OREGON MENTAL HEALTH REGULATORY AGENCY
Diversity Study

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KEEN INDEPENDENT RESEARCH

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SUMMARY REPORT — Executive Summary

Oregon Mental Health Regulatory Agency (MHRA) seeks to support the diversity of professionals licensed by the Oregon Boards of Psychology (OBOP) and Licensed Professional Counselors and Therapists (OBLPCT). MHRA engaged Keen Independent Research (Keen Independent) in June 2022 to conduct a diversity study and provide related services.

The research project developed by MHRA required the study team to:

- Examine existing policies and processes;
- Study the demographics of the professionals licensed by OBOP and OBLPCT (professional counselors, marriage and family therapists and psychologists, collectively "the professions");
- Collect and analyze external stakeholder feedback;
- Identify opportunities for and barriers to increasing the diversity of the professions; and
- If findings warrant, recommend changes in policies or practices to support greater diversity in the professions.

Approach

Keen Independent analyzed policies, procedures and demographic data, conducted comparative analysis and scanned academic literature and other research for relevant information. Keen Independent conducted in-depth interviews, focus groups, and a virtual workshop to gather stakeholder feedback (which obtained input from 1,793 individuals).

The study began in June 2022 and was completed in fall 2022. Keen Independent collaborated with MHRA leadership and staff throughout the process.

Key Results

- Mental health professionals in Oregon are less diverse than they are nationally and less diverse than Oregon's population.
- Complaints filed are not always proportionate to the race, ethnicity and gender demographics of those professionals.
- Professionals perceive more substantial impacts on diversity from factors other than licensing and regulation.
- Disparities in representation of people of color in professions are not *caused* by the State's licensing and regulation, but licensing and regulation policies and actions can passively *perpetuate or exacerbate* inequities and lack of diversity.
- Practitioners reported distrust of the complaints and investigations process and outcomes, which is an important equity issue.
- MHRA and the boards have opportunities to support diversity in the professions, acting independently or in collaboration with others.

Recommendations

Keen Independent's summary report recommends that MHRA and the boards consider taking action over time in five areas:

1. Make and sustain a visible, active commitment to DEI.
2. Reconsider licensing policies and procedures to support equity.
3. Add safeguards around complaints, investigations and disciplinary actions.
4. Audit and improve communications and service.
5. Identify and to the extent possible advocate for, influence or support changes in factors external to MHRA and the boards to foster equity.

SUMMARY REPORT — Introduction

Oregon Mental Health Regulatory Agency (MHRA) seeks to support the diversity of professionals licensed by the Oregon Boards of Psychology (OBOP) and Licensed Professional Counselors and Therapists (OBLPCT) (collectively the "boards"). MHRA engaged Keen Independent Research in June 2022 to conduct a diversity study and provide related services.

Keen Independent Research (Keen Independent) assessed how the policies and procedures of the boards for professional licensure and renewal and for handling complaints and investigations may differently impact licensees from historically marginalized groups compared with other professionals. The research project developed by MHRA required the study team to:

- Examine existing policies and processes;
- Study the demographics of the professionals licensed by the boards (professional counselors, marriage and family therapists and psychologists, collectively "the professions");
- Collect and analyze external stakeholder feedback;
- Identify opportunities for and barriers to increasing the diversity of the professions; and
- If findings warrant, recommend changes in policies or practices to support greater diversity in the professions.

A challenge for MHRA and the boards is to integrate considerations of equity as they fulfill their statutory roles: protecting the public from harm through licensing and regulation of psychologists, licensed professional counselors and marriage and family therapists in Oregon. Actions taken to support the diversity of the professions must not disregard the consumer protection mission of MHRA and the boards and actions taken to support consumer protection must not disregard their obligation to protect *all* Oregonians.

Study Approach

To conduct the diversity study, Keen Independent:

- Reviewed Oregon MHRA, OBLPCT and OBOP policies and procedures;
- Compared Oregon MHRA, OBLPCT and OBOP policies and procedures to those of regulatory boards for mental health related professions in Oregon and other states;
- Analyzed demographic data about counselors, therapists and psychologists in Oregon;
- Searched academic literature and other sources for relevant research and recommendations;
- Conducted in-depth interviews and focus groups;
- Received stakeholder comments submitted through a study website, telephone hotline and email address;
- Invited feedback through a virtual workshop (similar to an online survey with more opportunity for open-ended input);
- Conducted qualitative analysis of interviews, focus groups, virtual workshop and other feedback to the study team; and
- Conducted quantitative analysis of the virtual workshop.

