BHWC
BEHAVIORAL HEALTH WORKFORCE CENTER

Demographics of Providers in Community Mental Health Agencies in Illinois

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UNIVERSITY OF ILLINOIS CHICAGO
Jane Addams College of Social Work

Contents

Executive Summary

The Community Mental Health Provider Survey collected data from 555 providers across six Illinois regions to assess demographics, qualifications, and practice areas. This summary highlights key findings and their implications for enhancing community mental health services. A stratified random sample of 120 sites was selected from six areas of the state. Of the eligible sites, 74 (80.4%) agreed to participate and had staff submit surveys.

Key Findings and Implications

Age and Gender: The average age of providers was 37.9 years, with a significant majority (84.6%) female. Higher proportions of male providers were noted in regions 2 and Suburban Cook. The gender imbalance suggests potential challenges in achieving gender diversity. Targeted recruitment strategies are needed to address these disparities and ensure a more representative workforce.

Race and Ethnicity: Racial and ethnic diversity varied significantly by region. Chicago had more diversity compared to predominantly non-Hispanic white regions 3, 4, and 5. There was underrepresentation of multiracial populations and varying representation of African American/Black populations. These disparities highlight the need for diversity initiatives to better reflect Illinois' demographic composition and support cultural competence in service delivery.

Degree and Specialty: Most providers held a master's degree. Hispanic/Latinx and multiracial providers were more likely to have bachelor's degrees, while Asian and Black providers more frequently held advanced degrees (MA and higher). This variation suggests a need for supportive pathways and incentives for advanced education and licensure, particularly for minority groups.

Licensure/Certificate: The survey revealed an even split between licensed and unlicensed practitioners. Licensure rates varied by education level and racial and ethnic background. Addressing systemic barriers to licensure and exploring alternative pathways could enhance professional development and service quality.

Credentials: The QMHP credential was most common, with regional variations. Region 4 had higher percentages of MHPs, while Region 5 had more providers below the MHP level. Racial and ethnic differences in Medicaid credentials were also noted. Black providers were most likely to be below an MHP credential (24.6%), but also were more likely than other groups to have a QMHP credential. Hispanic/ Latinx and multiracial providers were least likely to have either a QMHP or an LPHA. Reviewing credentialing practices and support mechanisms could help to ensure equitable opportunities and service provision.

Language Services: Most providers (77.1%) offered services exclusively in English. Regions 4 and 5 had fewer than 5% of providers reporting service provision in a different language. Chicago providers had the highest rate of multilingual service provision, primarily in Spanish. Expanding language services and interpreter availability can improve accessibility for non-English speaking populations.

Primary Area of Practice: Adult mental health and lifespan services were predominant, with regional variations. Region 4 had a higher percentage of providers offering services for both child and adult mental health. Balancing service offerings to address both child and adult needs comprehensively is crucial for effective service delivery.

Tenure: Providers' experience ranged from less than a year to 51 years, with an average of 9 years. Region 2 had the longest average tenure. Developing targeted professional development and retention strategies can support experienced providers and integrate new professionals effectively.

Conclusion

The survey underscores the need for strategic improvements in diversity, accessibility, and service quality within Illinois' community mental health workforce. Addressing the identified gaps—such as gender and racial disparities, educational and licensure barriers, language service limitations, and credentialing differences—will be key to enhancing mental health care and meeting the diverse needs of the population.

Introduction

As established in the Illinois Healthcare and Human Services Reform Act (Public Act 102-0004, effective April 27, 2021), the Behavioral Health Workforce Center of Illinois (BHWC) seeks to increase access to effective behavioral health services through innovative initiatives to recruit, educate, and retain qualified and diverse behavioral health providers. One component of the Center's work is assessment of the behavioral health workforce to better understand key shortage areas and providers' retention and training needs.

There is little existing information about behavioral health providers across Illinois. To gain an understanding of the providers and challenges unique to different behavioral health settings, BHWC at the University of Illinois Chicago (UIC) created initiates focused on providers in community mental health, child and adolescent services, integrated care, serious mental illness services, and substance abuse and recovery. For each area, provider advisory groups provide input and help direct assessment activities. Surveys of providers were initiated to gain a broader understanding of provider characteristics and needs.

> *"Certified Comprehensive Community Mental Health Centers (CMHCs) respond to the unique mental health needs of the community with a continuum of services ranging from prevention/promotion through treatment and recovery. CMHCs collaborate with other social service and health care providers to deliver integrated care to individuals in the identified geographic service area. CMHCs must be nonprofit or local government entities."*
>
> Illinois Department of Human Services, Part 132 Medicaid Community Mental Health Services Program

This report presents findings on provider demographics from a statewide survey of behavioral health providers employed in outpatient community mental health settings in 2023-24. Examining demographics is crucial for an understanding of the composition and diversity of the behavioral health workforce in Illinois. This information allows for targeted interventions to address specific gaps and needs, ensuring that services are culturally relevant and accessible to all community members. Demographics including gender, age, race/ ethnicity, and education were compared across regions and disciplines.

Methods

This assessment sought to obtain a statewide, representative sample of behavioral health providers working in community mental health agencies. The sampling frame was built by starting with the Illinois Division of Mental Health (DMH) list of Community Mental Health (CMH) agencies, which includes Certified Community Behavioral Health Clinics, non-profit

organization, hospital-based clinics, programs within Federally Qualified Health Centers, county health departments, and other municipally funded programs and centers. Research staff expanded the list to include all the physical locations within each organization that provide direct services across the state and added locations of any new and eligible programs. Sites were included if they provided traditional outpatient mental health services and accepted publicly funded health insurance, such as Medicaid and managed care, for therapy services.[1] Private practice groups were not included. After listing physical locations across the state, staff identified 444 potential sites in the sampling frame.

To ensure statewide representation, the Illinois Department of Human Services regional map was used as a guide, separating Illinois into five regions. Region 1 was then divided into two categories, Chicago and suburban Cook County, creating a total of 6 regions. A stratified random sample of 120 sites was selected. For each of the regions 2-5 identified by Illinois DMH, 20 sites were randomly selected. For region 1, 20 sites were randomly selected from Chicago and an additional 20 from suburban Cook County.

Each selected site was contacted by email and, if necessary, by phone to determine eligibility for the survey. As shown in Table 1, 92 of the selected sites were eligible. Of the eligible sites, 74 (80.4%) agreed to participate and had staff submit surveys; on average, 7.5 providers responded from each site. The exact percentage of all eligible staff at each site who submitted surveys is unclear as the number of eligible staff is unknown.

Table 1. Site Response by Region (*N* = 120)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Total
Agreed	14	13	15	10	12	18	82
Responses Received	13	11	14	10	12	14	74
No Response	1	2	1	0	0	4	8
Ineligible	4	6	4	6	6	2	28
Declined	1	0	0	3	2	0	6

[1] Because separate surveys of providers working in substance use recovery programs and community-based programs for people with serious mental illness are being conducted, programs were only eligible if one component included traditional outpatient therapy.

Unknown	1	1	1	1	0	0	4

Reasons for ineligibility included reports that the site had no current providers, provided other services but not individual therapy, or provided only SUD services; that the location had been closed; and that the location was administrative only. Reasons for declining included that the administrator reported that they were not interested in the topic, did not have time to forward this survey, did not think their staff had time to complete the survey, or their agency's administration had denied the request for participation.

Once site eligibility was confirmed, the sites were provided with survey information to distribute to all their behavioral health service providers. Only staff providing services to people with mental health challenges were eligible, across levels of experience and education. Participants were given a $20 gift card as an incentive to complete the survey. The survey was completely anonymous, gathering no metadata about the participants. To receive compensation, participants were redirected to a separate form that was not connected to the actual survey.

A total of 555 providers responded to the survey. Responses for statewide analyses were weighted to reflect the state. Regional analyses are not weighted. For regional analyses, chi-square likelihood ratio tests were used to determine statistically significant differences between the regions on categorical variables (gender, race, education, etc.). For continuous variables (age, years of experience, and years at an agency), statistically significant differences were determined with independent sample T tests or one-way ANOVA tests. Similarly, differences between the sample and Illinois' population within different regions were tested using chi-square tests for categorical variables. All tests were two-tailed and used $p < 0.05$ to identify statistically significant differences. Statistically significant differences are differences that are not likely to be due to chance and are likely to be replicated in another similar sample.

