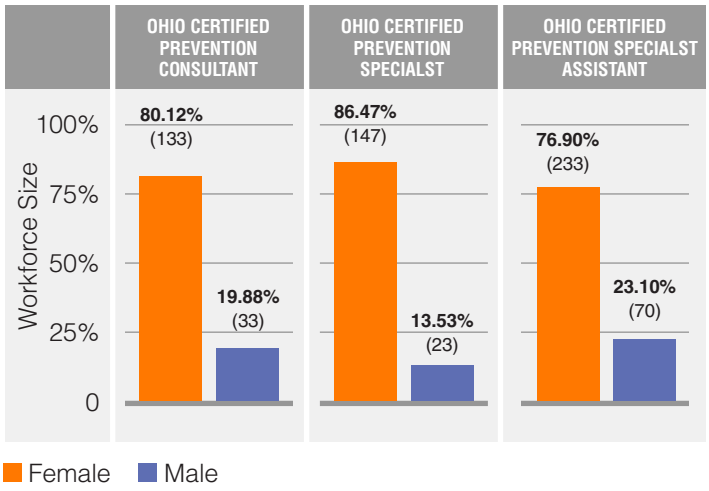
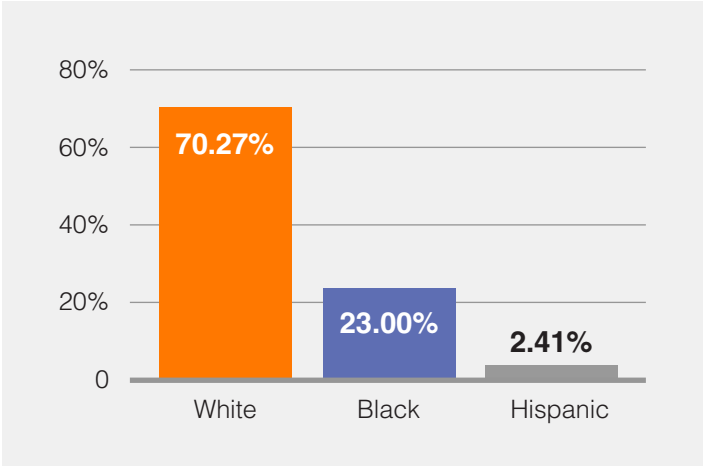


FIGURE 50:
Prevention Professionals by Race & Ethnicity

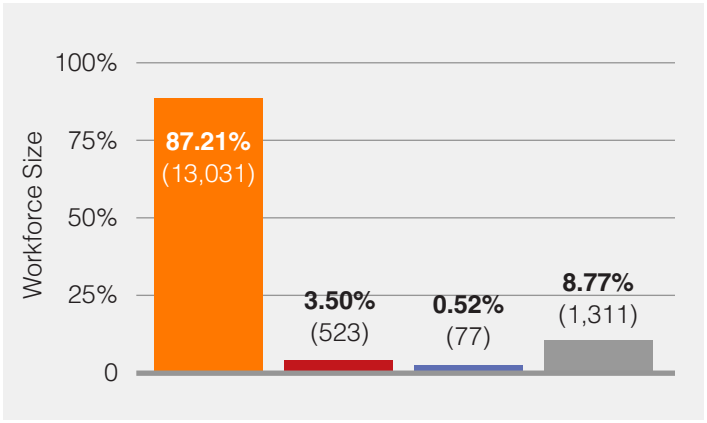


Pharmacists

The vast majority of pharmacists (87.2%) in Ohio are White (Figure 51). Just 3.5% of pharmacists are Black and 0.5% are Hispanic. Females are somewhat overrepresented at nearly 60% of the pharmacist population (Figure 52). Among male pharmacists, fewer identify as Black or Other than their female counterparts (Figure 53).

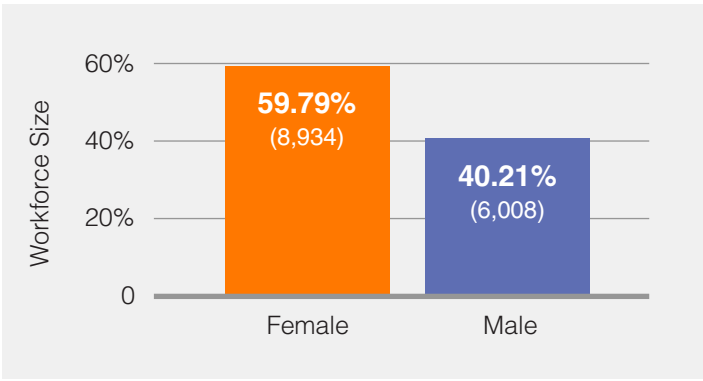
Considering all races, pharmacists are well-represented across the state, but 31% of ZIP Codes still do not have a single pharmacist. Like other behavioral health care professionals, pharmacists are clustered in major metropolitan areas (Figure 54) and this is particularly the case for pharmacists who identify as Black, Hispanic, or Other (Figures 55-57). Similar to workforce findings from other behavioral health professions, rural areas are disproportionately served by White pharmacists (Figure 58).