Topical analysis of supervised clinical experience. MHRA retained Keen Independent for additional analysis of supervised clinical experience requirements in October 2022. For this assignment, the study team compiled and analyzed comparative information from other U.S. states. We also analyzed relevant stakeholder feedback collected for the diversity study. In October 2022, Keen Independent presented results in public session to OBLPCT and submitted a written report to MHRA.

Organization of the Report

The report is organized as follows:

- Introduction;
- Key results; and
- Recommendations.

Information discussed in this summary document is supported by ten appendices and one topical analysis listed to the right.

- Appendix A summarizes the policies and procedures of MHRA, OBOP and OBLPCT and compares them to other regulatory agencies and boards.
- Appendix B analyzes demographic data for professionals subject to licensing and regulation by the boards.
- Appendix C describes the study methodology.
- Appendix D summarizes virtual workshop results.
- Several appendices examine feedback from practitioners, organized by the following topics:
  - Factors affecting diversity (Appendix E);
  - Licensing (Appendix F);
  - Complaints and investigations (Appendix G);
  - Equitable protection of mental health consumers and professionals (Appendix H);
  - Board composition (Appendix I); and
  - Opportunities and barriers (Appendix J).
- Appendix K defines key terms and concepts.

For ease of reference, the additional topical report on Oregon's supervised clinical experience requirement, which was requested and completed in October 2022, is included as Attachment 1 following the appendices listed above.

Study Participants

The MHRA diversity study had robust stakeholder participation. Endorsements for Keen Independent's diversity study helped promote engagement by members of the professions. These included:

- Oregon Psychological Association;
- Oregon Counseling Association; and
- Coalition of Oregon Professional Associations for Counseling and Therapy.

Focus groups and interviews. Keen Independent conducted focus groups with 18 Oregon mental health professionals (in four groups) and interviews with 60 individuals including:

- Mental health practitioners in Oregon (i.e., professional counselors, marriage and family therapists and psychologists);
- National mental health regulatory, policy or professional advocacy group contacts;
- Regulatory contacts for similar professions in Oregon and for counselors, therapists and psychologists in other states; and
- Internal MHRA stakeholders.

Interviews also included leaders of professional associations and individuals with experience as board members for the Oregon Board of Psychology or the Oregon Board of Licensed Professional Counselors and Therapists. Some practitioner participants identified themselves as involved in a patient advocacy organization.

Virtual workshop. Virtual workshop invitations and reminders to participate were emailed to professionals subject to licensing by OBLPCT and OBOP. The study team received input from 1,793 participants in the virtual workshop, which accounts for 17 percent of all mental health professionals under the two boards. This level of participation far exceeds what is typical for similar studies.

Practitioner characteristics. Practitioners who participated in the research process included a wide range of professional and demographic characteristics.

- Responses included practitioners from all three professions in all licensure stages and statuses (i.e., applicants for licensure including psychologist residents and registered associates as well as fully licensed professionals with active, semi-active and inactive license statuses).
- Participants ranged in experience from less than one year to more than 30 years.
- They included clinical supervisors, educators, professionals involved in patient advocacy organizations and people responsible for hiring and/or employing clinicians.
- Demographic characteristics of interviewees included representation across all race and ethnicity groups, a mix of genders, and professionals who identified as LGBTQ+.
- Participation also included individuals who reported a physical or intellectual disability, mental illness or neurodiversity.
- Participants live and practice throughout Oregon, including a mix of Portland area and non-Portland based professionals.

Methodology. The virtual workshop included ranking questions and open-ended questions, which allowed for both quantitative and qualitative analysis of responses. The team also examined qualitative information from interviews and focus groups.

Because of the large number of responses to the virtual workshop, one can consider the overall results reported in this study to be very close to what would be found if all practitioners had participated.

A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

Limitations. By design, identification of opportunities to change policies and practices to increase diversity in the professions emerged from analysis of stakeholder input. Stakeholder outreach focused on mental health and regulatory professionals.

The study purpose was to assess diversity and identify actions MHRA and the boards might take to support diversity in the professions. The study purpose did not include evaluating the impact on consumer protection of specific actions the boards might consider. As a result, the study scope did not include gathering input from stakeholders such as mental health consumers, their families or patient advocacy organizations. Therefore, information in this study on the potential consumer protection trade-offs of specific policy or practice change options is limited. [1]

As described in discussion of implementation and next steps at the end of this Summary Report (see page 26), MHRA and the boards should identify and prioritize potential actions that should be vetted through additional evaluation including consumer and consumer representative points-of-view.