Results

Age and Gender

Providers who participated in the survey were, on **average, 37.9 years old**, varying by about 11 years. Regional comparisons did not vary significantly and demonstrated a consistent age distribution, with averages of providers' age ranging from the mid-thirties to early forties.

Overall, **the majority identified as female** (Figure 1). In the analysis of gender diversity across regions, focusing solely on male and female categories revealed statistically significant differences. Region 2 and suburban Cook reported slightly higher proportions of male providers compared with other regions.

Due to the relatively small percentages of respondents identifying as non-binary, third gender, self-described, and those who preferred not to disclose their gender, these categories were consolidated into a single 'Diverse/Unidentified' category. Comparing this Diverse/Unidentified category against the male and female categories indicated **statistically significant differences across regions** (Table 2). However, the counts within the Diverse/Unidentified category are very small, which may impact the reliability of this specific finding.

Figure 1. Gender Percentage Overall (*N*=550)

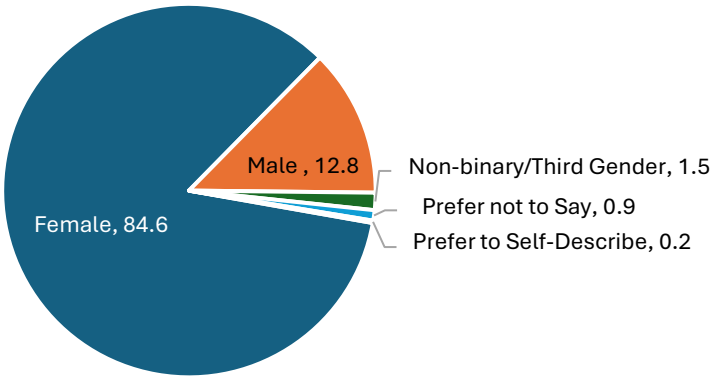


Table 2. Gender Percentages by Region

	1 (Chicago) *N* = 98	1 (Sub. Cook) *N* = 126	2 *N* = 98	3 *N* = 52	4 *N* = 63	5 *N*= 113	Total *N* = 550
Female*	88.8	76.2	80.6	86.5	87.3	88.5	84.0
Male*	10.2	19.0	18.4	7.7	12.7	8.0	13.3
Diverse/ Unidentified	1.0	4.8	1.0	5.8	0.0	3.5	2.7

*denotes statistically significant regional differences, Chi-Square likelihood ratio ($p < 0.05$)

Race and Ethnicity Across Regions

Across the state, just under two-thirds of providers identified as white (non-Hispanic/Latinx). The next most common identity was Hispanic/Latinx, followed by African

American/Black. Smaller percentages selected Asian, multiracial, and American Indian, Native American, and/or Alaskan Native.[2]

Race and ethnicity varied significantly across different regions of Illinois. Relatively little racial diversity was found in regions 3, 4, and 5, where 82% or more of providers were white non-Hispanic, less than 4% were Black, and similarly low percentages were Hispanic/ Latinx. In contrast, more diversity was found in Chicago, with 35.1% Hispanic/ Latinx, 20.6% Black, and 30.9% non-Hispanic white providers. Chicago also had the highest percentage of multiracial individuals (6.1%).[3] **Overall, suburban Cook and region 2 had higher levels of diversity when compared to the downstate regions.**

The Asian demographic was very low, ranging from 0% to 8.2% across regions, with the most representation in Chicago. The representation of American Indian, Native American, and/or Alaska Native was also minimal across all regions, with only 1.1% of providers selecting this category. Native Hawaiian or Pacific Islander was also an option for survey participants; however, this was not selected by any respondents.

> *Regions 3, 4, and 5 showed relatively little racial diversity, with 82% or more white non-Hispanic providers.*

To understand how much the racial and ethnic composition of providers in CMH settings reflects the population of each region, we compared these percentages to Illinois census data. In comparisons of census data and survey data, region 1 consists of both Chicago and suburban Cook as available census data did not separate Chicago and suburban Cook.

The racial representation of providers statistically varied from the population in some regions (Table 3).

- African American/ Black providers were significantly underrepresented in survey data in regions 1 and 5 and were overrepresented in region 2.
- Multiracial providers were significantly underrepresented in the survey in regions 1, 2, and 5.
- Asian providers were significantly underrepresented in region 2.
- White non-Hispanic providers were significantly overrepresented in the survey in region 5.
- American Indian, Native American, and/or Alaska Native and Hispanic/Latinx/Latine providers did not significantly differ from census data in any region.

[2] Two responses were not included in the analyses as one was not reported and another was the only participant that identified solely as American Indian, Native American, and/or Alaskan Native.
[3] See Appendix B for more details and full data table.

It is important to note that the census data referenced in the analysis represents the overall racial/ethnic composition of the entire Illinois population. The population served by the agencies is likely to be more diverse than the state population overall.

Table 3. State Census and Survey Race/Ethnicity Percentages by Region

		1	2	3	4	5	Overall
African American or Black	Census	22.9	7.1	8.6	6.7	11.5	14.1
	Survey	17.4*	11.2*	3.8	3.2	3.5**	10.6
American Indian, Native American, And/or Alaska Native	Census	1.1	0.7	0.3	0.2	0.3	0.8
	Survey	0	0	0	0	0.9	0.2
Asian	Census	7.8	6.6	3.5	1.1	1.0	5.9
	Survey	7.6	2*	5.8	0	0	4
White (non-Hispanic)	Census	40.5	63.5	76.7	85.2	79.2	58.3
	Survey	43.3	61.2	82.7	92.1	92**	65.9
Multiracial	Census	10.4	9.9	6.3	4.7	5.5	8.9
	Survey	4.0**	2**	3.8	3.2	1.8*	3.5
Hispanic/Latinx/ Latine	Census	26.2	19.3	6.8	2.8	3.5	18.2
	Survey	27.2	22.4	3.8	1.6	1.8	16.0

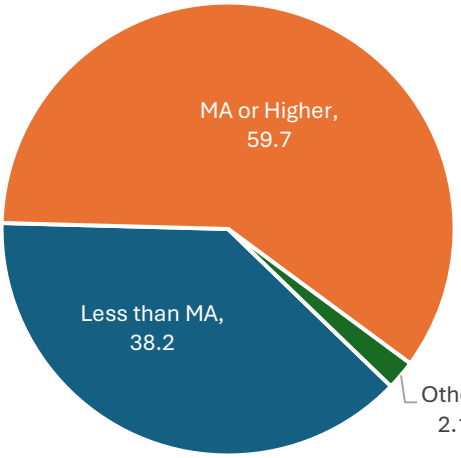
*Proportion in the sample is significantly different from the regional proportion at <.05. level (two-tailed);
**Proportion in the sample is significantly different from the regional proportion at the .01 level (two-tailed).

Census data retrieved from Illinois Department of Public Health. (April 2020). Population By Race for Illinois and Its Counties. Retrieved from **https://dph.illinois.gov/data-statistics/vital-statistics/illinois-population-data/population-race.html**
Census data retrieved from Illinois Department of Public Health. (April 2020). Population by Race and Ethnicity for Illinois and its Counties. Retrieved from **https://dph.illinois.gov/data-statistics/vital-statistics/illinois-population-data/population-race-ethnicity.html**

Education & Licensure/Certification

Across Illinois, **the most common educational qualification in community mental health was a master's degree**. This degree was most prominent across all regions, except region 4, where an equal percentage of providers held master's degrees and bachelor's degrees (46.0%). Differences in educational attainment across regions were not statistically significant. This also remained true when education levels were collapsed into 3 categories.[4] See Appendix C for more details.

Figure 2. MA or Higher Overall (*N* = 550)



Racial differences in the education attainment of providers were statistically significant. Hispanic and multiracial providers were more likely to have bachelor's degrees than other providers. Asian and Black providers had the highest rates of master's degrees. Additionally, the highest proportion of doctoral degrees was among Asian providers. Across all groups, the most common level of education was a master's degree, corresponding to the selection of sites that provided outpatient therapy for this survey.[5] Programs that only provide case management services, for example, are likely to be staffed by providers with less education.

