Factors Impacting the Development of a Diverse Behavioral Health Workforce

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KEY FINDINGS

The advantages of a diverse healthcare workforce have been well-documented in the literature. Studies have shown that minority providers are more likely to meet the needs of underserved populations and that a diverse workforce also leads to greater patient satisfaction. However, developing a diverse behavioral health workforce is challenging. The purpose of this study was to identify organizational barriers to recruiting and retaining behavioral health workers representing racial, ethnic, and sexuality minority groups.

A survey completed by 139 underrepresented minority behavioral health providers in Michigan showed that, overall, respondents feel that their organization values and fosters a culture of diversity, equity, and inclusion. Further, 68% of respondents are comfortable reporting discrimination and 74% are comfortable communicating about race and ethnicity at work. Almost three-quarters of employees believe their work is valued by their employer. However, 55% of respondents believe that they have limited opportunity for career advancement, despite over one-third reporting being interested in a leadership position (35%) and three-quarters reporting that they possess the necessary credentials to serve in a leadership role (78%).

Respondents identified the following factors as having the most influence on retention: ability to provide care for the population served by the organization (66%), the organizational mission (49%), and work location (48%); population served (68%) and organizational mission (55%) were also reported as top retention factors, along with job security (56%). Over one-third of respondents indicated that they intend to retire or otherwise leave the behavioral health field within the next five years for reasons that included retirement (51%), interest in other job opportunities (40%), and better income opportunities (39%). Addressing factors limiting recruitment and retention opportunities can benefit workforce capacity.

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BACKGROUND

Studies show that behavioral health workforce capacity could be strengthened by ensuring that health care providers are diverse in race, ethnicity, and other demographic and socioeconomic factors.[1-3] For example, providers who identify as part of a minority group are more likely to meet the service needs of underserved populations, as Black and Hispanic practitioners tend to practice in communities with higher concentrated populations of their respective racial/ethnic group and fewer physicians per capita.[4-6] Further, race and ethnic concordance of behavioral health providers and patients has been correlated with greater patient satisfaction.[4]

In the United States, the racial/ethnic composition of the behavioral health workforce is discordant from the population seeking behavioral health services. According to a 2004 study, non-Hispanic Whites accounted for 76% of all psychiatrists, 95% of psychologists, 85% of social workers, 80% of counselors, 92% of marriage and family therapists, and 90% of psychiatric nurses.[7] However, adults who are most likely to report using mental health services identify as two or more races, followed by whites, American Indians or Alaska Natives, blacks, Hispanics, and Asians.[8] Additionally, members of the LGBTQ community self-report higher mental health service use than their straight counterparts.[9] Identifying strategies for eliminating barriers to diversifying the behavioral health workforce among several provider characteristics may improve care for the diverse populations seeking mental health and substance use disorder prevention and treatment services.

Recruitment and retention of underrepresented minorities into the workforce tends to be a challenge across all health professions[2], but barriers to building a diverse provider workforce may be especially prominent in mental health and substance use disorder treatment settings. Legislative changes such as the Affordable Care Act and the Mental Health Parity Act have resulted in increased demand for services and changes to the health care delivery system. The critical need for more skilled providers, along with common behavioral health workforce development challenges such as high turnover, high workload, lack of sufficient resources, and stigma associated with behavioral health[10], combines to create considerable strain on workforce capacity. The effects of supply and demand imbalance are often exacerbated in rural areas, which are more vulnerable to workforce shortages and unmet service delivery needs.[10,11]

The literature provides some information on workforce development challenges related to improving diversity; however, specific factors have need more exploration. To address this gap in the literature, the Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan School of Public Health conducted a study of behavioral health providers in Michigan to assess work environment factors

that may be impacting the development of a diverse workforce through themes related to recruitment, retention, and job satisfaction. This report summarizes the findings of study participants who identified as part of a racial or ethnic minority group.

METHODS

BHWRC researchers developed a survey instrument from literature reviews and existing health workforce questionnaires. Prior to administering the study, questions were piloted with a subgroup of Consortium members and 30 behavioral health providers who hold National Council for Behavioral Health membership. Pilot test feedback was used to refine the survey.