[1] Many participants gave input that considered client interests, some reflected on their own experiences as mental health professionals and some identified themselves as involved in patient advocacy organizations However, participants were included because of their professional experience, not their consumer points-of-view. In addition, stakeholder input preceded the identification of possible policy and practice changes that may increase diversity.

Current Status of Diversity among Professionals

The study team examined the demographics of Oregon's psychologists, licensed professional counselors and marriage and family therapists compared to the population of Oregon and mental health practitioners nationally (see Appendix B).

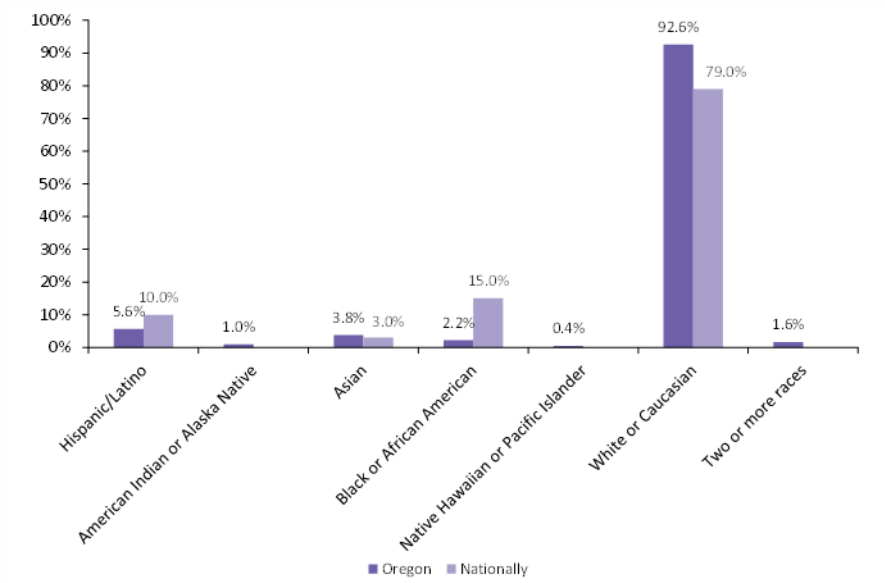
This analysis revealed disparities based on race and ethnicity, gender and languages spoken at home.

Mental health professionals in Oregon are less racially and ethnically diverse than the mental health professions in the nation.

- About 79 percent of mental health professionals in the United States identify as white alone compared to 93 percent in Oregon.
- Proportionately, there are seven times as many Black mental health professionals nationally compared to in Oregon.

The demographics of the mental health workforce across the nation and factors such as interest in mental health careers by people of color do not sufficiently explain the limited diversity in Oregon's professions. Factors that professionals believe contribute to limited diversity in the professions are described later in this Summary Report (page 11) and in Appendix E.

1. Race and ethnicity of all mental health licensees in Oregon compared to mental health professionals in the U.S., 2022



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

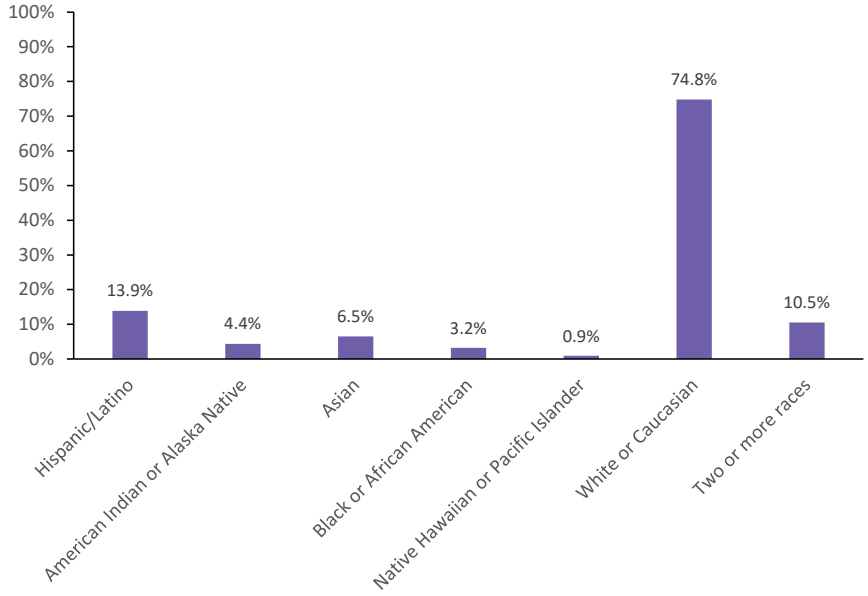
Source: Keen Independent Research from Oregon Mental Health Regulatory Agency, Bureau of Labor Statistics.