Table 4. Race/Ethnicity Percentages by Education Level

	African American / Black *N*=60	Asian *N*=25	Hispanic/ Latinx/ Latine *N*=97	Multi-racial *N*=20	White (non-Hispanic) *N*=347	Overall *N*=548
High School Diploma or GED	4.9	0.0	4.2	5.0	2.3	2.9
Associate's Degree or Some College	8.2	4.0	9.4	5.0	5.8	6.6
Bachelor's Degree	19.7	12.0	36.5	45.0	28.0	28.5

[4] "High school or GED," "Associate's degree or some college," and "Bachelor's degree" were collapsed into "Less than MA" and "Master's Degree," "Doctoral Degree," and "Doctor Of Medicine" was collapsed into "MA or Higher." "Other" remained the same.

[5] An additional survey has been completed that is focused on other programs provided to individuals with SMI.

Master's Degree	66.7	76.0	46.4	45.0	58.8	57.7
Doctoral Degree (PsyD, PhD, DSW, MD)	0.0	8.0	0.0	0.0	2.9	2.2
Other	1.7	0.0	3.1	0.0	2.0	2.0

Likelihood Ratio X^2 (20, N=548) = 27.7, p = 0.116

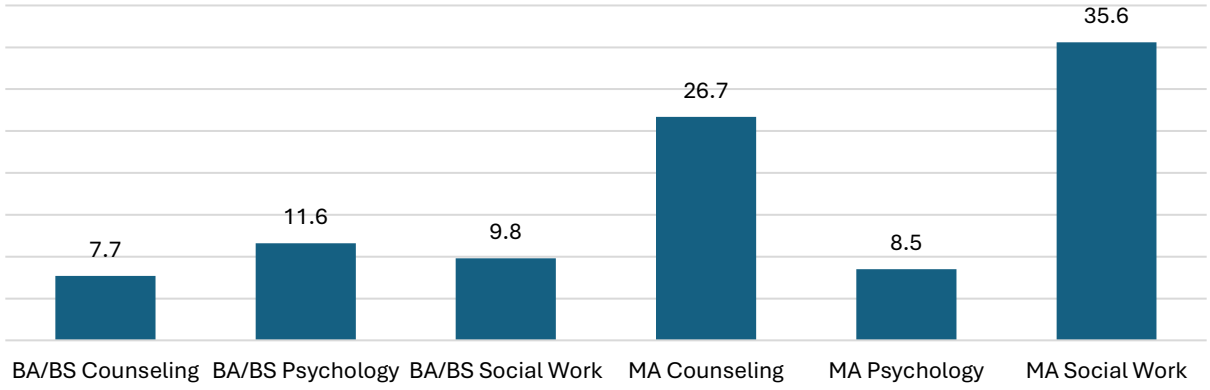
Providers identified their primary major or specialty during their education. **The most common was social work** (37.3%) followed by counseling (25.4%) and psychology (17%). This pattern remained the same when broken down across regions. Several categories had very few respondents (marriage and family therapy, psychiatry, nursing, and "other"). These were combined with other categories or removed from regional analyses to test for statistical significance.[6]

While there was variation in education level and specialty, **most providers (82.4%) had either a bachelor's degree or a master's degree.** The three most common specialties and majors (counseling, psychology, and social work) were examined within these post-secondary degrees to better understand the potential roles these providers might fill (Figure 3).[7] When looking at these providers, there were no significant differences regionally or by race/ethnicity in these categories. See Appendix F for more information.

[6] See Appendix F for details on the "other" category and for a full breakdown of the specialties overall and by region.

[7] Groups were divided into: providers with a BA/BS and Counseling specialty, providers with a BA/BS and Psychology specialty, providers with a BA/BS and Social Work specialty, providers with a Masters and Counseling specialty, providers with a Masters and Psychology specialty, and providers with a Masters and Social Work specialty. Detailed data tables can be found in Appendix F.

Figure 3. Bachelor Or Master Degrees And Most Common Specialty/ Major Percentage (*N* = 411)



Providers were equally divided between those who had a license or certificate (49.3%) and those who did not (50.7%), with no significant regional differences. Possession of a license or certificate significantly differed based on education level, as would be expected. Over three-quarters (77.4%) of those with a license were master's level educated. Further, 65.6% of all individuals with a master's degree had a license or certification, in contrast to the 19.2% of individuals with a bachelor's degree that reported having one.

Of those with a license or certification in Illinois, **LSW (10.1%) and LCSW (9.6%) were most common**, followed by LCPC (8.7%). Significant regional differences were present for LCSWs, being the most prevalent in region 3. Table 5 includes the five most common licenses and certificates statewide. See Appendix E for the full list.

Table 5. License/Certificate Type Percentage by Region (*N* = 552)

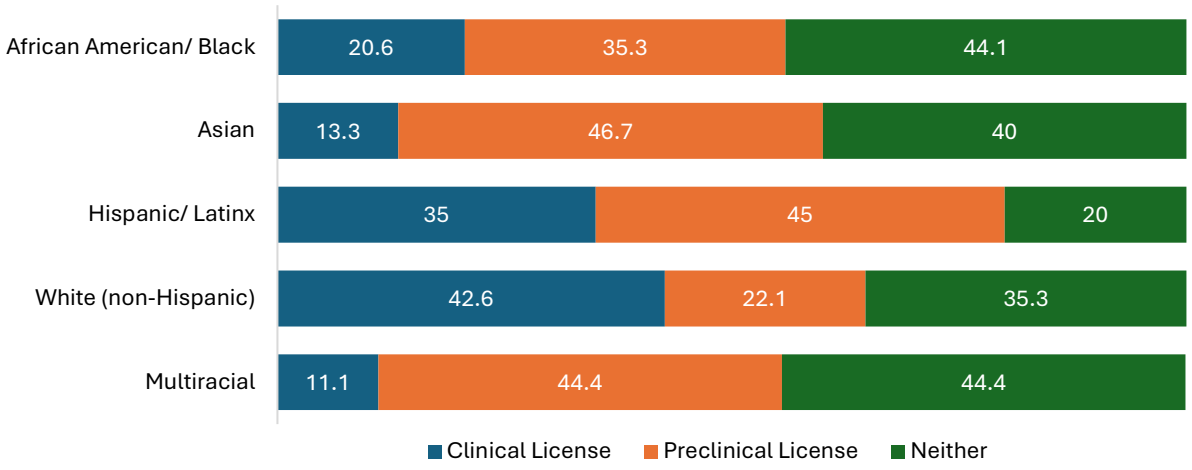
	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Overall
CADC	3.1	2.4	3	7.7	3.2	7	4.2
LCPC	5.1	10.3	9.1	5.8	11.1	9.6	8.7
LCSW*	11.2	12.7	7.1	19.2	6.3	4.4	9.6
LPC	6.1	6.3	6.1	5.8	3.2	8.8	6.3
LSW	13.3	11.1	8.1	11.5	12.7	6.1	10.1
None	51.1	40.8	54.0	44.2	58.3	58.3	50.7

*denotes statistically significant regional differences, Chi-Square likelihood ratio ($p < 0.05$)

License/certificate type significantly varied by race/ethnicity.

- White non-Hispanic providers had the highest rate of clinical licenses (42.6%), but also had the lowest proportion of providers with a preclinical license (22.1%).
- African American/ Black providers and multiracial providers were most likely *not* to have either a clinical or preclinical license (44.1% and 44.4%, respectively).
- Hispanic/ Latino providers had the highest rate (80%) of either a clinical or preclinical license.
- Multiracial and Asian providers were least likely to have a clinical license (Figure 4).

Figure 4. Masters & Doctoral Level Providers: Clinical & Preclinical Licenses By Race/Ethnicity (%)



Likelihood Ratio X^2 (8, N=288) = 22.739, p =0.004

When examining racial differences within specific degrees, there were no significant racial differences in licensure rates, possibly due to lower numbers in these subpopulations. See Appendix G for full data tables.