The 50-question online survey questionnaire was developed in Qualtrics and took approximately 25 minutes to complete. It was organized into the following themes to help researchers better understand the composition of the behavioral health workforce:

- Demographic information
- Educational background
- Workforce setting and occupational role
- Work experience and management responsibilities
- Work environment and job satisfaction
- Recruitment, retention, and promotion factors
- Diversity, equity, and inclusion in the workplace

The study population included 128 member organizations of the Michigan Association of Community Mental Health Boards, which is composed of private and public mental health provider organizations and housing assistance organizations. Organizational representatives were sent a recruitment email with an overview of the BHWRC's research activities, a summary of the study, and an invitation to participate in the interview. Contacts at the organizations were asked to disseminate the survey by email to all employees who met the study's eligibility criteria of providing direct care services for prevention or treatment of mental health or substance use disorders. A $100 gift card raffle was used as a response incentive. We did not collect identifying information from respondents due to the sensitive nature of some survey questions.

Descriptive analyses were conducted with the survey data. We used a broad-based survey design; however, because project aims include developing a better understanding of the behavioral health work environment and factors that may impact the diversity of the workforce, we chose to limit our study

analyses to include individuals who represent racial, ethnic, and sexual minority groups. The University of Michigan Institutional Review Board reviewed the study design and deemed it exempt from ongoing review.

RESULTS

Demographic Summary

A total of 395 respondents completed the survey, 233 of which (59%) met the study criteria. Approximately 59% (n=139) of respondents were direct behavioral health service providers and are included in this analysis. Demographic data show that 66% identified as Black/African American, 5% as American Indian/Alaskan Native, and 5% as Asian, and less than 1% as Native Hawaiian or other Pacific Islander; 24% identified as White or Caucasian in addition to another race. Seven percent identified as having Hispanic/Latino ethnicity. Approximately 6% of those who completed the survey identified as LGBTQ (Table 1). Seventeen percent spoke a language in addition to English, the majority of which reported to be Spanish (n=12) and American Sign Language (n=4). Filipino, Arabic, Chaldean, Hindi-Urdu, German, and Kannada were reported by two or fewer respondents. Nine percent of survey respondents were not born in the United States.

Table 1. Demographic Profile of Survey Respondents

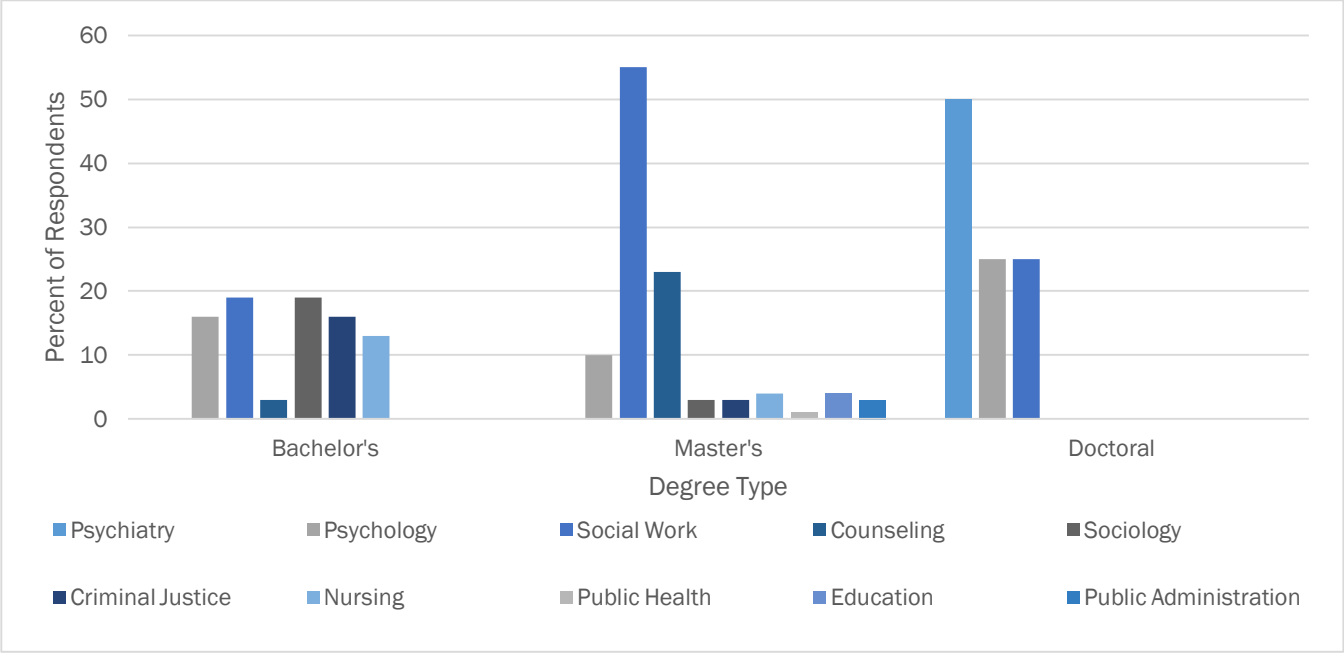
Demographic Characteristic	No.	%
Race/Ethnicity		
Black/African American	86	66%
Asian	6	5%
American Indian/Alaskan Native	6	5%
Native Hawaiian or Pacific Islander	1	<1%
White/Caucasian in addition to another race	31	24%
Hispanic/Latino	9	7%
Sexual Orientation		
Gay or Lesbian	10	8%
Bisexual	9	7%
Pansexual or queer	3	2%