FIGURE 51: Pharmacists by Race and Ethnicity
Counts and Percentages



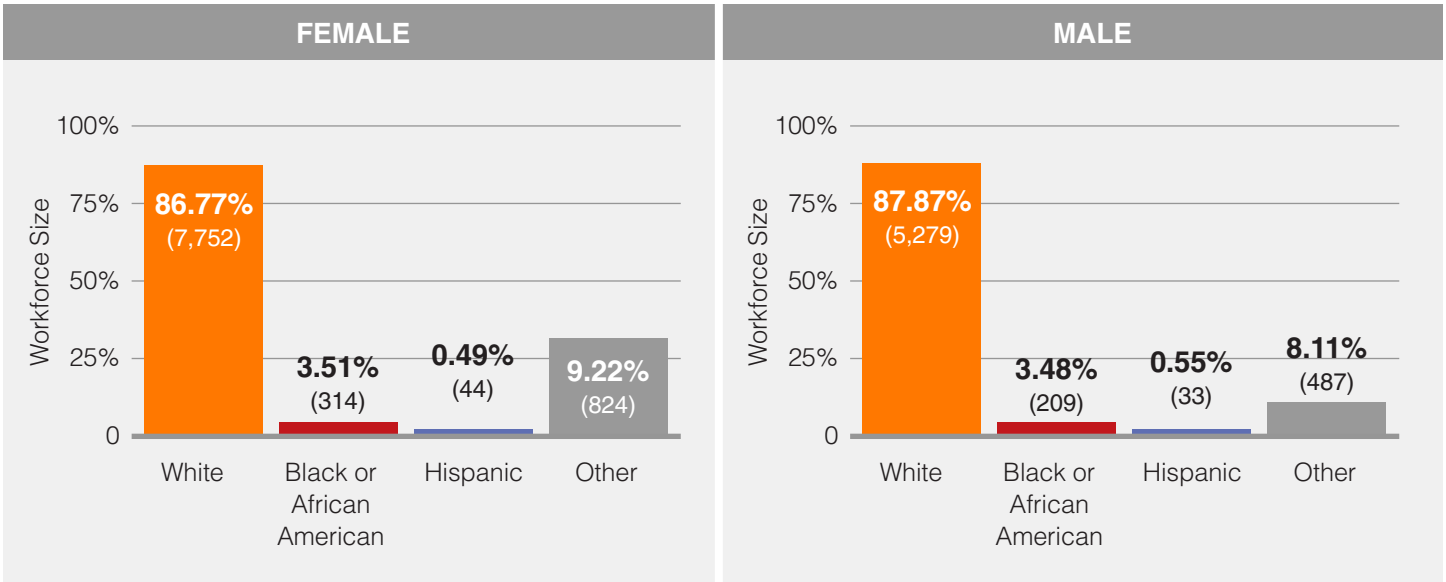
Pharmacy Board Demographic Data

FIGURE 52: Pharmacists by Gender
Counts and Percentages



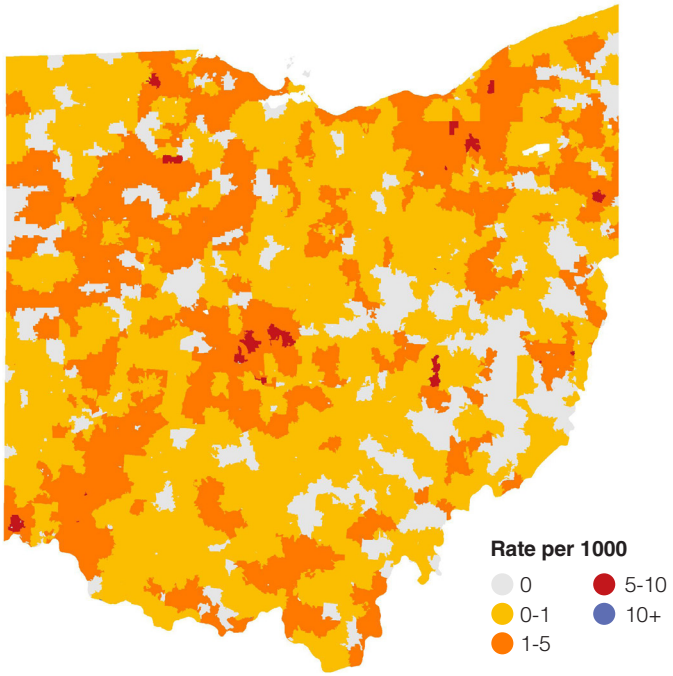
Pharmacy Board Demographic Data

FIGURE 53: Pharmacists by Race & Gender | Percentages within each Gender



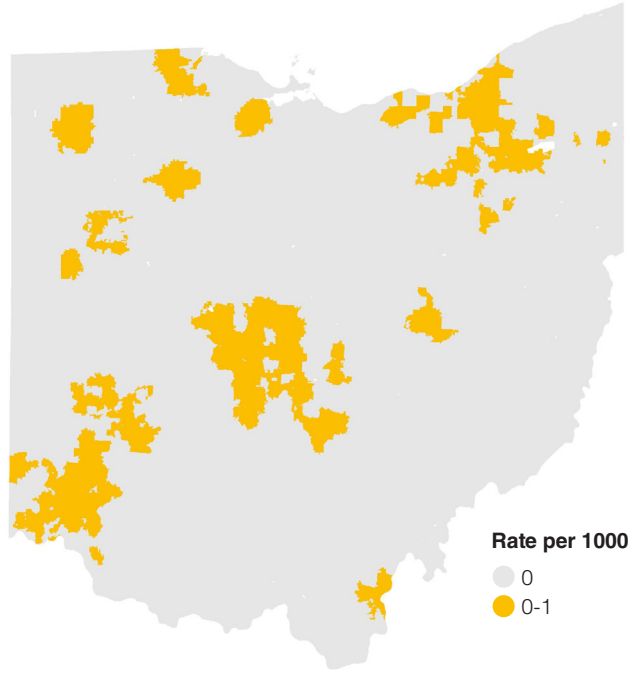
Pharmacy Board Demographic Data

FIGURE 54: Pharmacist Workforce (All Races)
per 1000 ZIP Code Population



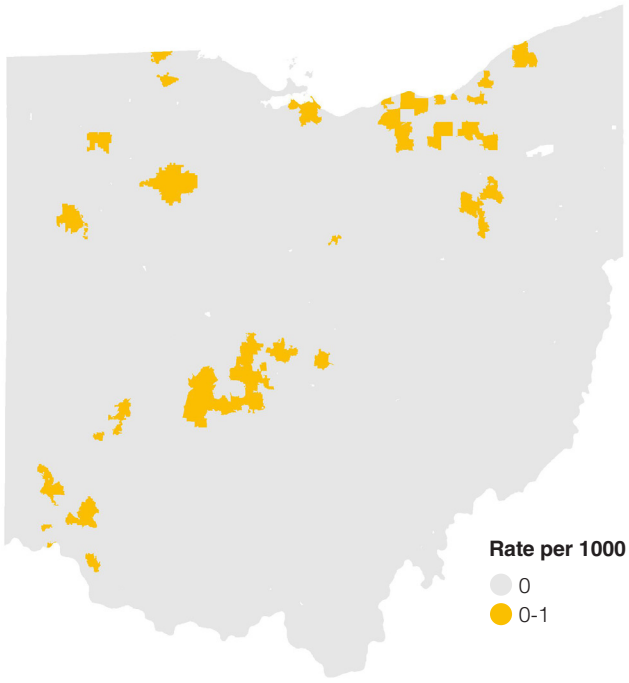
Data Source: Pharmacy Board & Census 2020

FIGURE 55: Black Pharmacist Workforce
per 1000 ZIP Code Population



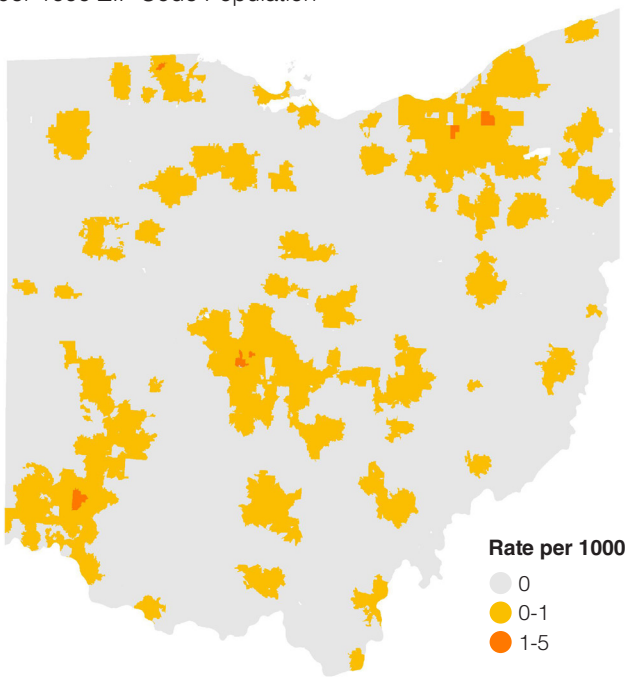
Data Source: Psychology Board & Census 2020

FIGURE 56: Hispanic Pharmacist Workforce
per 1000 ZIP Code Population



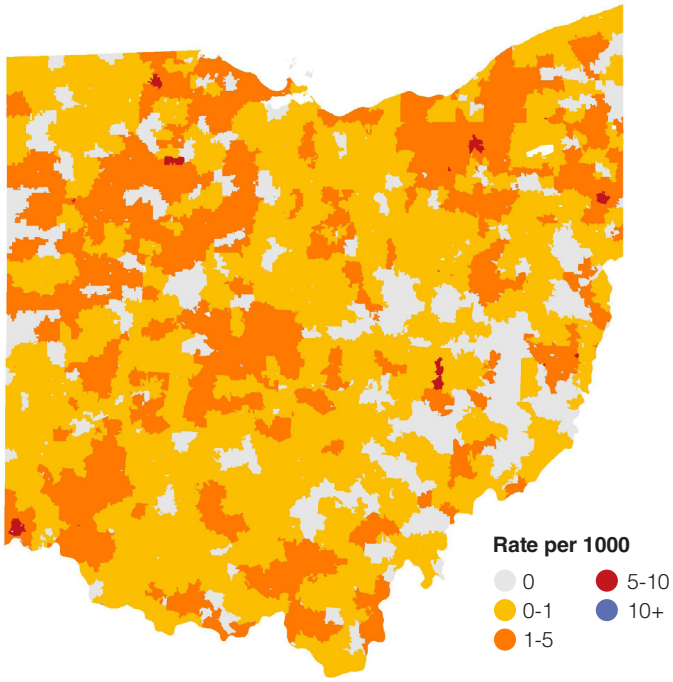
Data Source: Pharmacy Board & Census 2020

FIGURE 57: Pharmacist Workforce (Other Race)
per 1000 ZIP Code Population



Data Source: Pharmacy Board & Census 2020

FIGURE 58: White Pharmacist Workforce
per 1000 ZIP Code Population



Data Source: Psychology Board & Census 2020

Nurses

The Ohio Board of Nursing includes data on a spectrum of nurses, including licensed professional nurses (LPNs), registered nurses (RNs), and advanced practice registered nurses (APRNs) across many specialty areas. This report compares nurses that are most likely to provide behavioral health services (those in family medicine/primary care, pediatrics, and psychiatry) with those not in behavioral health specialties. The majority of behavioral health nurses are White and the behavioral health nursing workforce is disproportionately White among those who have more education and broader scopes of practice (Figure 59). Approximately 77% of behavioral health LPNs are White, while 85% of RNs and APRNs are White. Conversely, while 18% of behavioral health LPNs are Black, just 10% of RNs and APRNs are Black showing that Black Ohioans are underrepresented among advanced levels of behavioral health nurses (Figure 60). Compared to the non-behavioral health nursing workforce, Black

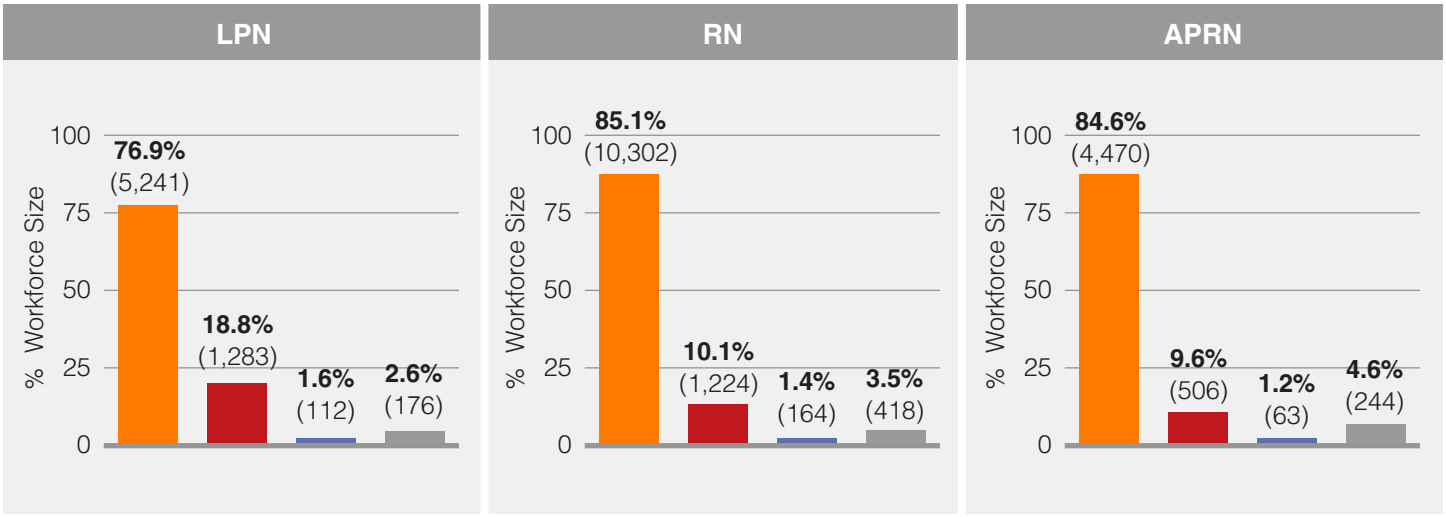
LPNs are somewhat less likely to be represented among behavioral health specialties and more likely to be practicing in a behavioral health field if they are either RNs or APRNs.

Approximately 90% of behavioral health nurses are female. The percentage of female behavioral health nurses, however, declines as level of practice increases (Figure 61). Approximately 92% of behavioral health LPNs are female, while 90% of behavioral health RNs and 89% of APRNs are female. Figure 62 provides the racial and ethnic breakdown of both male and female nurses across different levels of practice. Among female behavioral health LPNs, 18% are Black and less than 2% are Hispanic. Their male counterparts include more Black LPNs at 25% of male LPN population but just 1.5% of male LPNs are Hispanic. At the RN level, nearly 10% of female behavioral health nurses are Black and just over 1% are Hispanic. Among male behavioral health RNs, 13% are Black and just over 2% are Hispanic. Just under 10% of female behavioral health APRNs are Black and 1% are Hispanic. Similarly, just under 10% of male behavioral health APRNs are Black and just over 2% are Hispanic.

Independent of level of practice, the intersection of educational attainment and race among behavioral health nurses was analyzed (Figure 63). Relative to their peers at each education level, Black behavioral health nurses were the most well represented among those with Associate degrees (15%). Just 10% of behavioral health nurses with Bachelor's degrees were Black and 1.5% were Hispanic and these numbers were similar for Black (9%) and Hispanic (1.2%) behavioral nurses earning master's degrees. Seventeen percent of behavioral health nurses holding doctoral degrees were Black, but just 1.5% were Hispanic.