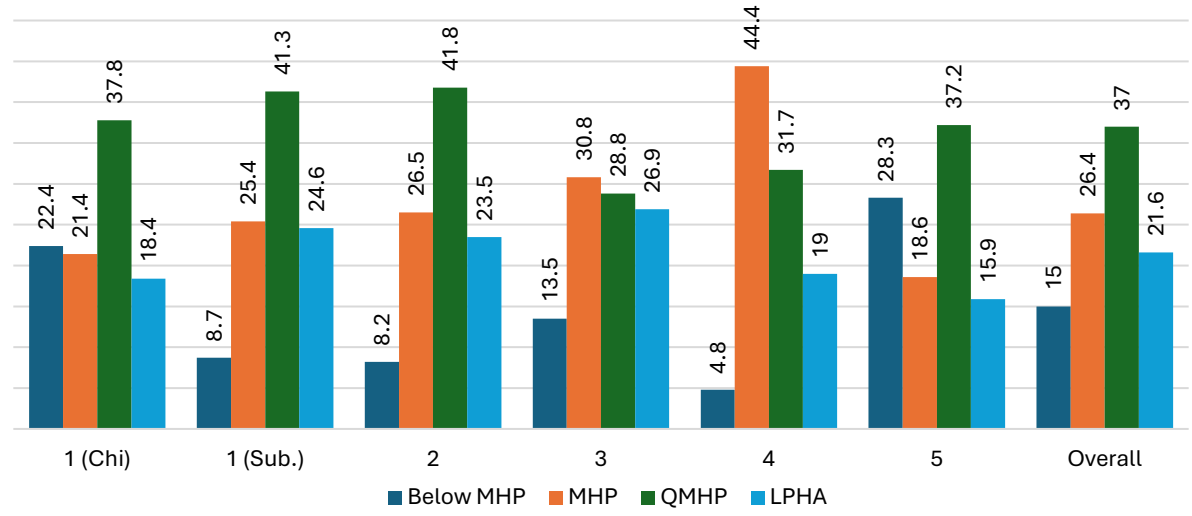
In addition to examining licenses and/or certificates, provider credentials allowing them to bill at different amounts for CMH services via Medicaid were explored. Specifically, regional differences between Mental Health Professional (MHP), Qualified Mental Health Professional (QMHP), and Licensed Practitioner of the Healing Arts (LPHA) credentials were examined. Participants were not explicitly asked if they bill under and/or qualify for a Medicaid credential. To determine the probable credentials of the various professionals, responses to education, licensure/certification, and specialty questions were used.[8]

[8] For providers not clearly qualifying for MHP, a potential 53 additional providers (9.7% of all respondents) may meet the criteria based on number of years of experience and education level. Given that this

Overall, the QMHP credential was the most prevalent (37%), followed by the MHP credential (26.4%), and the LPHA (21.6%), with the lowest percentage of providers (15.0%) not clearly qualifying as a MHP (designated as "Below MHP"**). Across the sample, more than half (58.6%) of providers were at least a QMHP or higher.**

When looking across the state, significant differences between regions emerged, with **region 4 having a notably higher percentage of individuals with the MHP** compared with the rest of Illinois. Outside of regions 3 and 4, QMHP was the most prominent credential. While most regions reported a small percentage of providers that did not clearly qualify as a MHP, region 5 demonstrated a relatively high percentage of these providers (Figure 5).

Figure 5. Medicaid Credential by Region (%)



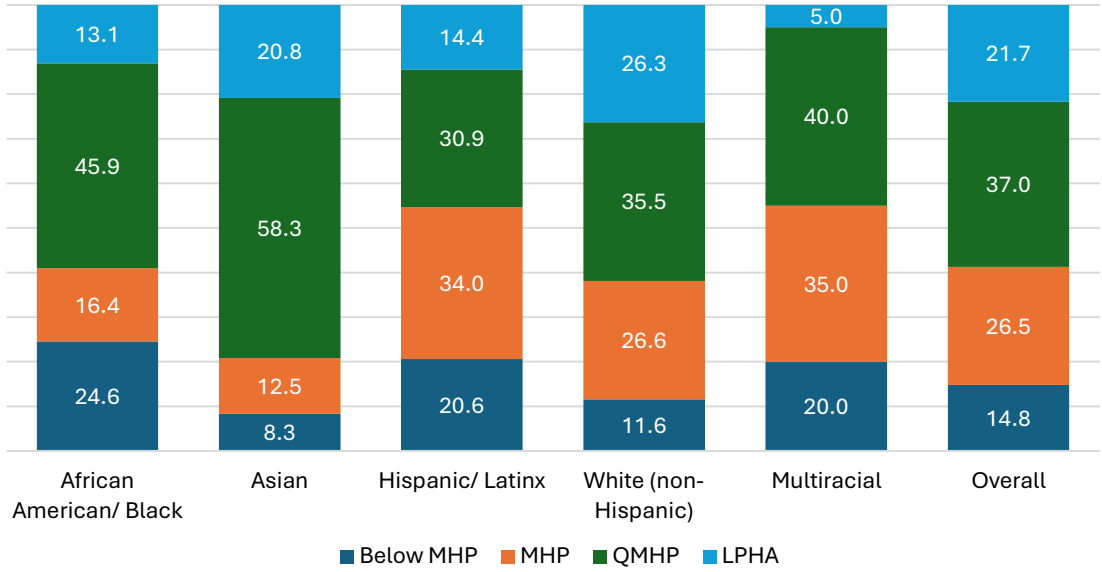
Likelihood Ratio X^2 (15, N=550) = 44.523, $p < 0.001$

Given the importance of having providers that qualify as a QMHP and LPHA, the combination of these credentials was examined regionally as well. **There were no significant regional differences in the frequency of QMHPs and LPHAs combined**, with at least half of CMH providers in all regions meeting this level of credential. See Appendix D for additional details on how providers' credentials were determined.

There were significant racial/ethnic differences among Medicaid credentials, as shown in Figure 6. White non-Hispanic and Asian providers were least likely to be below an MHP credential. Black providers were most likely to be below an MHP credential (24.6%), but also were more likely than other groups to have a QMHP credential. Hispanic/ Latinx and multiracial providers were least likely to have either a QMHP or an LPHA.

experience must be supervised by a QMHP for the provider to bill as a MHP, it is impossible to determine definitively their credentials and they were not included in the analysis to avoid inflating the sample.

Figure 6. Medicaid Credential by Race/Ethnicity (%)

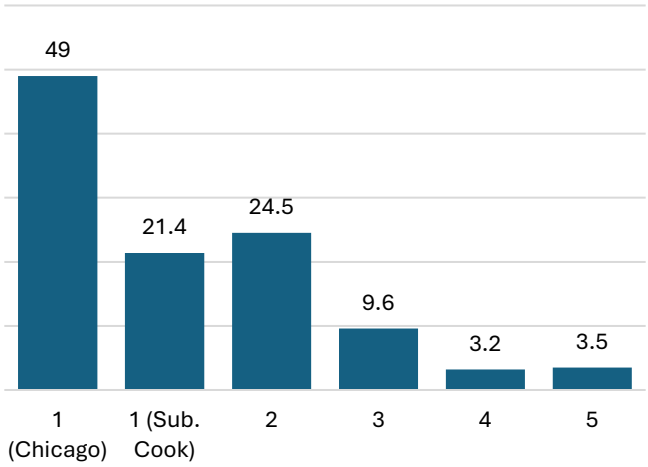


Likelihood Ratio X^2 (12, N = 548) = 33.381, p <0.001

Providing Services in Another Language

Most providers (77.1%) in Illinois do not provide services in a language other than English. The percentage of providers delivering services in another language without the use of an interpreter **varied significantly by region**, with Chicago having the highest percentage of providers delivering services in a language other than English, compared to less than a quarter in all other regions (Figure 7).