Educational Background, Licensure, and Certification

The survey asked respondents to report their highest level of completed education; 58% (80/137) held a Master's degree, 23% (31/137) held a Bachelor's degree, 9% (13/137) held a High School diploma, or

equivalent, 7% (9/137) held an Associate degree and 3% (4/137) held a Doctoral degree. Doctoral degrees included MD/DO in Psychiatry (50%; 2/4), Doctorate in Social Work (25%; 1/4), and Doctor of Psychology (25%; 1/4). Respondents who held Master's degrees included specialties such as Social Work (55%; 44/80), Counseling (23%; 18/80), Psychology (10%; 8/80), Nursing (4%; 3/80), Education (4%; 3/80), Public Administration (3%; 2/80), Sociology (3%; 2/80), Criminal Justice (3%; 2/80), and Public Health (1%; 1/80). Bachelor's degree fields included Social Work (19%; 6/31), Sociology (19%; 6/31), psychology (16%; 5/31), Criminal Justice (16%; 5/31), Nursing (13%; 4/31), and Counseling (3%; 1/31) (Figure 1).

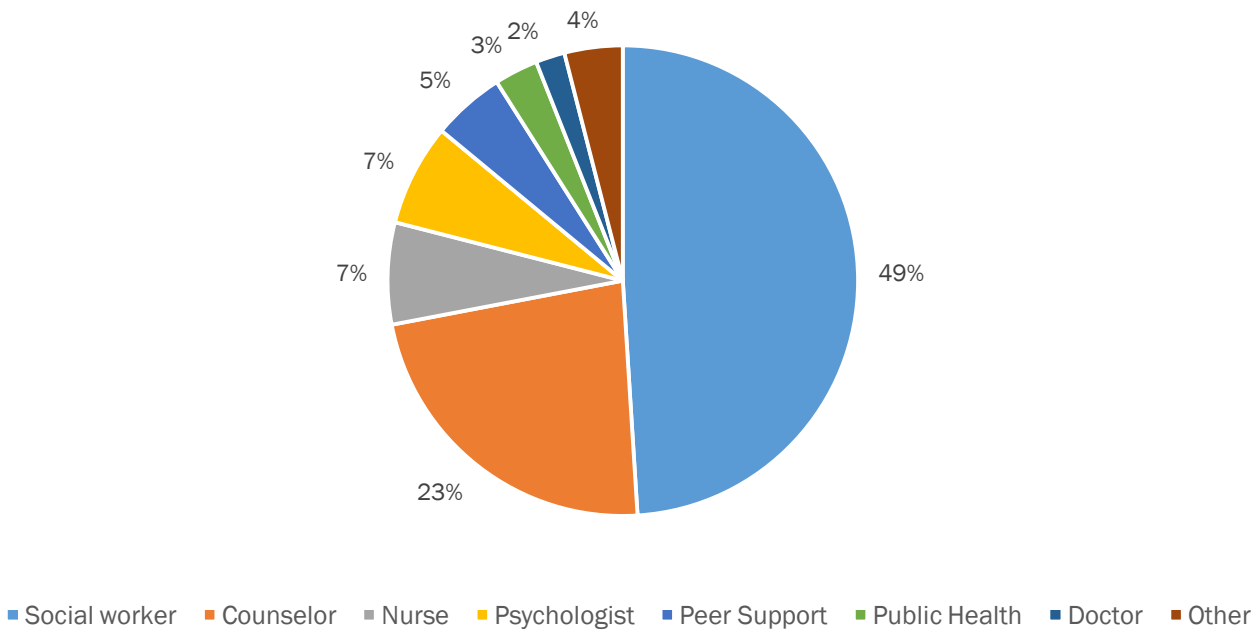
Figure 1. Educational Background of Survey Respondents