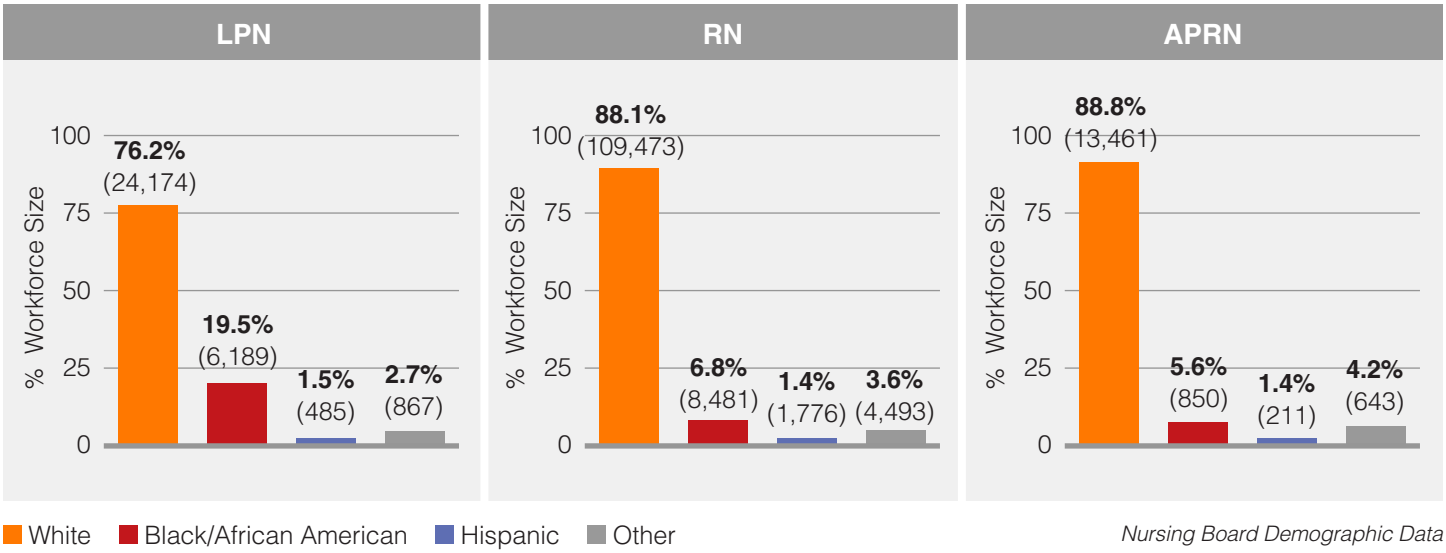
Looking at the geographic distribution across Ohio, behavioral health nurses overall are concentrated outside of major metropolitan areas (Figure 64). Black behavioral health nurses, however, were primarily concentrated in the greater metropolitan areas of Cleveland, Columbus, Cincinnati, and Toledo (Figure 65). There were a comparatively small number of Hispanic behavioral health nurses practicing in Ohio, although they were distributed more evenly across the state instead of being concentrated in metropolitan areas (Figure 66). Behavioral health nurses identifying as neither White, Black, or Hispanic were distributed across the state with additional concentration in major metropolitan areas (Figure 67).

FIGURE 59: Behavioral Health Nurses by Race & Ethnicity | Counts and Percentages



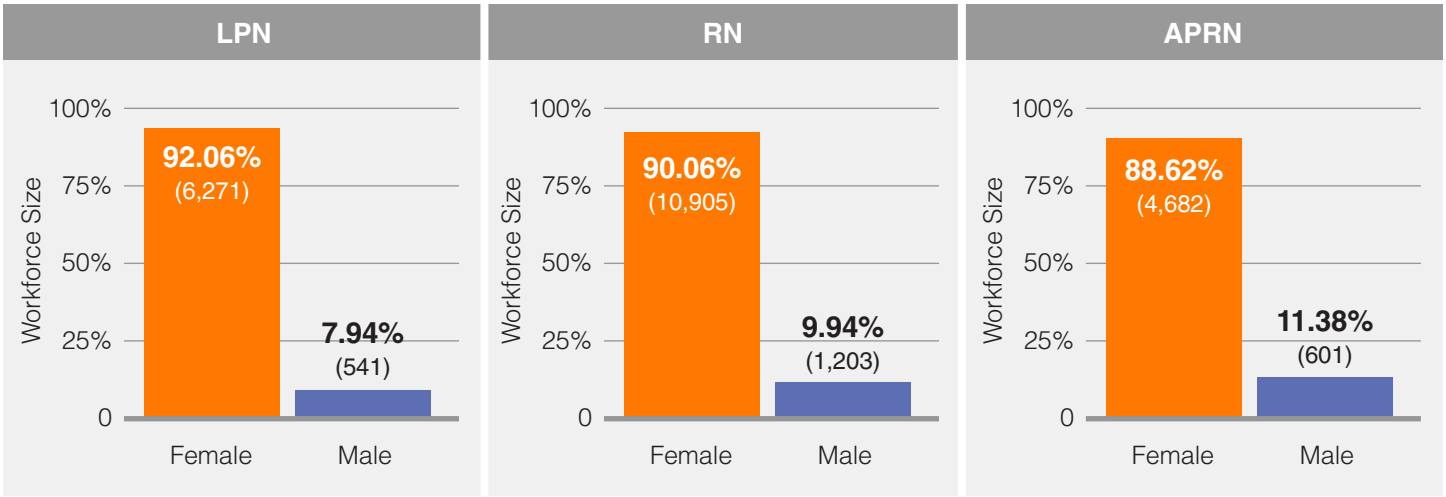
Nursing Board Demographic Data

FIGURE 60: Non-Behavioral Health Nurses by Race & Ethnicity | Counts and Percentages



Nursing Board Demographic Data

FIGURE 61: Behavioral Health Nurses by Gender | Percentages and Counts

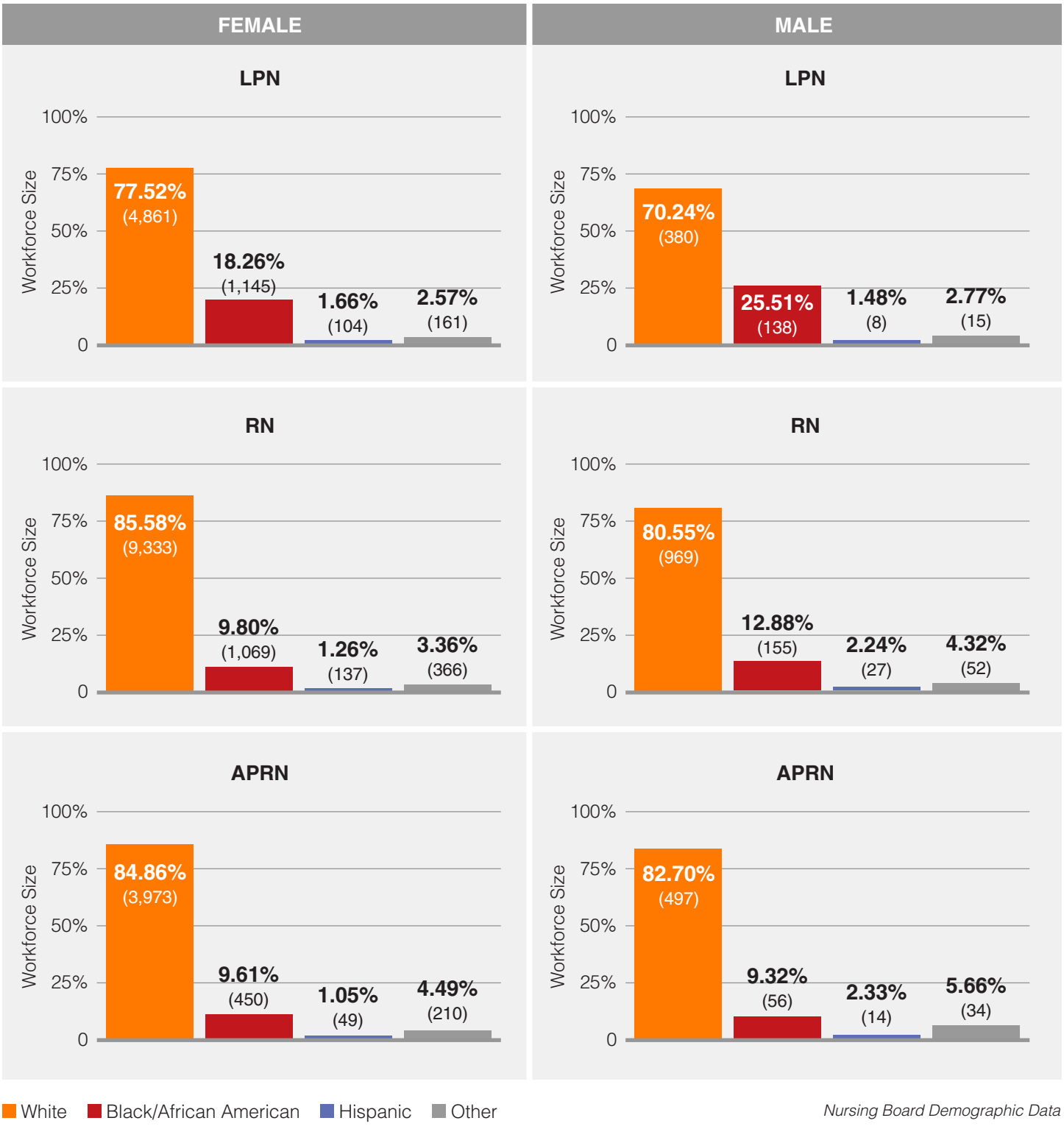


Nursing Board Demographic Data

"Currently there is a significant difference between the number of Ohioans who identify as BIPOC and the number of BIPOC behavioral health providers."