Oregon's mental health professionals are also less racially and ethnically diverse than the population of Oregon.

- About 75 percent of Oregon residents identify as white compared to 93 percent of Oregon mental health professionals.
- Every race and ethnicity group except white is underrepresented in the professions relative to their proportion in Oregon's population. For example, people who are Hispanic/Latino are about 14 percent of Oregon's residents, but less than 6 percent of mental health professionals.

The demographics of Oregon do not sufficiently explain the demographics of Oregon's mental health workforce. Factors that professionals believe contribute to limited diversity in the professions are described later in this Summary Report (page 11) and in Appendix E.

2. Racial and ethnic groups in Oregon, 2020



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent, https://www.census.gov/library/stories/state-by-state/oregon-population-change-between-census-decade.html

Most mental health professionals in Oregon are women, which is similar to national patterns.

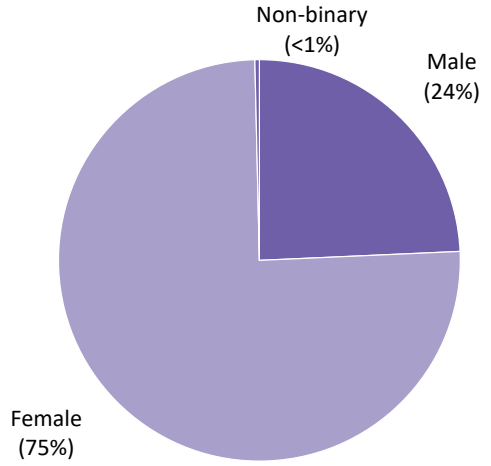
- About 75 percent of mental health professionals in Oregon reported their gender as female, which is similar to the nation.
- About half of Oregon's population is female.

Nationally, high representation of women in a field often correlates with lower pay for people working in that field.[2] Jobs that entail taking care of others ("care work"), including counseling, therapy and psychology, suffer an additional wage penalty.[3] Although the care work wage penalty is paid by both men and women in these occupations, the total penalty falls more on women as women dominate these professions.[4]

Oregon's mental health professionals are less diverse in terms of languages spoken at home than the population of Oregon.

For example, 9 percent of Oregonians speak Spanish at home, but only 6 percent of Oregon's mental health professionals do.

3. Gender of all mental health licensees in Oregon, 2022



Note: One percent of all licensees did not indicate their gender.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

[2] Levanon. A., England, P. & Allison, P. (2009). Occupational feminization and pay: assessing causal dynamics using 1950–2000 U.S. Census Data. *Social Forces*, *88*(2). 865–891. https://doi.org/10.1353/sof.0.0264

[3] England, P., Budig, M. & Folbre, N. (2002). Wages of virtue: The relative pay of care cork. *Social Problems*, *49*(4), 455–473. https://doi.org/10.1525/sp.2002.49.4.455

4 Ibid.

Demographic Characteristics of Complaint Respondents

The study team analyzed anonymized top-level data about complaints against practitioners between 2017 and 2022 and compared available demographics about the professionals subject to complaints ("respondents") to the demographics of the professions (see Appendix B).

Complaints against professionals are not always proportionate to the race, ethnicity and gender demographics of the professions.

- Practitioners in certain race and ethnicity groups were overrepresented in complaints relative to their proportion of the professions in several instances. These included:
  - Black and Hispanic/Latino psychologists;
  - Hispanic/Latino professional counselor registered associates; and
  - Marriage and family therapist associates of color, especially those who are Multiracial or American Indian/Alaska Native. (However, licensed marriage and family therapists of color were underrepresented in complaints.)
- Male practitioners were overrepresented in complaints in all professional groups examined.

Small numbers of professionals in certain racial and ethnic categories and even smaller numbers of complaints for the time period evaluated mean these quantitative analyses cannot provide strong answers about either the presence or absence of race or gender disparities in complaints.