Licensure and Certification

Overall, 78% (104/133) of respondents held licensure or certification, the most common of which were social worker (49%, 49/101) and counselor (20%, 20/101) (Figure 2). Thirty-seven percent (49/133) held at least one form of licensure or certification with clinical supervision designation, while 41% (55/133) did not have clinical supervision designation. Further, 45% (45/101) of respondents held an additional professional license or certification, 15% (15/101) of which held clinical supervision designation and 30% (30/101) did not.

Figure 2. Professional Licensure and Certification of Survey Respondents (n=101)



Work Setting and Occupational Role

Respondents described their primary employment setting (i.e., the organization where most hours during the week are spent) as a community mental health service/authority (including non-profit organizations) (59%; 82/138); non-profit organization (15%; 21/138); hospital/health system (9%; 12/138); clinic/ambulatory care facility (3%; 4/138); private group practice (3%; 4/138); and solo practice (2%; 3/138).

Participants were asked to report how many patients/clients their primary organization serves annually and the size of the community directly served by the organization. Approximately 45% (60/133) of respondents indicated that their primary organization served less than 5,000 patients/clients annually; 22% (29/133) served 5,000-9,999; 14% (18/133) served 10,000-24,999; 5% (6/133) served 25,000-49,999; and 12% (16/133) served 50,000 or more patients annually. Behavioral health workers were employed at organizations that served a wide range of populations sizes. Twenty-four percent (31/132) of respondents reported that their primary organizations served a community size of fewer than 2,500 persons; 28% (37/132) between 2,500-49,999 persons; 20% (26/132) between 50,000-249,999 persons; 19% (25/132) between 250,000-999,999 persons; and 9% (12/132) 1 million or more persons.

The employees in this study represent a variety of behavioral health professions, including: clinical social

workers (30%, 42/138); case managers (11%; 15/138); counselor (10%, 14/138); non-clinical social worker (6%; 8/138); peer support specialist (5%, 7/138); psychologist (4%; 6/138); registered nurse (4%; 5/138), behavioral health specialists (4%, 5/138), paraprofessional (1%, 2/138), psychiatrist (1%; 2/138), community health worker (<1%; 1/138), and "other" (22%; 31/138). Survey respondents who chose "other" specified their professional role as supervisors, prevention specialists, intake specialists, home health care providers, residential specialists, and outpatient substance abuse therapist, among others.

Job roles and responsibilities varied among respondents. However, of the 138 employees who responded to the question, an average of 24% of their time was spent engaging in direct patient care or client services, followed by administration, business, or program management (13%), assessment or evaluation (13%), and case management (12%) (Table 2).

Table 2. Job Functions of Respondents (% Time Spent)

Organizational Role	n	%
Direct patient care/client services	138	24%
Administration/business or program management	138	13%
Assessment/evaluation	137	13%
Case management	138	12%
Clinical or community consultation and prevention	138	6%
Clinical supervision	138	4%
Report writing/grant writing	139	4%
Treatment planning and team consultation	138	4%
Workforce development: teaching and training	138	3%
Medication prescription and management	138	2%
Research-related activities	139	2%
Case presentation meetings	139	1%
Other human services (e.g. forensics, consulting)	139	1%
Assessment/evaluation	137	13%
Case management	138	12%
Indirect patient care (e.g. phone calls, reviewing labs, charting)	139	7%
Other	138	4%

Work Experience and Management Responsibilities

Approximately 3% of respondents reported having less than 1 year of experience in behavioral health; 24% have 1-5 years; 22% have 6-10 years; 19% have 11-15 years, 10% have 16-20 years; 8% have 21-25 years, and 14% have more than 25 years of work experience in behavioral health (Table 3).

Thirty-four percent (46/136) of respondents indicated that they manage or supervise people in their organization: 22% (10/46) have been managing or supervising staff for less than 1 year; 35% (16/46) 1-5 years; 13% (6/46) 6-10 years; 11% (5/45) 11-15 years; and 16% (9/46) more than 15 years. Of those with management experience, 51% (24/47) directly supervise 1-5 people; 26% (12/47) 6-10 people; 13% (6/47) 11-25 people; 6% (3/47) 26-50 people; and 4% (2/47) more than 50 people.