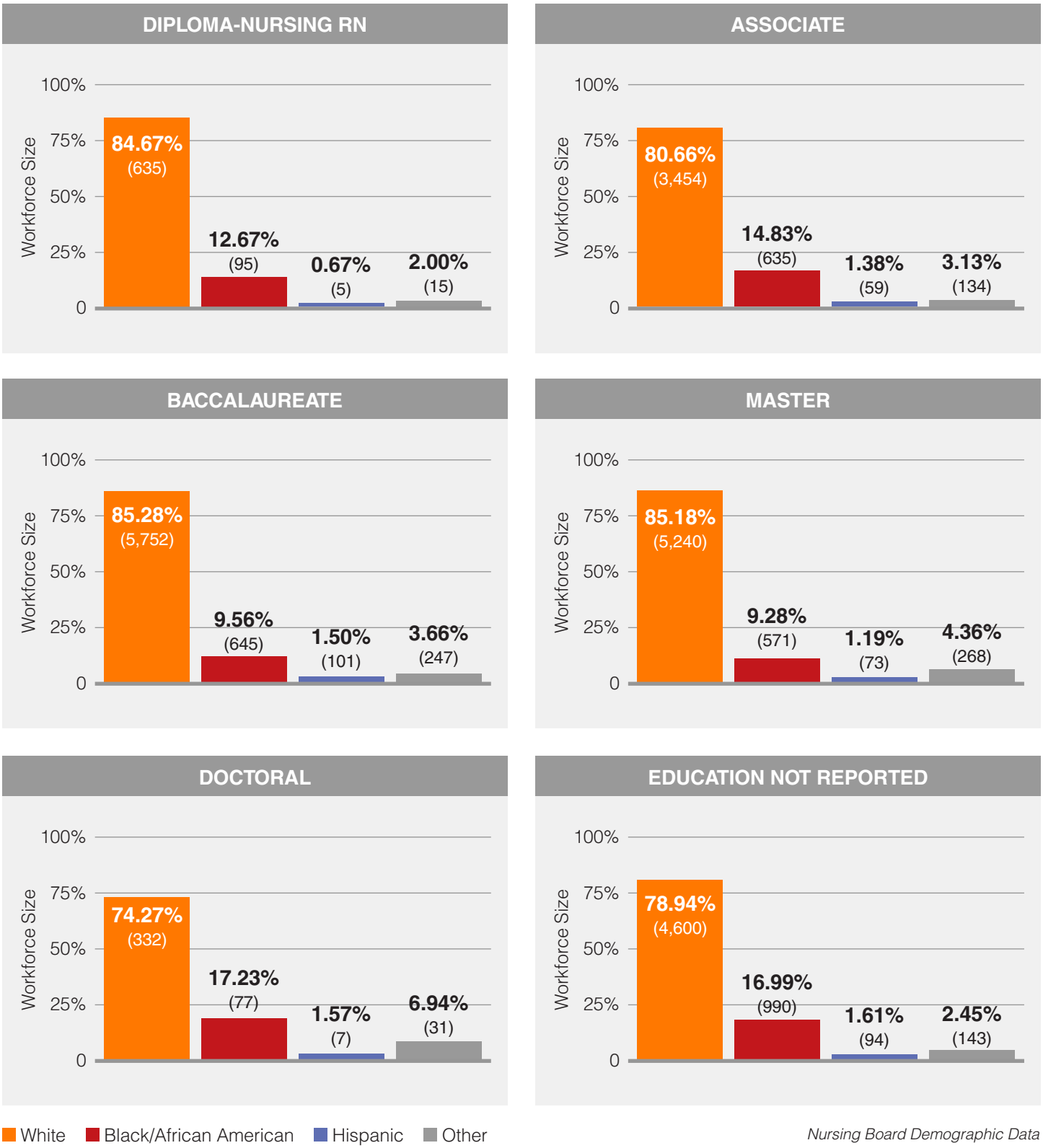
— JOAN ENGLUND, EXECUTIVE DIRECTOR MHAC

FIGURE 62: Behavioral Health Nurses by Gender, Level, Race, and Ethnicity | Percentages within each Gender/Level



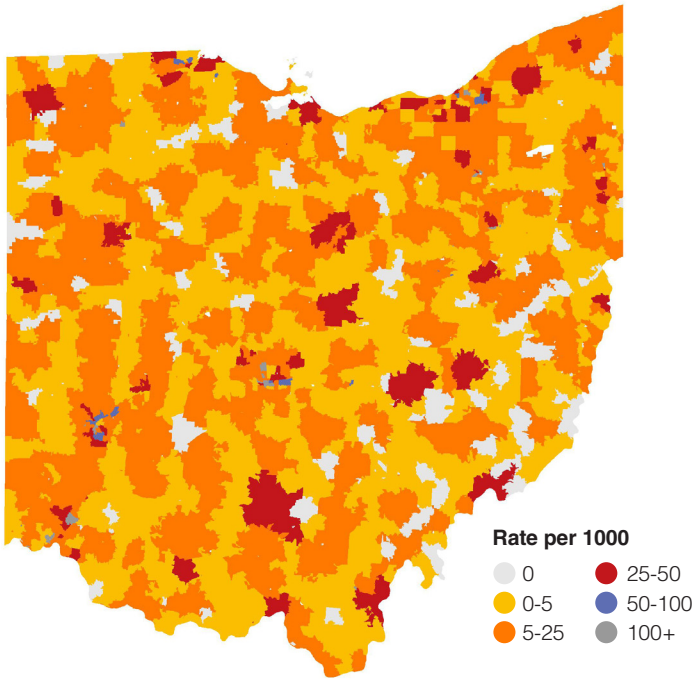
Nursing Board Demographic Data

FIGURE 63: Behavioral Health Nurses by Education, Race, & Ethnicity | Percentages within each Education Category



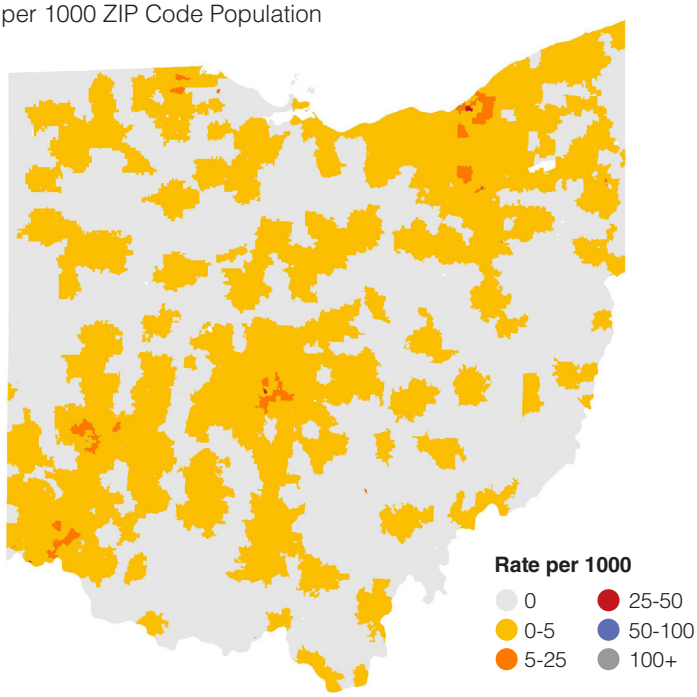
Nursing Board Demographic Data

FIGURE 64: Behavioral Health Nurses (All Races)
per 1000 ZIP Code Population



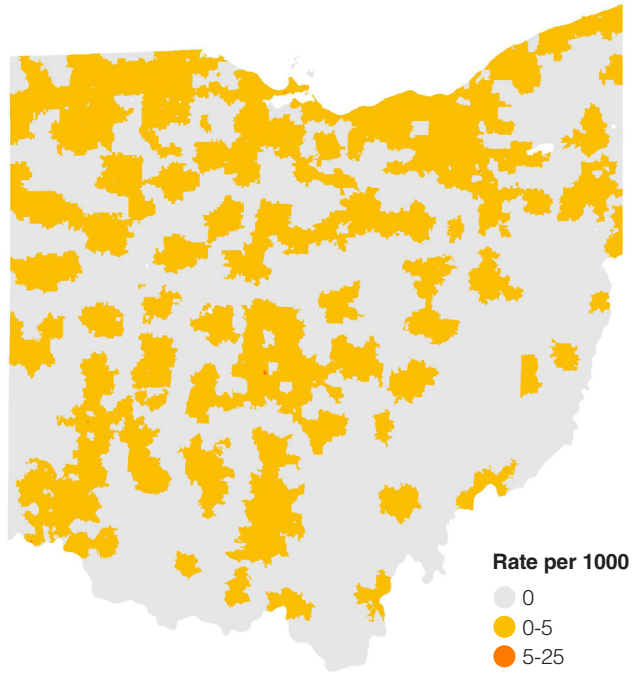
Data Source: Nursing Board & Census 2020

FIGURE 65: Behavioral Health Nurses (Black)
per 1000 ZIP Code Population



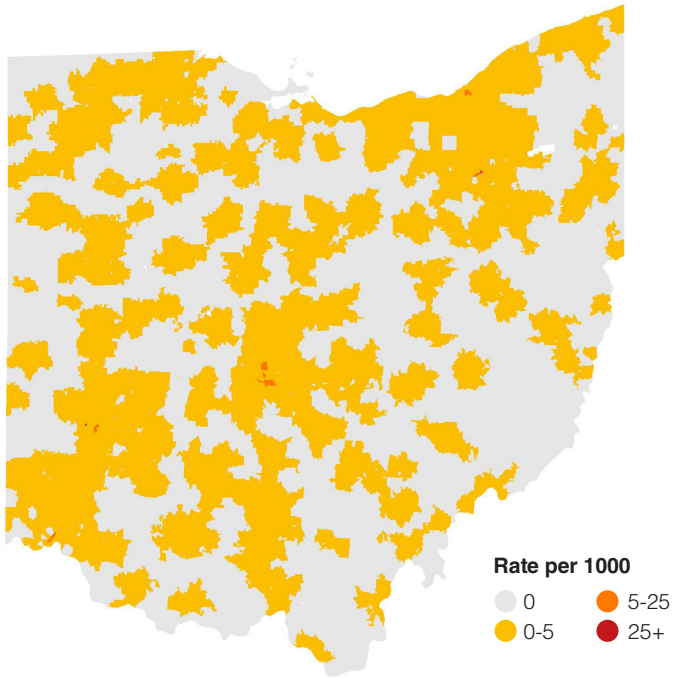
Data Source: Nursing Board & Census 2020

FIGURE 66: Behavioral Health Nurses (Hispanic)
per 1000 ZIP Code Population



Data Source: Nursing Board & Census 2020

FIGURE 67: Behavioral Health Nurses (Other)
per 1000 ZIP Code Population



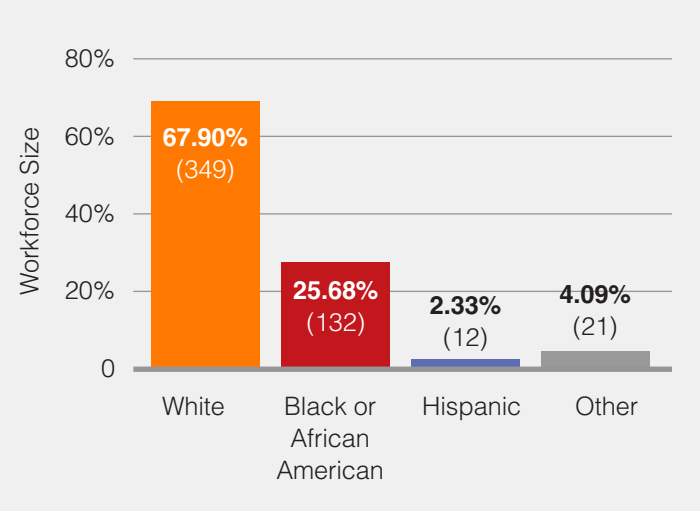
Data Source: Nursing Board & Census 2020

Peer Support Professionals

Peer supporters are certified by OhioMHAS. These professionals utilize lived-experience paired with specialized training to support individuals in recovery. Based on data shared by the OhioMHAS in August 2022, there are approximately 4,375 peer supporters in Ohio. Of these, only 519 records contained peer supporter location by ZIP, race, and ethnicity. As such, only these 519 records are included in this analysis. Of the peer supporters included in this analysis, approximately 68% are White and 25% are Black, with Hispanic and Other, making up 2.3% and 4.1% of this workforce respectively (Figure 68). Relative to the Ohio population, Black peer support specialists are somewhat overrepresented in this workforce while Hispanic professionals are underrepresented.