Figure 7. Service Provision in Another Language Percentages by Region (*N* = 550)

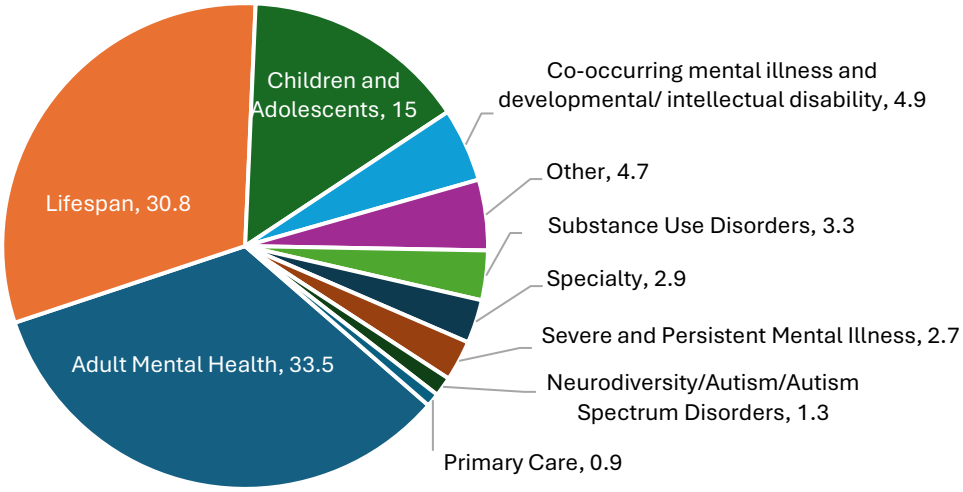


The most common additional language was Spanish for all regions except region 3, where the most common additional language in service provision was Mandarin. However, even for the providers that accommodated languages other than English, **these services only consumed less than 20% of providers' time.** See Appendix E for additional information on the time spent providing services in another language.

Primary Area of Practice

The two most common population practice areas were "adult mental health" and "lifespan"[9] (Figure 8). The percentages serving different populations **were significantly different across regions.**

Figure 8. Primary Area of Practice Overall (*N* = 547)



Specifically, for Chicago, region 2, region 3, and region 5, the most prevalent area was adult mental health, which was particularly dominant in **regions 2 and 3 with approximately half of respondents reporting adult mental health as their primary area of focus**. For region 1 (suburban Cook) and region 4, the most common area of practice was both child and adult mental health (lifespan). Notably, **lifespan services was the primary area of focus for over two-thirds of respondents in region 4** (Table 6). These findings suggest that clients seeking services for children and adolescents might have more difficulty accessing services in regions 2 and 3, given that about half of providers report only serving adults.

Table 6. Most Common Primary Areas (%) of Practice by Region (*N* = 433)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5
Adult Only*	26.5	27.2	53.1	48.1	12.7	33.6
Child & Adult*	24.5	29.6	24.0	26.9	66.7	25.7

[9]Lifespan refers to providers that indicated primary area of practice as "both child and adult mental health."

Child Only	19.4	13.6	13.5	9.6	7.9	20.4

*denotes statistically significant regional differences, Chi-Square likelihood ratio ($p < 0.05$)

The practice areas Neurodiversity/Autism/Autism Spectrum Disorders (ASD) and Primary Care were least common primary areas with many of the regions (2, 3, 4, and 5) having no providers report Neurodiversity/ASD as a primary area of practice. Similarly, a number of the regions (1, 2, and 3) reported having no providers with Primary Care as a primary area of practice. The low representation in these areas is likely due to the survey's focus on community mental health settings, rather than health clinics, specialty clinics, and/ or integrated care settings.

Practice Tenure

The average number of years' experience overall in the field was 9 years with a range from less than a month to 51 years. Notably, the average varied significantly across different regions, with region 2 having the longest average tenure (Table 7). Providers' years at their agency of employment at the time of survey participation **averaged 4.4 years** and ranged from less than a year to 35 years, with no significant difference found across regions (Table 7).

Table 7. Average Years (and Standard Deviation) of Experience and Years at Agency by Region

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Overall
Years Experience* (*N* = 547)	7.5 (7.5)	9.3 (9.9)	10.8 (10.6)	9.8 (8.8)	6.7 (7.5)	7.9 (8.0)	8.7 (9.0)
Years at Agency (*N* = 550)	3.8 (4.9)	4.0 (5.5)	4.6 (6.7)	4.3 (5.9)	4.2 (4.8)	5.2 (6.0)	4.4 (5.7)

*Denotes statistically significant regional differences, one-way ANOVA ($p < 0.05$)

It should be noted that reliance on a cross-sectional sample, as in this study, will overestimate the length of employment, as providers with relatively short periods of employment are less likely to be selected at any given point. To better understand the experiences of those who leave their positions after a short period of employment, sampling would ideally occur for each provider at the point of employment.

Summary of Findings

Age and Gender: The average age of providers was 37.9 years. The majority of providers were female, accounting for 84.6% of respondents. The regional representation of male and female providers was significantly different, with region 2 and suburban Cook reported slightly higher proportions of male providers compared with other regions.

Race and Ethnicity: Race and ethnicity varied significantly by region of Illinois, with more diversity found in Chicago compared to the relatively little racial diversity found in regions 3, 4, and 5 (82% or more of providers being non-Hispanic white). Generally, the racial/ethnic makeup of respondents was representative of Illinois census data, with a few significant differences. These differences were found in underrepresentation of the multiracial population (regions 1, 2, and 5) and both over- and underrepresentation of the African American/ Black population (underrepresented in regions 1 and 5 and overrepresented in region 2).

Degree and Specialty: The predominant educational qualification among providers in all regions was a master's degree. However, there were statistically significant racial differences in the education level of providers, with Hispanic/Latinx and multiracial providers more likely to have bachelor's degrees than other providers and Asian and Black providers were more likely to have master's or higher-level degrees than other providers. Primary majors or specialties during their education were most commonly social work (37.3%) and counseling (25.4%). Several categories had very few respondents, including marriage and family therapy, psychiatry, and nursing.

Licensure/Certificate: The survey highlighted a nearly even split between practitioners with and without a professional license or certificate, with rates not varying significantly across regions. However, possession of a license or certificate significantly differed based on education level, with 65.6% of all individuals with a master's degree reporting a license or certification, in contrast to the 19.2% of individuals with a bachelor's degree. LSWs were the most common licensure (10.1%) throughout the State and were most prominent in Chicago (13.3%). LCSWs varied significantly across regions and were most prevalent in region 3 (19.2%).

The specific types of licenses/certificates significantly differed based on race/ethnicity. There were also significant racial/ ethnic differences in the rates of preclinical vs. clinical licenses in providers with a master's or doctoral degree, with white non-Hispanic providers having the highest rates of clinical licenses and Hispanic/Latinx, Asian, and multiracial providers having the highest rates of preclinical licenses.

Credentials: Overall, the QMHP credential was the most prevalent (37%), followed by the MHP credential (26.1%), the LPHA (21.6%), and providers that are below a MHP (15.2%). Significant differences between regions were noted, with region 4 having a notably higher percentage of MHPs compared with the rest of Illinois (43.8%). Region 5 demonstrated a relatively high percentage of providers that were below the MHP level (29.2%) compared to other regions' small percentages. There were significant differences in Medicaid credentials based on race/ ethnicity, with white non-Hispanic providers having the highest rates of LPHAs (26.3%). In contrast, the highest rates of the QMHP credential were among African American/ Black (45.9%), Asian (58.3%), and multiracial (40.0%) providers. The most common credential for Hispanic/Latinx providers was MHP (34.0%).

Language Services: Over three-quarters of providers (77.1%) reported offering services exclusively in English. The percentage of providers delivering services in another language without the use of an interpreter varied significantly by region. Chicago had the highest percentage of multilingual service provision, with 49% of providers offering services in languages other than English, primarily Spanish. In contrast, less than 5% of providers reported providing services in another language in regions 4 and 5.

Primary Area of Practice: Adult mental health and lifespan services ("both child and adult mental health") were the most common primary areas of practice, with both showing significant differences between regions. Providers from regions 2 and 3 primarily served adult mental health only, with approximately half of respondents (53.1%; 48.1%) reporting this as their primary area of focus. Parents may have particular difficulty in obtaining behavioral health services for their children in these areas.