Table 3. Number of Years of Employment in Behavioral Health [n(%)]

Number of Years	In Current Job Title (n=136)	In Current Place of Employment (n=131)	In Behavioral Health (n=133)
<1 year	15 (11%)	13 (10%)	4 (3%)
1-5 years	57 (42%)	64 (49%)	32 (24%)
6-10 years	30 (22%)	21 (16%)	29 (22%)
11-15 years	13 (10%)	10 (7%)	25 (19%)
16-20 years	7 (5%)	9 (7%)	13 (10%)
21-25 years	6 (4%)	6 (5%)	11 (8%)
>25 years	8 (6%)	8 (6%)	19 (14%)

Leadership and Promotional Opportunities

When asked how likely they are to become part of senior leadership at their primary place of employment, 41% (55/136) of respondents reported they were unlikely or very unlikely to become a part of senior leadership; 21% (29/136) were undecided; and 25% (35/136) thought they were likely or very likely. Thirteen percent (17/136) of respondents were currently serving in a senior leadership role at their primary place of employment.

Participants were asked to rate their level of agreement with a series of statements related to their future as senior leadership in their primary place of employment. Forty-seven percent (25/54) were not interested in serving in a leadership role, while 35% (19/54) of respondents were interested. Seventy-eight percent (44/53) of respondents reported that they currently possess the credentials necessary to serve in a leadership role; however, 55% (29/53) believe they have limited opportunity for career advancement in their organization and 50% (27/54) agree that they do not receive sufficient training or support to grow

into a leadership position. When asked if they feel comfortable discussing promotional opportunities with supervisors, 58% (28/54) strongly agreed or agreed; 20% (11/54) did not, while 28% (15/54) neither agreed nor disagreed. Approximately 20% (11/54) of participants feel that their organization preferentially chooses leaders based on demographic characteristics, 35% (19/54) disagreed with this statement, and 45% (24/54) neither agreed nor disagreed (Table 4).

Table 4. Leadership and Promotional Opportunities [n(%)]

Statement	n	Strongly Disagree/Disagree	Neither Agree nor Disagree	Strongly Agree/Agree
I am not interested in a leadership role	54	19 (35%)	10 (19%)	25 (46%)
I feel comfortable discussing my promotion opportunities with my supervisor	54	11 (20%)	15 (28%)	28 (52%)
I do not receive sufficient training or support to grow into a leadership role	54	17 (31%)	10 (19%)	27 (50%)
My organization preferentially chooses leaders based on demographic characteristics	54	19 (35%)	24 (45%)	11 (20%)
I have limited opportunity for career advancement in my organization	53	16 (30%)	8 (15%)	29 (55%)
I currently possess the credentials necessary to serve in a leadership role	53	7 (13%)	5 (9%)	42 (78%)

Work Environment and Job Satisfaction

Survey participants were asked several questions about their work environment and job satisfaction. Approximately 28% (29/137) had experienced or witnessed discrimination in their primary place of employment; 56% (76/137) had not had this experience; 16% (22/137) were unsure. When asked to elaborate upon experiences with workplace discrimination, 66% (19/29) respondents reported discrimination based on race and sexual orientation. Specifically, discrimination related to promotions was noted.

Other participants reported witnessing behavioral health providers' discrimination against the patient population. For example, one respondent witnessed racist remarks from a psychiatrist and "inappropriate behavior towards transgendered patients." Another participant suggested that behavioral health workers often discriminate against others living with substance use and mental health diagnoses. One participant who works with incarcerated populations indicated that social work staff sometimes engage in discriminatory behavior with patients based on race and substance use status.

Survey participants were also asked to rate their level of agreement with several statements regarding their organization's ability to provide a culture of diversity, equity, and inclusion for employees. Approximately 68% (91/133) of survey participants agreed or strongly agreed that their organizational leaders have created a safe, inclusive work environment for all employees; 17% (22/133) disagreed or strongly disagreed; 15% (20/133) neither agreed nor disagreed. Further, 74% (99/134) of respondents agreed or strongly agreed that they are comfortable communicating about race and ethnicity at work and 68% (91/134) are comfortable reporting discrimination to supervisors. Eleven percent (15/134) and 16% (22/134) disagreed or strongly disagreed with these statements, respectively; 15% (20/134) and 16% (21/134) neither agreed nor disagreed. Nearly half (41%; 53/132) reported that they agreed or strongly agree that issues of discrimination are discussed at work; 37% (48/132) disagreed or strongly disagreed; 23% (31/132) neither agreed nor disagreed.