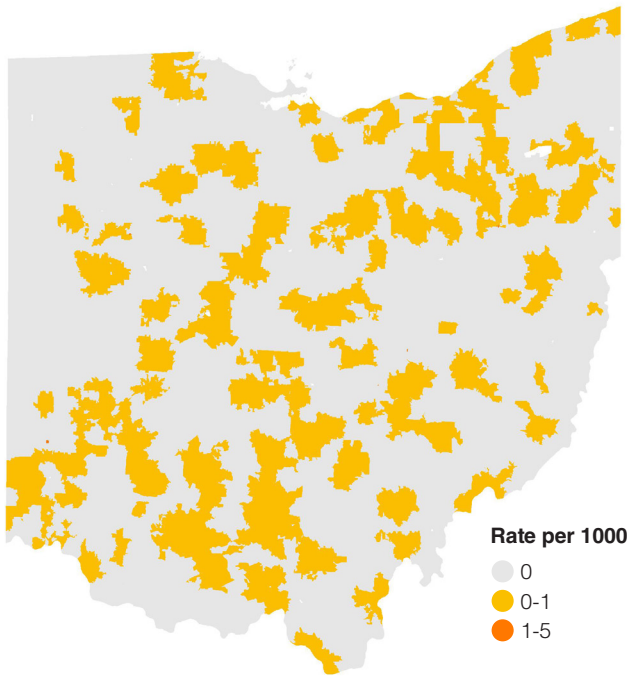
Unlike other behavioral health professionals, peer supporters are represented in many of Ohio's rural counties (Figure 69). Interpret the number of peer supporters in each ZIP code with caution because of the limitations of the dataset. From the data analyzed, White peer supporters, in particular, are located outside of major metropolitan areas (Figure 70). Black, Hispanic, and Other peer supporters are located both in major metropolitan areas and in smaller communities throughout the state (Figures 71-73).

FIGURE 68: Peer Support Professionals Workforce by Race and Ethnicity | Counts and Percentages



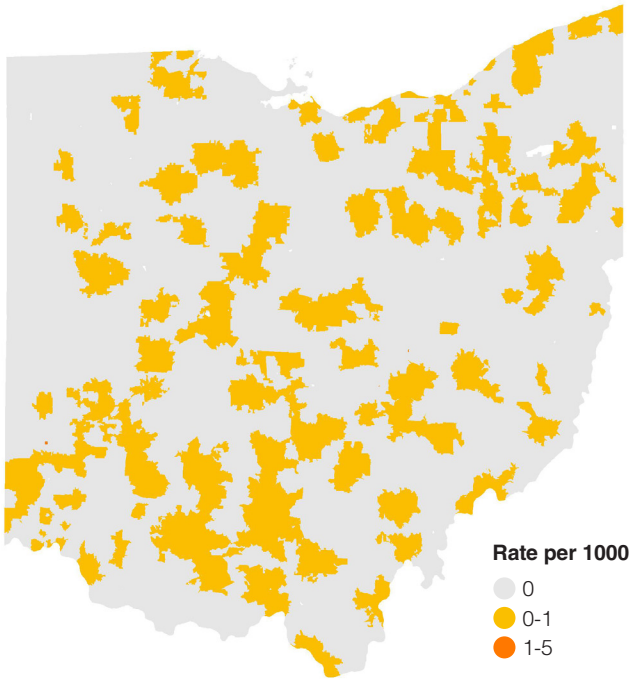
Peer Support Demographic Data

FIGURE 69: Peer Support Professionals (All Races) per 1000 ZIP Code Population



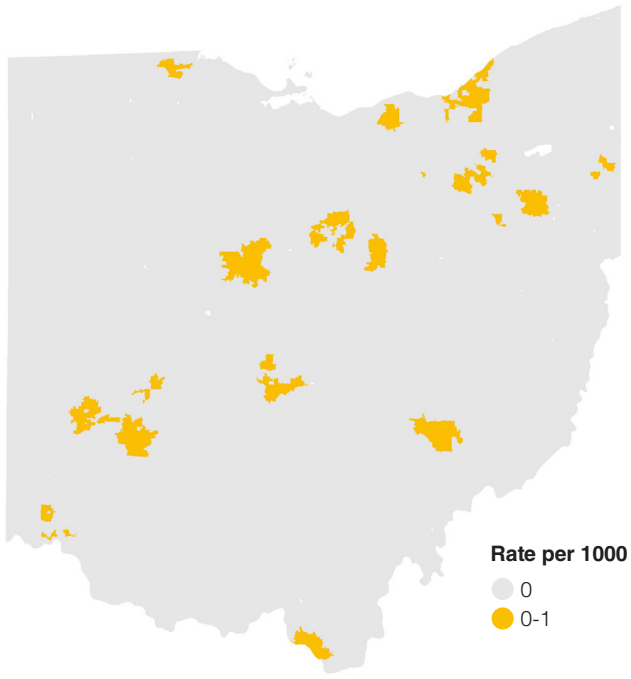
Data Source: Peer Support Board & Census 2020

FIGURE 70: Peer Support Professionals (White)
per 1000 ZIP Code Population



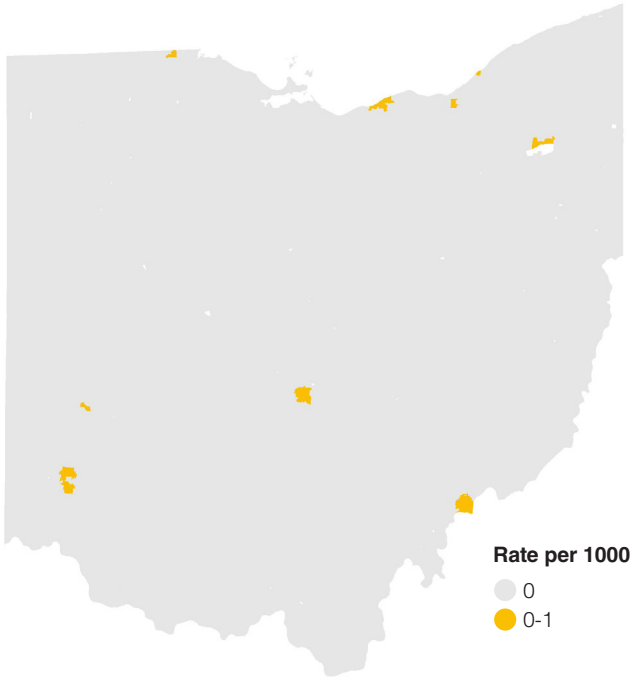
Data Source: Peer Support Board & Census 2020

FIGURE 71: Peer Support Professionals (Black)
per 1000 ZIP Code Population



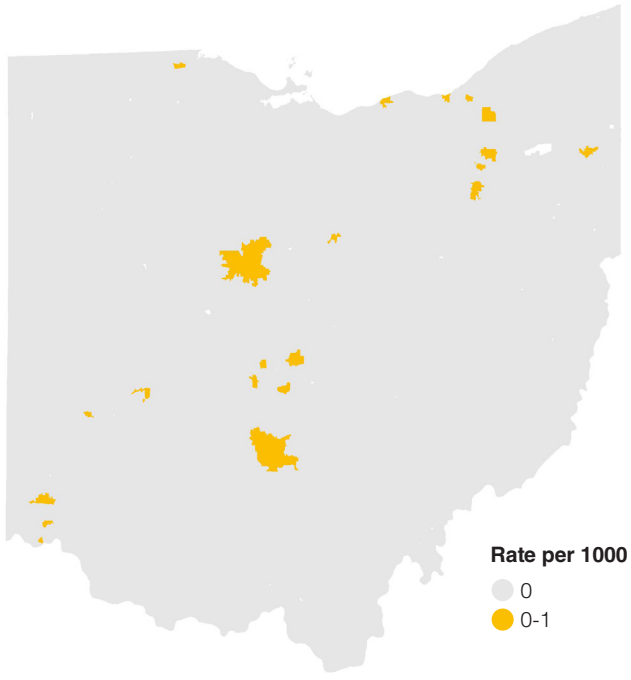
Data Source: Peer Support Board & Census 2020

FIGURE 72: Peer Support Professionals (Hispanic)
per 1000 ZIP Code Population



Data Source: Peer Support Board & Census 2020

FIGURE 73: Peer Support Professionals (Other Races)
per 1000 ZIP Code Population



Data Source: Peer Support Board & Census 2020

Special Analysis: Adult Care Facility Operators (ACFs)

Adult Care Facilities (ACFs) are licensed sites that serve Ohioans aged 18 and above who benefit from a protective level of care. This level of care means that the individual needs less than 24-hour support to prevent harm due to a cognitive impairment, supervision of at least one activity of daily living and/or medication administration, and assistance with at least three instrumental activities of daily living. These sites are licensed as Class 2 Residential Facilities by OhioMHAS and typically house individuals who have a serious mental illness and/or elders with a cognitive impairment. No more than 16 individuals may be served per site. Rooms are typically shared, and three meals and a snack are provided daily. Residents must be willing to accept guidance as appropriate and live in a compatible manner with others in the home. Room and board services are included in a daily rate, and subsidies may be available for eligible individuals. These facilities do not provide clinical treatment and residents have free choice of treatment providers to meet their clinical needs.

As of November 2022, there were 926 Residential Class 2 ACFs licensed in Ohio. The majority of these sites are located in urban areas, with 53.4% of all homes located in Cuyahoga, Franklin, and Hamilton Counties. More than 74% of all ACFs exist within just six counties: Cuyahoga, Franklin, Hamilton, Lucas, Montgomery, and Summit. There are 25 counties that do not have any ACFs (Figure 74).