Tenure: The number of years of experience for providers in the field ranged from less than year of experience to 51 years, with a mean number of years of experience of 9 years. This average varied significantly across different regions, with region 2 having the longest average tenure (10.8).

Discussion and Implications

The Community Mental Health Provider Survey, which included 555 mental health service providers from randomly selected sites across the state, provides a snapshot of the demographics and disciplines of providers working in community mental health agencies across the state. Notably, the survey identified a pronounced gender imbalance, with a vast majority (84.6%) of respondents identifying as female, suggesting potential challenges in gender diversity among providers. Additionally, racial and ethnic representation among providers skewed heavily towards white non-Hispanic individuals, especially in regions 2 through 5, indicating a need for increased diversity to ensure culturally competent care.

The provision of services in languages other than English (bilingual services) was also low, with a significant majority of providers (77.1%) only offering services in English. This may hinder access for non-English speaking populations. However, there was a higher proportion providing bilingual services in Chicago, mainly in Spanish, highlighting the potential to expand these services to improve accessibility. Understanding the extent that the particularly low percentage of providers in regions 4 and 5 providing bilingual services affects services access is needed.

Survey findings indicate that the primary areas of practice across the state include adult mental health and lifespan services, reflecting a strong foundation for addressing prevalent mental health issues. However, findings also suggest that regions 2 and 3 may have a need for additional service providers with specialized training to work with children and adolescents, as these providers were significantly underrepresented in these regions. Additionally, the inclusion of very few providers with specialties including Marriage and Family Therapy and psychiatry point to potential gaps in the workforce that may impede clients from receiving the specialized types of services they need.

Over half (57.6%) held a master's degree. Whether this educational level meets the needs of CMH agencies will be explored in additional analyses. The survey included sites that provided outpatient therapy to focus on outpatient treatment, which ideally is provided by master's level clinicians, but providers of other supportive services were also included. An additional Center report is focused on the types services provided and the characteristics of providers (educational level and credential).

The near-even split of unlicensed and licensed practitioners may point to potential barriers in the licensure process or a lack of necessity for licensure in some positions. In particular, racial and ethnic differences in the attainment of full licensure (LCSW) for master's level providers highlight potential barriers. Recent changes in licensure policies in social work, which now offer an option to obtain licensure with additional practice hours rather than a passing licensure exam, could address this disparity over time.

Several license and certificate types were uncommon in this sample (RN, LMFT, physician, etc.). Given that this survey targeted CMH agencies, this is unsurprising. Many CMH centers do not have medical providers or other specialized providers on staff, and this finding reinforces that the most common licenses and certificates in these settings are masters-level behavioral health credentials (LSW, LPC, LCSW, LCPC). The particular shortage of psychiatry and PhD level psychology in the behavioral health workforce has been noted in the state's licensure data, corresponding with these findings. The low percentage of providers who can prescribe medication raises questions about the accessibility of psychiatry services and the adequacy of the integration of medication management in the sites.

The reason for so few marriage and family therapists in CMH agencies also corresponds to the low number of LMFTs in practice in Illinois. As this specialty is much less common overall, these providers may not be initially hired in CMH settings. They also may move into private practice more quickly, as is likely for PhD-level psychologists and psychiatrists.

Several limitations should be considered when interpreting the findings from this study. The exclusion of private practices from this survey limits the generalizability of these findings to publicly funded community-based services that include outpatient therapy as at least one component of services provided by the site. Furthermore, there were very few psychiatrists, doctoral level psychologists, and psychiatric nurses in this sample and so the findings do not represent their experiences.

Additionally, although extensive outreach to settings to increase the response rate resulted in inclusion of 80% of agency sites whose staff participated in the survey, the exact response rate of eligible staff is unknown. Staff who chose not to participate could vary from those who are represented in these results. The cross-sectional selection of staff also has resulted in the inclusion of more long-term staff, as each provider's chances of being included is correlated with their length of employment at a selected site. Future research focused on those who remain in their positions for short periods of time is needed.

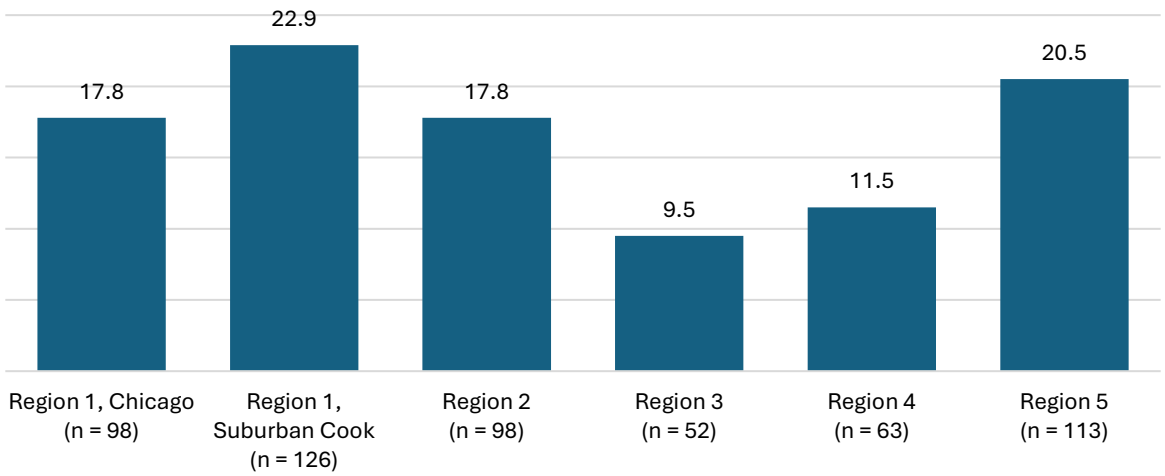
Overall, findings from the CMH Provider Survey underscore the need for targeted recruitment and retention strategies to enhance gender, racial, and linguistic diversity among mental health providers in Illinois. Addressing these gaps, alongside expanding educational and licensing support for providers, is key in ensuring equitable and effective mental health care across the state.

Appendices

Appendix A
General Population

The chart below illustrates the percentage distribution of participants in the stratified sample across regions. This distribution is potentially impacted by a number of factors, including variation in the total number of eligible sites, the average number of staff per agency in different regions, and response rates.

Figure A1. Distribution (%) by Region



Appendix B
Race/Ethnicity

Participants were able to select more than one race/ethnicity. In order to evaluate categorical differences, these groups were combined into one variable. Participants that selected more than one race and/or ethnicity were categorized as "Multiracial." Table B1 provides clarity on those participants' identities.

Table B1. Multiracial Categorization

Multiracial category	Number of Participants
African American/Black, American Indian, Native America, and/or Alaskan Native, white	1
African American/Black, Hispanic/Latinx	3
American Indian, Native America, and/or Alaskan Native, Hispanic/Latinx	3
African American/Black, white	5
American Indian, Native America, and/or Alaskan Native, white	1
American Indian, Native America, and/or Alaskan Native, white, Asian	1
Asian, white	4

29 respondents selected "Another Race;" 27 of those individuals indicated that they were Hispanic/Latinx either as a free response, on the ethnicity question, or both. Each participant is only counted once for the "Hispanic/Latinx" category. 5 people stated that they are multiracial or mixed race. 2 did not provide any information about their race and/or ethnicity. Individuals that reported they were "Hispanic/Latinx" and white were included in the "Hispanic/Latinx" category.

Table B2. Race/Ethnicity Percentages by Region

	1 (Chicago) *N* = 97	1 (Sub. Cook) *N* = 126	2 *N* = 98	3 *N*=52	4 *N*=63	5 *N*=112	Overall *N* = 550
African American or Black	20.6	15.1	11.2	3.8	3.2	3.6	11.0
Asian	8.2	7.1	2.0	5.8	0.0	0.0	4.4
Hispanic/Latinx/Latine	35.1	21.4	22.4	3.8	1.6	1.8	17.6

Multiracial	6.1	3.2	3.1	3.8	3.2	1.8	3.6
White non-Hispanic	30.9	53.2	61.2	82.7	92.1	92.9	63.0

Likelihood Ratio X^2 (20, N = 548) = 156.3, p <0.001

Differences in education by race/ethnicity were not statistically significant. Almost two-thirds of African American/Black respondents and just under half of Hispanic/Latinx providers held a master's degree. Similarly, for White non-Hispanic providers, master's degree the was most common. Multiracial respondents were evenly split between holding a bachelor's degree and a master's degree.