Approximately 74% (98/133) of participants agreed or strongly agreed that their work is valued by their employer; only 13% (17/133) disagreed or strongly disagreed with this statement; 13% (18/133) neither agreed nor disagreed. Nearly all participants (87%; 116/133) felt their work in their organization is valued by members of the community they serve (Table 5).

Table 5. Work Environment and Job Satisfaction [n(%)]

Statement	n	Strongly Disagree/Disagree	Neither Agree nor Disagree	Strongly Agree/Agree
My organization values and fosters a culture of diversity, equity, and inclusion	137	20 (14%)	21 (15%)	96 (71%)
I am comfortable reporting discrimination	133	22 (16%)	21 (16%)	91 (68%)
I am comfortable communicating about race/ethnicity at work	134	15 (11%)	20 (15%)	99 (74%)
Issues of discrimination are discussed at work	132	48 (36%)	31 (23%)	53 (41%)
My work is valued by my employer	133	17 (13%)	18 (13%)	98 (74%)
My work in this organization is valued by members of the community I serve	133	4 (3%)	13 (10%)	116 (87%)

Recruitment, Retention, and Retirement

Respondents were asked several questions about their primary organization's recruitment and retention efforts. First they were asked to provide feedback on any personal experiences that led them to work in behavioral health. Nearly one quarter (22%; 30/134) of participants indicated that mentorship from a

behavioral health professional was a strong factor in choosing their career in behavioral health. Other factors reported by respondents included: educational opportunities that focused on or promoted engagement with behavioral health (42%; 56/134); a family member or friend has/had experience with mental health/substance use disorder (34%; 45/134); personal experience with mental health/substance use disorder (30%; 40/134); and positive experience with an individual working in behavioral health care (26%; 35/134).

Respondents provided feedback on the extent to which their organization's recruitment and retention efforts influenced them to accept their current position and continue employment (Table 6).

Table 6. Influence of Organizational Benefits and Opportunities in Recruitment and Retention [n(%)]

Recruitment/Retention Factor	Accept Position Initially				Continue Employment			
	n	Not at All	A Little	A Lot	n	Not at All	A Little	A Lot
Health benefits	130	45 (35%)	34 (26%)	51 (39%)	129	39 (32%)	25 (21%)	57 (47%)
Job security	128	33 (26%)	34 (27%)	61 (47%)	123	25 (20%)	29 (24%)	69 (56%)
Retirement benefits	130	68 (52%)	37 (29%)	25 (19%)	122	55 (45%)	34 (28%)	33 (27%)
Work location	130	35 (27%)	33 (25%)	62 (48%)	119	25 (21%)	32 (27%)	62 (52%)
Organizational mission	131	21 (16%)	46 (35%)	64 (49%)	119	22 (18%)	32 (27%)	65 (55%)
Opportunities for professional growth and development	129	30 (23%)	40 (31%)	44 (46%)	120	29 (24%)	31 (26%)	60 (50%)
Opportunity for promotion	131	47 (36%)	40 (30%)	44 (34%)	120	47 (39%)	32 (27%)	41 (34%)
History of organization	130	39 (30%)	46 (36%)	45 (34%)	121	34 (28%)	41 (34%)	46 (38%)
Culture of organization	129	40 (31%)	44 (34%)	45 (35%)	122	37 (30%)	36 (30%)	49 (40%)
Opportunity to work with organization's staff	127	40 (32%)	45 (35%)	42 (33%)	122	32 (26%)	43 (35%)	47 (39%)
Population served by the organization	127	14 (11%)	29 (23%)	84 (66%)	125	8 (6%)	32 (26%)	85 (68%)
Paid time off	128	34 (27%)	42 (33%)	52 (40%)	123	28 (23%)	35 (28%)	60 (49%)
Flexible work schedule	129	31 (24%)	33 (26%)	65 (50%)	124	21 (17%)	29 (23%)	74 (60%)
Fair pay	128	23 (18%)	50 (39%)	55 (43%)	125	30 (254%)	39 (31%)	56 (45%)

Approximately 34% (45/136) of respondents plan to retire or otherwise leave their position at their primary place of employment within the next 5 years, 10% (14/136) in 6-10 years; and 21% 929/136) in more than 10 years. Nineteen percent (26/136) were undecided about when they would retire and 16% (22/136) did not currently have plans to leave their position at their primary place of employment.