FIGURE 74
Number of Adult Care Facilities in Ohio Counties

OhioMHAS Licensed Residential Facilities (As of 11/1/22):

Class 2: 926 homes

** There may be some discrepancy and actual numbers of homes may be slightly lower due to Licensure and Certification Tracking System (LACTS) migration.*

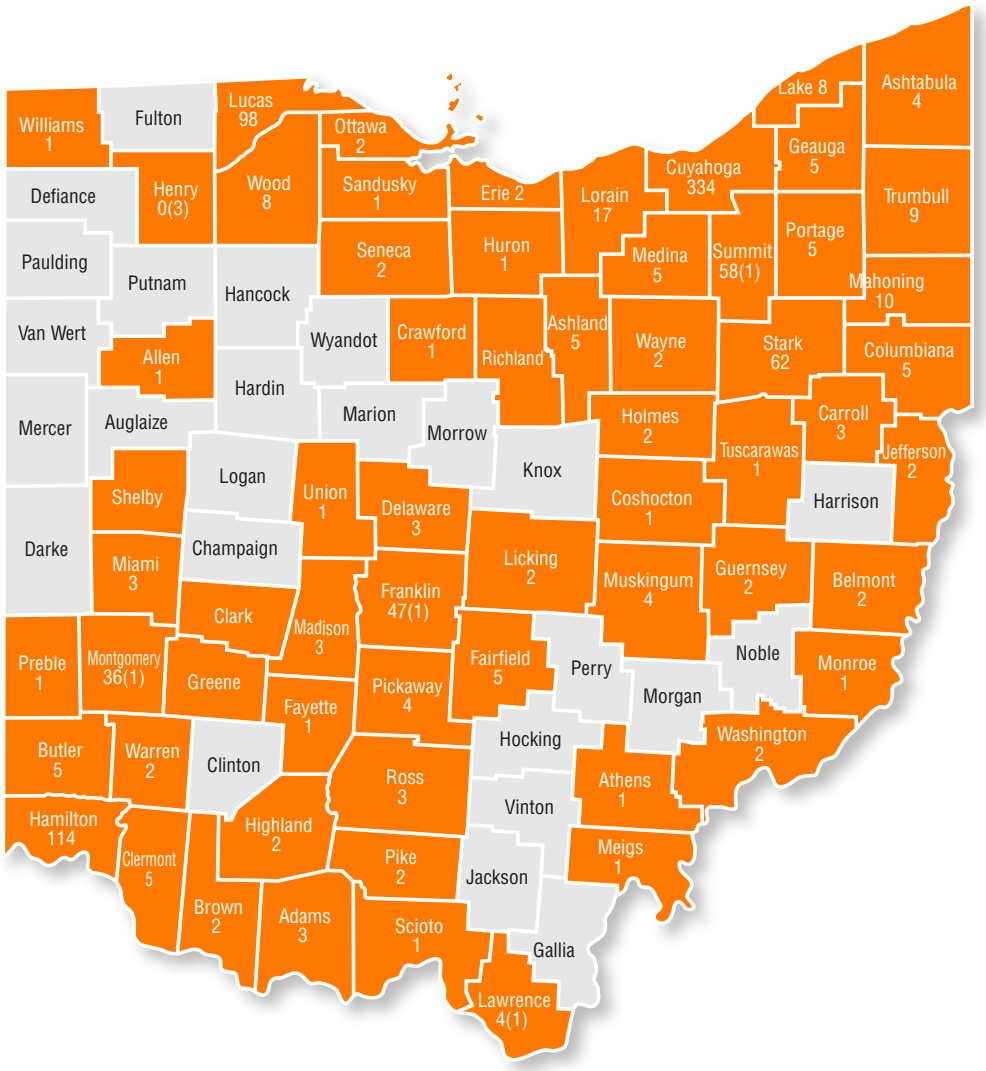
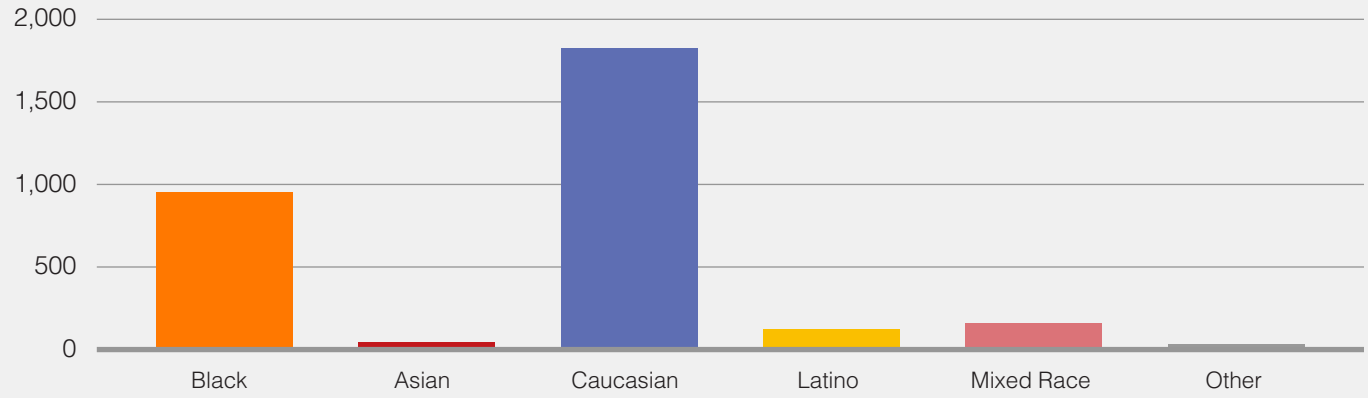


FIGURE 75: Adult Care Facility Client Demographics (2020 NAMI Ohio Survey)



Were it not for the existence of this form of housing support, it is plausible that many ACF residents would be struggling with housing insecurity or outright homelessness, which puts their physical and behavioral health outcomes at further risk.

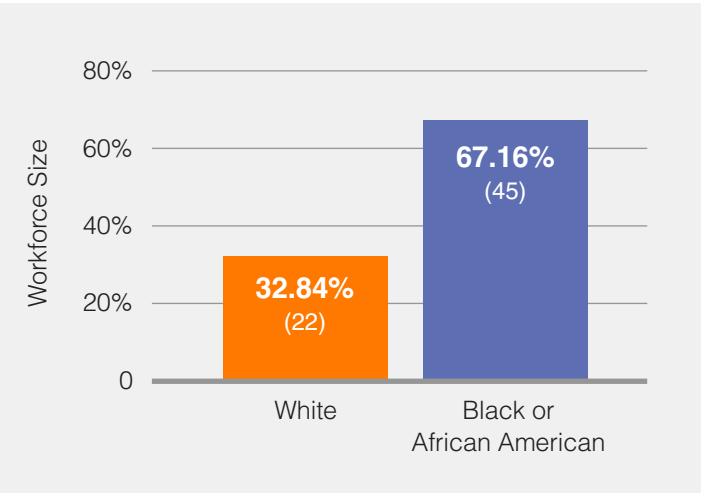
In 2020, the National Alliance on Mental Illness Ohio (NAMI Ohio) conducted an internal survey of Ohio's Adult Care Facilities. At that time, there were 955 licensed ACFs, and survey responses were received from 73% of these facilities (i.e., approximately 550 ACFs.) Among other topics explored, the NAMI Ohio survey posed questions regarding client demographics. Survey responses (Figure 75) indicated that, of clients residing within respondent ACFs, more than 37% were non-White (note that "Caucasian" is the term employed in the NAMI Ohio survey).

Given the relatively high proportion of non-White clients residing in ACFs and the fact that the survey did not include the demographics of ACF operators, ACF operators were included in this research project as a special analysis to discern whether the demographics of ACF providers were more closely aligned with residents' demographics than is the case with licensed clinical professionals and Ohio's non-White population.

With the support of the Ohio Adult Care Facility Association (which is housed at NAMI Ohio), the research team surveyed ACF operators to learn more about the operators' demographic data, with 67 operator participants providing data to a statewide survey. Approximately 33% of respondent ACF operators are White, with the remaining 67% identifying as Black or African American (Figure 76). For ethnicity, approximately 42% report African origin, 32% report other ethnic origin, and 24% report non-Hispanic origin. Just 1 participant, or 1.6% of respondents, reported Hispanic origin (Figure 77).

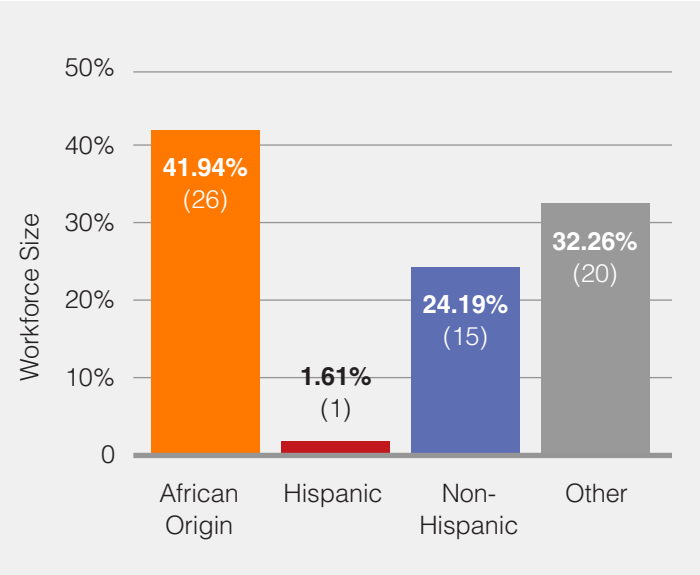
Nearly 80% of ACF operator participants identified as female (Figure 78). Black ACF operators are more often female as compared to their White counterparts (Figure 79). The average age range of respondent operators was between 56 and 65 years old. ■

FIGURE 76: Adult Care Facility Operator Data by Race | Counts and Percentages



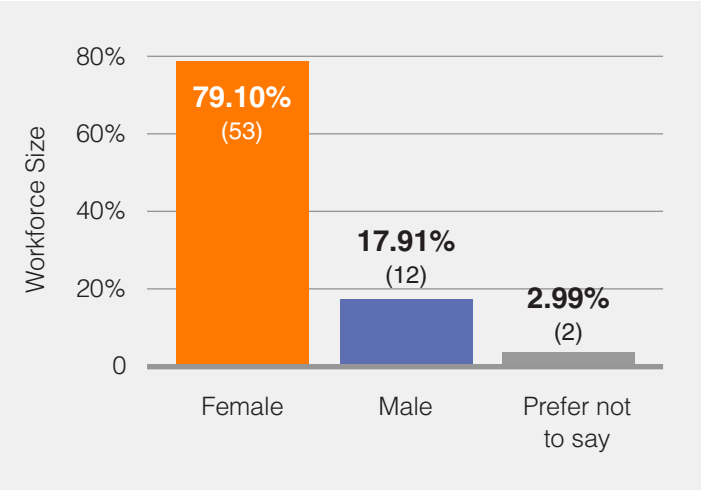
Survey and Analysis Conducted by Report Research Team