Table B3. Highest Education Percentages by Race/Ethnicity (*N* = 549)

	African American/ Black	Am. Indian, Native America, and/or Alaskan Native	Asian	Hispanic/ Latinx	Multiracial	White (non-Hispanic)
High School or GED	4.9	0.0	0.0	4.2	5.0	2.3
Associate's degree or some college	8.2	100.0	4.0	9.4	5.0	5.8
Bachelor's degree	19.7	0.0	12.0	36.5	45.0	28.0
Master's Degree	65.6	0.0	76.0	46.9	45.0	59.0
Doctoral Degree	0.0	0.0	0.0	0.0	0.0	2.0
Doctor of Medicine	0.0	0.0	8.0	0.0	0.0	0.9
Other	1.6	0.0	0.0	3.1	0.0	2.0

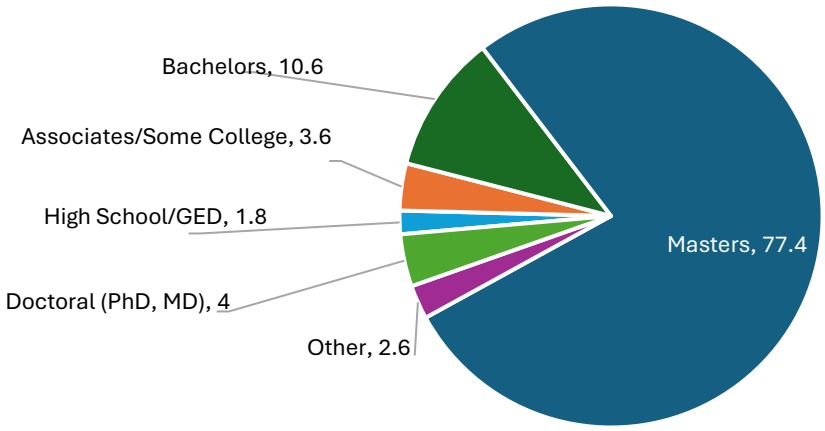
Appendix C
Education & Licensure

Table C1. Highest Education Percentages by Region (*N* = 550)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Overall
High School or GED	4.1	0.0	2.0	1.9	1.6	8.0	3.1
Associate's degree or some college	7.1	6.3	3.1	5.8	4.8	15.9	7.6
Bachelor's degree	24.5	27.8	27.6	32.7	46.0	20.4	28.2
Master's Degree	59.2	62.7	62.2	55.8	46.0	51.3	57.1
Doctoral Degree (PsyD, PhD, DSW)	1.0	2.4	1.0	0.0	1.6	2.7	1.6
Doctor of Medicine (MD)	1.0	0.8	2.0	0.0	0.0	0.0	0.7
Other	1.0	0.0	2.0	3.8	0.0	1.8	1.6

However, possession of a license or certificate did significantly differ based on education level, as would be expected. Over three-quarters of those with a license were master's level educated. Further, 65.6% of all individuals with a master's degree had a license or certification, in contrast to the 19.2% of individuals with a bachelor's degree that reported having one.

Figure C1. Licensure Percentage by Education Level



Appendix D
Medicaid Credentials

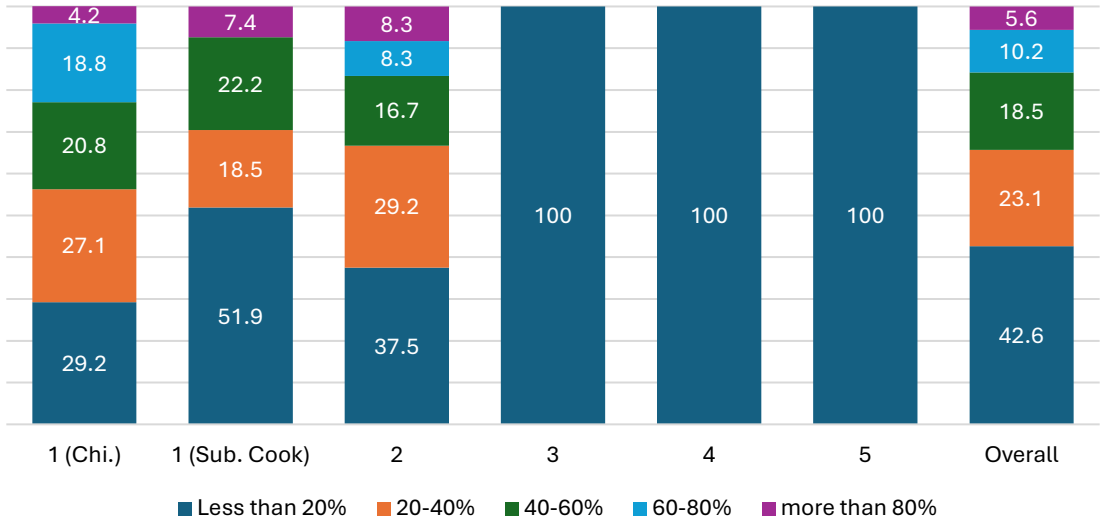
Providers were deemed a Mental Health Professional (MHP) if they met any of the following criteria: hold a bachelor's degree in a human service field (social work, psychology, counseling, behavioral health); hold a professional certificate (CRSS, CPRS, CFPP, LPN); and/or the individual identified themselves as a MHP in the free response license/certificate question. There may be providers that qualify as MHPs based on years of experience under the supervision of a QMHP, it is not possible to determine based on this survey.

To determine if a provider meets criteria as a Qualified Mental Health Professional (QMHP), education, licensure/certification, and specialty were also used. Individuals were deemed QMPHs if they met the following criteria: reported a master's degree in counseling, psychology, social work, marriage and family therapy, or another behavioral health profession; selected they were a Registered Nurse and/or Advanced Practice Nurse (APN); are a physician; and or hold a doctorate in psychology, counseling, or social work. The final category of credentials was the Licensed Practitioner of the Healing Arts (LPHA). Providers that qualified for LPHA and QMHP were only designated as LPHA as it is a higher category of credential. LPHA criteria included the following: providers held an independent practice license (LCSW, LCPC, LMFT); hold a doctoral degree; are a physician; or are an APN with a specialty in psychiatry.

Appendix E
Regional Differences in Additional Language

The amount of time providers spent providing services in another language was relatively low, with most providers reporting that they spend less than 20% of their time doing so. The highest percentages of time spent using another language were found in Region 1, particularly Chicago. Regions 1 (Suburban Cook) and 2 reported more providers using another language more frequently whereas all providers speaking another language in Regions 3, 4, and 5 reported using the language less than 20% of the time.

Figure E1. Percentage of Provider Time Spent Providing Services in Another Language (*N* = 108)



Appendix F
Differences in Majors/Specialties

Table F1. All Majors/ Specialties Percentage by Region (*N* = 530)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Overall
Counseling	22.6	26.4	26.0	27.5	41.9	38.8	30.0
Psychology	16.1	18.4	25.0	9.8	19.4	10.7	17.0
Social Work	44.1	36.8	31.3	45.1	29.0	33.0	36.2
Nursing	1.1	1.6	3.1	3.9	3.2	3.9	2.6
Medicine/ Psychiatry	1.1	1.6	6.3	2.0	1.6	1.0	2.3
Other (behavioral health)	2.2	8.0	4.2	3.9	3.2	2.9	4.5
Other (non-behavioral health)	12.9	6.4	4.2	7.8	1.6	9.7	7.4

Statistically significant regional differences, Chi-Square likelihood ratio ($p < 0.05$)

Other – behavioral health includes: substance use, recovery specialist, peer support, occupational therapy, human services, family services, family resources manager, family resource advocate, community home services, CRSS, case management, behavior analysis, Applied Behavior Analysis, ABA, and Peer Recovery Support Specialist.