When asked about factors are motivating plans to leave their current employment, the most frequent response was retirement eligibility (51%; 29/57), followed by interest in other job opportunities (40%; 23/57); better income opportunities (38%; 22/57); career prospects elsewhere (30%; 17/57); lack of opportunity for career advancement (30%; 17/57); inability to achieve a comfortable work/life balance (25%; 14/57), lack of professional satisfaction (25%; 14/57); and lack of leadership/proper management (21%; 12/57) (Table 7).

Table 7. Factors Impacting Plans to Leave Current Place of Employment (n=57)

Factor	No.	%
Retirement eligibility	29	51%
Interested in other job opportunities	23	40%
To earn better income	22	39%
Better career prospects exist elsewhere	17	30%
Little opportunity for career advancement	17	30%
Unable to achieve a comfortable work/life balance	14	25%
Work is not professionally satisfying	14	25%
Lack of leadership/proper management	12	21%
Dissatisfied with job responsibilities	11	19%
Work environment is uncomfortable	10	18%
I do not feel valued by my supervisors/peers	9	16%
Position did not meet expectations	7	12%
Personal responsibilities or commitments	6	11%

DISCUSSION

The study findings highlight a few important barriers to recruitment and retention of a diverse behavioral health workforce. Other studies have demonstrated that lack of diversity within the behavioral health workforce is markedly apparent at the leadership level.[12,13] Perhaps not surprisingly, concerns about career advancement were noted by some providers of color in our study, as over one-third of respondents reported interest in being promoted to a leadership position but nearly half felt they were unlikely to advance to senior leadership. A need for more training was noted by some respondents, though most reported currently having the credentials to serve in a leadership role. Further, several qualitative responses referenced non-minorities who do not possess the necessary credentials being promoted more quickly than minority employees who do possess the necessary credentials. Some respondents also noted that people of color were not being considered for promotional opportunities or not being given the opportunity to apply for them. Although this study reflects a small state-specific sample, it is important to

consider the structural barriers within healthcare organizations that are inhibiting the development of, and opportunity for, minority healthcare providers to assume leadership positions within behavioral health. In addition to being a concern for behavioral health service delivery, from a workforce development perspective, the diversity of organizational leadership should be carefully addressed as a means for strengthening recruitment and retention practices.

This study also found that the majority of respondents felt that their work environment was safe and inclusive for all employees, yet over 30% disagreed or felt neutral about this, suggesting that some employers may need to focus additional efforts on creating a work environment where all employees can thrive. Although most of the reasons for preparing to depart from the field of behavioral health were based on retirement eligibility, lack of career advancement opportunities, and ability to find better paying jobs elsewhere, work environment, leadership, and feeling valued by peers and supervisors were also important considerations for employee retention.

This study has some limitations. First, this cross-sectional study is a convenience sample of behavioral health providers in Michigan, which limits generalizability to other populations. Future studies would benefit from utilizing a random sample that oversamples providers of color; however, finding a sampling frame that provides such information is difficult. Second, we cannot accurately estimate the number of participating organizations or the total number of behavioral workers who received the survey so were unable to calculate a response rate. Despite these limitations, this study highlights some key factors to consider when addressing recruitment and retention of a diverse workforce.

CONCLUSIONS AND POLICY CONSIDERATIONS

The demographic characteristics of employees of behavioral health provider organizations tend to show similar pattern to the health care system at large: there is a need to develop specific strategies to recruit and retain underrepresented minority individuals to serve as behavioral health providers. In summary, the findings of this study show that recruitment and retention of people of color in the behavioral health workforce is likely impacted by a combination of factors known to be important to all workers- job security, benefits, sufficient pay- as well as factors that may differentially affect minority workers, such as barriers to promotion and a safe work environment that is free from discrimination. Specific recommendations for action primarily rest on employers. First, more resources to guide career advancement in the organization is recommended, as some employees of color perceive limited opportunity to advance despite feeling qualified for leadership positions. For example, development of organizational succession plans and staff career ladders may help formalize promotion opportunities. In addition, although most reported working in

an organization that values diversity, equity, and inclusion, some reported workplace discrimination, which may reflect a need for better reporting options, additional training for administrators and employees, further discussion of organizational values and norms, and mechanisms for addressing structural barriers that are impeding the establishment of a safe and equitable work environment.

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