FIGURE 77: Adult Care Facility Operator by Ethnicity
Counts and Percentages



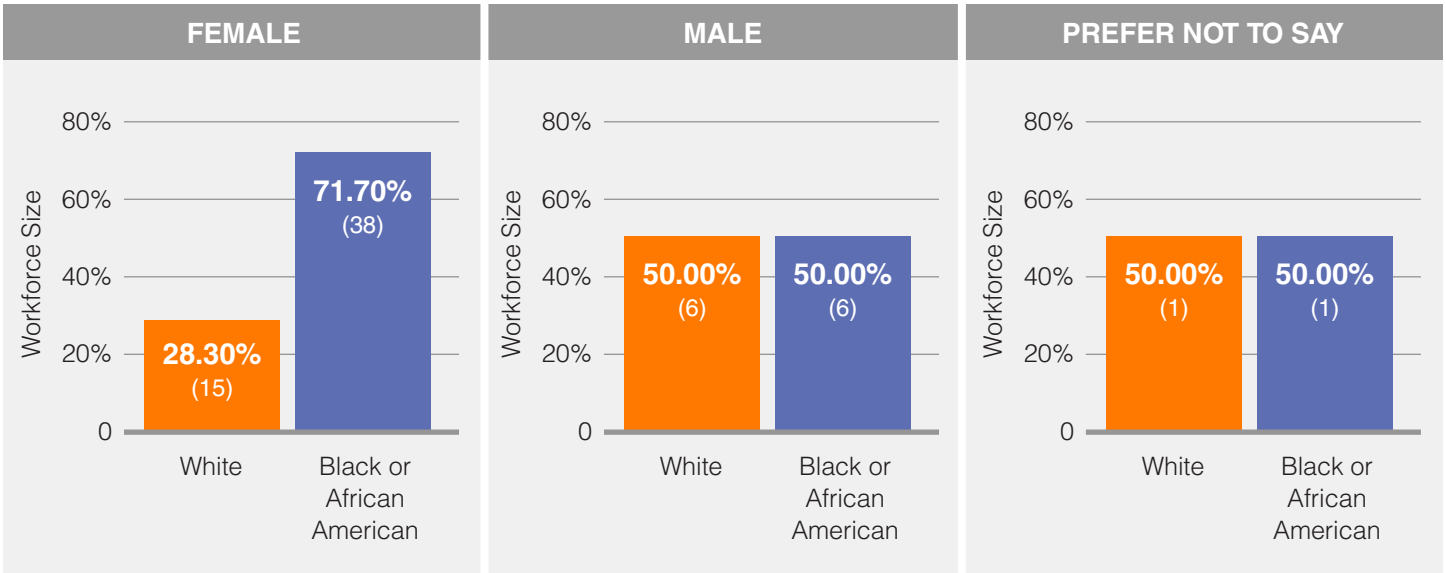
Survey and Analysis Conducted by Report Research Team

FIGURE 78: Adult Care Facility Operator Data by Gender | Counts and Percentages



Survey and Analysis Conducted by Report Research Team

FIGURE 79: Adult Care Facility Operator Data by Race & Gender | Percentages within each Gender



Survey and Analysis Conducted by Report Research Team

Summary of Data Analysis and Limitations

Available data suggest that there are profound disparities in the availability of Black and Hispanic behavioral health professionals. In general, metropolitan areas of the state are better served, as are university towns. These findings indicate that rural Ohioans of color may face the most limited access to behavioral health care professionals, particularly to those who share a similar racial and ethnic identity.

Racial and ethnic diversity in the behavioral health care workforce varies depending on the level of education required. For example, Black professionals are highly concentrated among counselors and social workers and chemical dependency professionals with lower educational attainment. These findings suggest that systemic biases in education as well as interpersonal bias in admissions processes may play a role in racial and ethnic representation in the behavioral health workforce.[25]

Considerable variation also exists regarding racial and ethnic representation among behavioral health professionals. Black professionals are better represented among chemical dependency providers and peer support specialists but critically underrepresented in several professions including psychologists, physicians, and pharmacists. Hispanic Ohioans are underrepresented across all behavioral health professions with more substantial gaps among pharmacists, chemical dependency professionals, and physicians.

The languages spoken by providers data indicate that patients who do not speak English are unlikely to find a service provider who can speak their language regardless of provider type. The only non-English language reported for any service providers type was Spanish. Further, many professional types had a significant amount of missing language data. A summary of languages spoken data are available in Table 2. The geographic information provided in this report illustrates the discrepancy between the location of providers of color and the people of color who need behavioral health services. Geographic data provides information that can help those seeking to improve racial and ethnic diversity in the behavioral health workforce by illustrating areas of greatest need. Further, the data presented in this report are useful for determining where and for whom cultural competency training and other education around the social determinants of health are needed.

The limitations of this report's analysis include the difficulty of comparing racial and ethnic demographic data across different licensure and professional types and the inability to enumerate the specific identities of individuals from some racial and ethnic categories such as Hispanic and Asian.

Comparison is difficult because each board or professional group collects race and ethnicity data differently, using a variety of terminology. For example, some use the term White, while others use Caucasian. For ethnicity, there is typically only the choice of Hispanic, though sometimes the term Latino is used. Neither of these terms differentiates important distinctions in national or regional identities. Further, the vast array of identities labeled as Other become undifferentiated, leaving many individuals, including those that are multi-racial, unrepresented in this report.

For Asian groups, a lack of specificity is especially limiting, as these populations can include individuals from many different regions (i.e., East Asian, Southeast Asian, & Central Asian). Beyond regional differences, Asian populations have national and sub-national identities that are relevant to the quality of provider/patient relationships. ■

Recommendations

Improving the lack of diversity in the behavioral health workforce and its negative impact on racial and ethnic equity requires coordinated, data-driven, and equity-informed action. The following recommendations are presented based on the findings from the present research report as well as reports and recommendations developed by other stakeholders (i.e., OhioMHAS's Disparities and Cultural Competence (DACC) Advisory Committee).[26]

There are six areas where action is needed, including:

1. **Improve engagement of BIPOC communities in planning and decision-making.**
2. **Collect and use data to understand behavioral health workforce needs related to race and ethnicity.**
3. **Conduct statewide workforce planning and programming in a way that facilitates diversity, equity, and inclusion in behavioral health.**
4. **Improve recruitment, retention, and advancement of BIPOC professionals by creating a more culturally inclusive workplace.**
5. **Align behavioral health workforce efforts across state agencies and all other relevant partners.**
6. **Establish a pipeline for future BIPOC workers.**

Table 3 includes the six action areas as well as additional details or action steps about how to carry out the recommendations. Further, the organizations or individuals responsible for implementing the recommendations are listed. Report 1 of this series includes a recommendation to form a statewide task force to improve racial and ethnic equity in behavioral health. As a placeholder, the acronym REETF, or Racial & Ethnic Equity Task Force, is used to indicate actions this task force will complete.

TABLE 3: Recommendations for Improving Racial and Ethnic Equity in Ohio's Behavioral Health Workforce

RECOMMENDATION 1	Improve engagement of BIPOC communities in planning and decision-making
DETAILS, STEPS, AND/OR ACTIONS	**INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION**
A. Directly involve BIPOC stakeholders in the development of diversity and equity initiatives. 1. Have BIPOC communities identify their spokespeople/representatives.	
B. Engage BIPOC stakeholders to develop community-centered, culturally competent outreach initiatives that ensure representation from consumers of behavioral health services. 1. Take into account barriers to participation for marginalized groups such as education level, literacy rate, housing status, access to technology, time constraints, transportation needs, child care, substance use, psychiatric diagnosis, disability, cost, and any other barriers identified by potential participants. 2. Seek to understand, identify, and implement strategies to reduce stigma and mistrust among BIPOC communities.	Relevant licensing boards, direct service agencies, government officials, university administrators, community leaders, Black professional organizations, and peer support.
C. Educate vulnerable behavioral healthcare consumers (i.e., marginalized groups, people with serious mental illness) on their rights and options. 1. Offer training and conduct outreach where people already congregate - churches, support groups, etc.	Direct service agencies, government agencies, researchers, faith organizations (health ministries), and community groups addressing inclusion, i.e., National Association for the Advancement of Colored People (NAACP).

Continued

TABLE 3 continued

RECOMMENDATION 2	Collect and use data to understand behavioral health workforce needs related to race and ethnicity

DETAILS, STEPS, AND/OR ACTIONS	INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION
A. Standardize data collected across all behavioral health licensing boards. 1. Require the collection of race and ethnicity for licensure. a. Make race and ethnicity two separate questions. b. Make race and ethnicity forced choice questions, but allow selection of multiple answers. Include "prefer not to answer" and "unknown" as choices. 2. Add a question about whether licensees practiced direct care in the last 12 months if not already included. 3. Require reporting of location(s) of practice. 4. Require reporting of provider's specialties. 5. Make language(s) spoken data a forced choice question and enable selection of all that apply. Include a "prefer not to answer" choice. i. Ensure inclusion of American Sign Language (ASL) and population-specific sign languages (e.g., Black American Sign Language).	Relevant licensing boards and organizations in partnership with REETF.
B. Institute board licensing requirement that licensees must update their information by January 1, 2024 and bi-annually thereafter.	
C. Regularly assess progress of recruitment and retention efforts by measuring the extent to which the behavioral health workforce reflects Ohio's racial and ethnic demographics.	
D. Develop systems to improve local level information about behavioral health and racial and ethnic equity. 1. Work with local community organizations and others involved in addressing behavioral health and racial equity to identify what type of data collection systems align with local needs and capacities. a. Engage behavioral health licensing boards for technical assistance if needed. 2. Begin by developing a system for collection of race and ethnicity data on providers and clients served in behavioral health organizations. 3. Share successful data collection models across community organizations through statewide conferences and other forums. 4. Begin compiling and reporting local level data to state licensing boards once local data collection systems are established and refined.	