Behavior Analysis and Applied Behavior Analysis were included in this category as they were all from one site and would be overrepresented in the full sample.

Other – non-behavioral health includes: wildlife biology, transition support specialist, special education, sociology, respiratory therapy, political science, education, marketing, literature, liberal arts, information technology, health science, heather and human physiology, heath administration, gerontology, general, English, criminal justice, communications and peace, business management, business administration, biology, applied sciences, accounting, art, and anthropology.

The free response "other" category was reviewed by research personnel to determine if the entries should be included with existing specialties. The following entries were added to "Counseling" due to the overlapping type of education and job role: marriage and family therapy, rehabilitation counseling, human services counseling, dance movement therapy and counseling, crisis response and counseling, crisis counseling, creative arts in therapy with a focus on visual art, counseling and art therapy, children's therapy, and mental health counseling. The following were included with "Psychology": special education/psychology, rehabilitation psychology, psychophysiology, psychology and criminology, clinical psychology, and behavioral health.

Table F2. Bachelor's and Master's Degrees in the Three Most Common Majors/ Specialties by Region (%)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Overall
BA/BS and Counseling	6.9	4.2	3.9	10.0	17.3	10.0	7.9
BA/BS and Psychology	9.7	14.6	15.8	5.0	19.2	7.1	12.3
BA/BS and Social Work	9.7	10.4	9.2	15.0	7.7	4.3	9.1
MA and Counseling	20.8	28.1	27.6	22.5	28.8	41.4	28.6
MA and Psychology	8.3	6.3	14.5	7.5	3.8	4.3	7.6
MA and Social Work	44.4	36.5	28.9	40.0	23.1	32.9	34.5

Likelihood Ratio X^2 (25, N = 406) = 37.493, p = 0.052

There is a potential trend in regional as well as racial/ethnic differences at the $p < 0.10$ level of significance for specialty when only looking at providers with a bachelor's or master's degree.

Table F3. Bachelor's and Master's Degree in the Three Most Common Majors/ Specialties by Race/ Ethnicity (%)

	African American/ Black *N*=45	Asian *N*=17	Hispanic/ Latinx/ Latine *N*=73	Multiracial *N*=15	White (non-Hispanic) *N*=261
BA/BS in Counseling	2.2	0.0	9.6	6.7	8.8

BA/BS in Psychology	11.1	5.9	19.2	20.0	9.6
BA/BS in Social Work	8.9	5.9	16.4	13.3	8.4
Master's in counseling	33.3	17.6	26.0	13.3	27.2
Master's in psychology	13.3	29.4	4.1	6.7	7.3
Master's in social work	31.1	41.2	24.7	40.0	38.7

Likelihood Ratio X^2 (20, N = 411) = 30.281, p = 0.065

Appendix G
Differences in License/Certification

Table G1. License/Certificate Type Percentage by Region (*N* = 552)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5	Overall
APN*	1.0	0.0	6.1	1.9	0.0	0.9	2.1
CADC	3.1	2.4	3	7.7	3.2	7.0	2.9
Clinical Psychologist	0.0	0.0	1.0	0.0	0.0	1.0	0.3
Community Health Worker	3.1	4.0	1.0	3.8	0.0	0.9	2.1
CRSS	3.1	4.0	2.0	0.0	1.6	4.4	1.4
LCPC	5.1	10.3	9.1	5.8	11.1	9.6	7.8
LCSW*	11.2	12.7	7.1	19.2	6.3	4.4	10.6
LPC	6.1	6.3	6.1	5.8	3.2	8.8	5.4
LPN*	0.0	0.0	0.0	3.8	0.0	0.0	0.7
LSW	13.3	11.1	8.1	11.5	12.7	6.1	9.4
LMFT	0.0	0.8	0.0	0.0	0.0	0.0	0.1
Physician	1.0	0.8	2.0	0.0	0.0	0.0	0.8
RN	0.0	0.8	3.0	1.9	3.2	1.8	0.7
OTHER	6.1	9.5	3.1	1.9	3.2	4.4	4.7

*denotes statistically significant regional differences, Chi-Square likelihood ratio ($p < 0.05$)

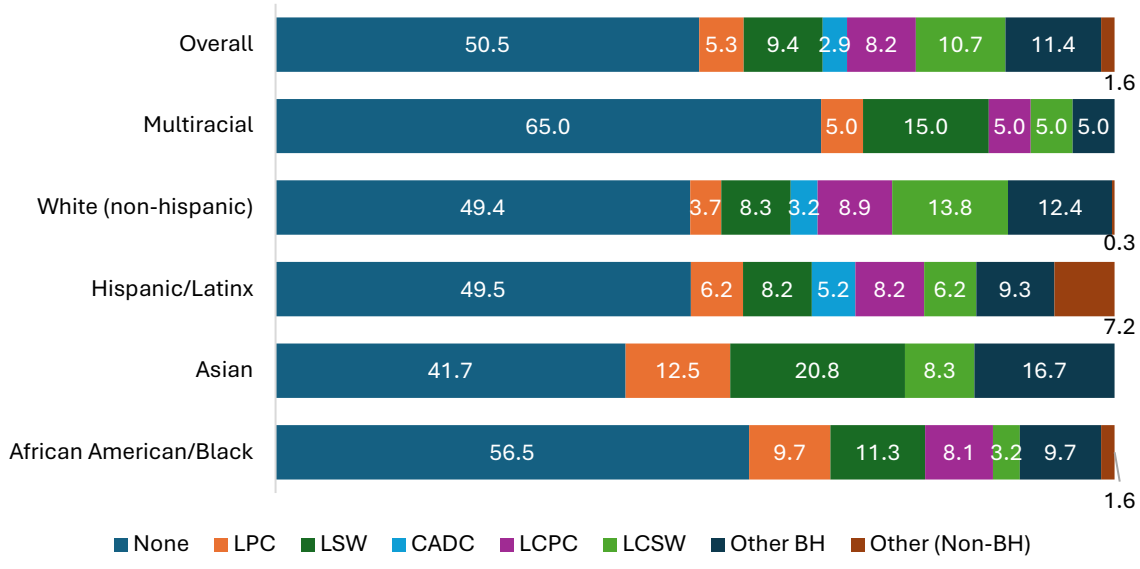
"Other" includes self-reports of the following: QMHP, QIDP, PEL Social Work Endorsement, NCSP, NCC, National Certified Counselor, MHP, accounting, metal health tech, CAN, Certified Specialist in Psychometry, Certified Registered Occupational Therapist (OTR/L), CCTP, DSP, CTRS, Board Certified Diplomate in Clinical Social Work, Board Certified Behavior Analyst, APRN.

For categorical analyses, types of licenses and certificates were combined to create one variable. If a provider reported more than one license/certificate, the highest level of

licensure was recorded. For instance, if a provider reported having both a LSW and LCSW, they were counted in the LCSW category. Since there were several license types that were held by only a few providers, they were collapsed into two categories, “other BH” (behavioral health) or “other”. “Other BH” contained the following: CRSS, Clinical Psychologist, Community Health Worker, CFPP, CRC, self-reported “MHP”, QMHA, APN, LPN, RN, CNA, BCBA, “Certified Specialist in Psychometry”, “Certified Registered Occupational Therapist”, and Physician. “Other” contained the following: QIDP, “accounting”, CMA, COTA/L, and DSP.

Differences in license/certificate type by race/ethnicity were statistically significant. Among African American/Black respondents, slightly over half do not have a license or certificate, with the LSW (11.3%) and LPC (9.7%) being the most common. White non-Hispanic providers show a varied distribution with about half not having a license or certificate, and the LCSW (12.8%) and “other behavioral health” (12.4%) being the most common. About half of Hispanic/Latinx providers lacked a license/certificate, with a fairly even split between LSW (8.2%), LCPC (8.2%), LPC (6.2%), and LCSW (6.2%). Multiracial respondents were the least likely racial/ethnic group to have a license or certificate with two-thirds not having one. The most common license for multiracial providers was the LSW (15%).

Figure G1. Licence/Certificate Type by Race/Ethnicity (%)



Likelihood Ratio X^2 (28, N = 552) = 52.941, p = 0.003