Continued

TABLE 3 continued

RECOMMENDATION 3	Conduct statewide workforce planning and programming in a way that facilitates diversity, equity, and inclusion in behavioral health

DETAILS, STEPS, AND/OR ACTIONS	INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION
A. Educate the public, employers, school systems, government, health plans, and others about the stigma around behavioral health disorders that creates barriers to workforce development.	Relevant licensing boards, behavioral health organizations, state government agencies, and Ohio General Assembly, in partnership with REETF, media, professional associations, and higher education.
B. Educate systems that overlap with behavioral health, especially other health care providers, such as primary care, on basic behavioral health and cultural competency to build awareness of how other sectors can improve and bridge access to behavioral health services through trainings such as Behavioral Health 101 or Mental Health First Aid.	
C. Evaluate the local and statewide behavioral health continuum of care for workforce implications. 1. Identify the role of each type of care delivery organization in the continuum of care. 2. Identify where the system has been impacted by workforce shortages. 3. Use the evaluation findings to create an overarching state and specific local plans to address the identified systemic issues.	
D. Expand OhioMHAS and ODHE workforce efforts by providing additional financial resources and incentives for both behavioral health providers and higher education institutions to increase education and training. 1. Identify non-workforce specific funds from other state agencies that could supplement funds used to address racial and ethnic equity in the behavioral health workforce. 2. Review State Workforce Innovation Opportunity Act plans that offer policymakers opportunities to integrate diversity initiatives across agencies and programs that support workforce development. 3. Investigate funding opportunities from federal sources and potential legal settlements. 4. Investigate integrated health financial models that could result in more sustainable funding for organizations that provide both behavioral and physical health services as a means for increased financial support of the behavioral health system.	

Continued

TABLE 3 continued

Recommendation 3 Continued	
DETAILS, STEPS, AND/OR ACTIONS	**INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION**
E. Engage with health plans and enforcement authorities regarding behavioral health parity compliance issues, particularly in terms of increasing compensation for behavioral health providers.	Relevant licensing boards, behavioral health organizations, state government agencies, and Ohio General Assembly, in partnership with REETF, media, professional associations, and higher education.
F. Engage behavioral health professionals to identify and find ways to address barriers to licensure, including but not limited to, licensure reciprocity for out-of-state providers and duplicative training requirements for multiple licenses.	
G. Develop and fund programs to increase the diversity of languages spoken by Ohio's workforce.	
H. Develop and fund incumbent worker training programs, scholarships, internships, field placements, and residency positions in behavioral health organizations.	

Continued

TABLE 3 continued

RECOMMENDATION 4	Improve recruitment, retention, and advancement of BIPOC professionals by creating a more culturally inclusive workplace	
	DETAILS, STEPS, AND/OR ACTIONS	**INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION**
	A. Conduct a cultural audit, ideally conducted by someone outside of the organization being audited, to identify whether and how the organization is inclusive for BIPOC staff. 1. Include assessment of leadership styles, organization's stated vision and values, observed employee values and behaviors, procedures and policies, communication styles, workplace environments, reward and recognition programs, and perceptions of organizational identity, including language, symbols, and pictures in the audit. 2. Evaluate traditionally accepted professional tenets of workplace success, such as timeliness, schedules, leadership style, and work style. 3. Center traditionally marginalized voices in assessments and assess hiring, firing, promotion practices, and work culture in real time.	
	B. Use findings from the cultural audit to create plans for improving the culture to support existing and attract new BIPOC staff. 1. Assess progress of cultural improvement efforts by ensuring provider workforce is similar to local area's racial and ethnic demographics.	Behavioral health organizations, REETF, and organizations who provide cultural competence training.
	C. Focus on wellness in the workplace: 1. Adopt flexible scheduling and work hour policies. 2. Ensure sufficient health care coverage so employees can afford behavioral health services. 3. Provide flexible benefit options.	
	D. Establish and fund mentorship programs that pair new BIPOC employees with experienced BIPOC employees. 1. Include effort towards formal and informal mentoring in promotion decisions.	
	E. Recruit and train more Community Health Workers from BIPOC communities. 1. Emphasize recruitment of people who speak languages in addition to English.	

Continued

TABLE 3 continued

Recommendation 4 Continued	
DETAILS, STEPS, AND/OR ACTIONS	**INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION**
F. Mandate Culturally and Linguistically Appropriate Services (CLAS) trainings or continuing education units (CEUs) specific to CLAS. 1. Provide training in workplaces for existing staff. 2. Ensure training for licensing boards and their licensees is ongoing (at least every two years). 3. Collect data on how many behavioral health providers, by race and ethnicity, have completed cultural competence training and/or obtained certification.	Behavioral health organizations, REETF, and organizations who provide cultural competence training.
G. Establish diversity, equity, and inclusion officers within behavioral health organizations.	
H. Examine licensing board policies that prohibit hiring people with criminal histories and make appropriate changes, including not automatically disqualifying applicants with criminal histories.	Relevant licensing boards and REETF.
I. Encourage licensing boards to make written exams available in the language of the test taker.	
J. Develop and fund programs that enable behavioral health organizations to offer opportunities for their BIPOC staff to advance in their careers through additional training and education. 1. Provide financial stipends to behavioral health organizations to enable employees seeking additional education to have reduced work hours. Stipends would cover the cost of paying someone else to cover the work duties of the person pursuing additional education. 2. Provide stipends, tuition reimbursement, and supports to employees. 3. Provide financial support to BIPOC supervisors providing supervision to lower credentialed staff seeking an advanced credential and to the employer.	State agencies, the Ohio General Assembly, and behavioral health organizations.

Continued

TABLE 3 continued

RECOMMENDATION 5	Align behavioral health workforce efforts across state agencies and all other relevant partners
DETAILS, STEPS, AND/OR ACTIONS	**INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION**
A. Align workforce efforts across relevant agencies and identify duplication in workforce initiatives around diversity, equity, and inclusion.	REETF
B. Remain engaged and aware of opportunities related to the Governor's Wellness Workforce Initiative.	
C. Ensure resources are shared across similar initiatives.	REETF, OhioMHAS, Ohio Department of Health, Ohio Department of Higher Education, Ohio Department of Development, Governor's Office of Workforce Transformation, and RecoveryOhio.
D. Develop and disseminate common, no-cost, training resources on behavioral health topics. 1. Promote awareness of existing trainings that are available online.	OhioMHAS
E. Increase wages for community behavioral health staff that are comparable to the same education and provider level as their physical health counterparts. 1. Increase Ohio Medicaid reimbursement rates for community behavioral health services to levels that support treatment agencies' ability to provide and sustain quality services, including the recruitment and retention of a workforce to fully meet the needs of clients with complex behavioral health needs. 2. Advocate for Medicare to reimburse for a full range of community behavioral health services and provide reimbursement for these services at rates that support clinical and operational sustainability. 3. Increase private insurance reimbursement rates to ensure mental health and substance use disorder parity. 4. Require private insurance and health plans to still cover services when those services are provided by professions permitted by Medicaid. 5. Ensure pay equity through employment policies and practices. 6. Develop financial and care delivery models that result in increased revenue to provider organizations.	Ohio Department of Medicaid, Ohio General Assembly, Centers for Medicare and Medicaid Services, state government agencies, health plans, parity enforcement agencies, and behavioral health organizations.

Continued

TABLE 3 continued

RECOMMENDATION 6	Establish a pipeline for future BIPOC workers	
DETAILS, STEPS, AND/OR ACTIONS		**INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION**
A. Implement recommendations in the Governor's Wellness Workforce Initiative including creating and supporting ongoing incentives to recruit, retain, and financially support students with marginalized identities for the duration of their academic and licensure process.		
B. Implement recommendations from the Governor's Wellness Workforce Initiative to create scholarships, paid internships, and tuition reimbursement programs to reduce financial constraints BIPOC communities experience when pursuing behavioral health professions. 1. Help with or fully cover test preparation services and testing costs.		
C. Arrange and finance formal mentorship programs that pair BIPOC professionals working in behavioral health with BIPOC students.		
D. Mandate cultural competency training for faculty, staff, and administrators.		Higher education institutions, Ohio Department of Education, Ohio Department of Higher Education, and relevant licensing boards, and REETF.
E. Include cultural competence curriculum in both undergraduate and graduate coursework requirements.		
F. Focus on diverse student recruitment for behavioral health majors, specifically working towards increasing recruitment of Black and Hispanic providers in the fields of psychology, physicians, and pharmacists. 1. Develop specific recruitment plans directed at recent immigrants. 2. Provide moving expense support for Spanish speakers from other places in the U.S. (i.e., Puerto Rico and Texas) to increase the number of Spanish-speaking providers. 3. Incentivize behavioral health professionals to learn another language.		
G. Offer students field experiences in diverse settings.		
H. Collect from higher education institutions relevant workforce data in terms of racial and ethnic demographics of students enrolled and initiatives to recruit students from BIPOC communities as it relates to their behavioral health education programs.		

Continued

TABLE 3 continued

Recommendation 6 Continued	
DETAILS, STEPS, AND/OR ACTIONS	**INDIVIDUALS OR ORGANIZATIONS RESPONSIBLE FOR IMPLEMENTATION**
I. Establish community college/behavioral health partnerships to credential behavioral health professions in two-year degree programs.	Higher education institutions, Ohio Department of Education, and relevant licensing boards.
J. Develop curriculum to introduce behavioral health to younger students; provide trainings and certifications such as mental health first aid and hold health career education programs (fairs, camps, etc.).	Middle and High Schools
K. Establish stackable certificates and entry level education opportunities as a vehicle for early entry into the field.	Higher education institutions, Ohio Department of Education, and relevant licensing boards.
L. When developing career awareness messaging, reinforce that the value of the behavioral health field as a reputable and valuable health profession that serves people with mental health and/or substance use disorders.	State agencies, higher education institutions, and behavioral health organizations.
M. Invest funds to pay for behavioral health workforce pipeline development programs with the goal of improving racial and ethnic diversity and overall capacity within the field.	State agencies, local government entities, and ADAMH boards.

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Appendix: CLAS Standards

The OMH created the original CLAS standards to provide guidance to providers on effective and culturally appropriate services for diverse populations. The standards are responsive to the practices, needs, and health beliefs of diverse populations. The OMH has mandated that certain services be implemented, ensuring the provision of government funding for these initiatives. Through the website www.thinkculturalhealth.hhs.gov the OMH provides free resources to help providers and organizations learn how to effectively implement the strategies.

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
2. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

1. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

1. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
2. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
3. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
4. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
5. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
6. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
7. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Cultural competence training impacts engagement, diagnosis, treatment and outcomes. It provides the tools to effectively assess a providers service population to identify who they are and where adjustments in standard outreach and treatment protocol are needed – such as language barriers, how do you communicate with a community/an individual, elimination of preconceived/often incorrect assumptions about a community which directly impacts a proper diagnosis, what is that communities cultural relationship with healthcare and the likelihood your standard follow up protocol will be followed. All these are issues that will determine a successful outcome. ■

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