However, the overrepresentation of certain groups in some categories suggests the need to be aware of the potential for bias to affect which professionals are more likely to be subject to complaints.[5]

[5] MHRA is required to investigate all complaints about the professionals it regulates. Complaints may be filed by any member of the public or by professionals who become aware of potential violations by other clinicians.

Distrust of the complaints and investigations process and outcomes is an important equity issue to recognize and address.

Qualitative analysis of practitioner comments found some evidence of distrust that complaints and investigations are equitable. Participants described processes that are subjective and therefore open to bias. Practitioners expressed concern that processes that are deliberately opaque to protect confidentiality lack checks and balances on potential bias.

Participants described concerns that investigations and board deliberations may not consider mitigating factors. Mitigating factors may be of particular concern for people of color who are more likely to have past interactions with the criminal justice system, for example.

They also expressed concern about what they perceived as law enforcement-style investigation techniques. There were concerns about bias and unfair treatment regarding practitioners of color. Fear about the use of law enforcement was also described as a possible deterrent for potential complainants.

When there is a complaint … from a client …, the implicit bias of the client and those on the board do not have checks and balances.

Biracial, female licensed professional counselor

Investigations and handling of complaints are too subjective … leaving a lot of room for inequity. Clearly delineated policies and fines for specific violations would reduce this.

White, female licensed professional counselor

I sat in board meetings where there was no consideration of the person's race, culture, identity [or] demographic gender expression when making decisions [about complaints]. I sat in meetings and [discussed past] convictions …. There should be a consideration that there [are more] arrests for Black individuals than white individuals.

Mental health practitioner of color

It appears that the board attempts to take a more colorblind approach [to investigating], instead of being aware of factors that may increase [the] likelihood of complaints against BIPOC.

Middle Eastern, female licensed psychologist

I feel like I would literally be calling the police on a fellow clinician [if I filed a complaint against them], and that does not sit right with me.

Asian American/Pacific Islander, female licensed professional counselor

The investigation process is abusive, intimidating, and punitive in ways that create fear for all providers. I am especially concerned about women of color or LGBTQ persons who are often trauma survivors, who in an investigation are treated in ways that can retraumatize them often over simple mistakes that harmed no one.

White, male licensed professional counselor

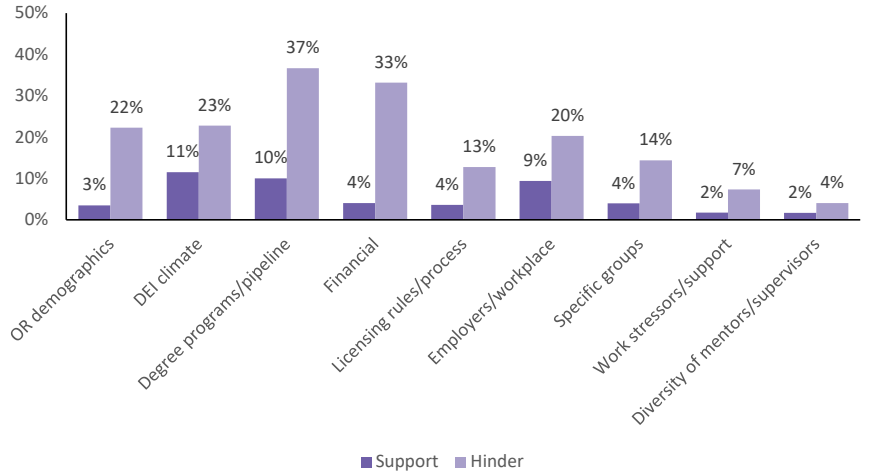
Factors Affecting Diversity

The study team asked counselors, therapists and psychologists in Oregon about factors affecting the diversity of the professions resulting in open-ended answers from 1,487 individuals. The team subsequently conducted both qualitative and quantitative analysis of the results.

The factors perceived as having the biggest impact on diversity are education programs and financial pressures.

Participants from all demographic groups and professions described education and financial concerns as hinderances to diversity. These issues are largely outside the purview of MHRA and the boards, aside from the financial impacts of licensing (discussed separately). Education barriers and financial pressures are not unique to Oregon.

4. Factors mentioned that support or hinder diversity in the mental health professions



Note: N = 1,487.
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

Education. Participants most frequently attributed limited diversity in the professions to a lack of diversity in the pipeline of graduates from Oregon's relevant degree programs. They particularly emphasized the limited diversity of graduates. Agency staff and participants with board experience frequently shared the view that diversity or lack of diversity in the professions begins well before licensing and regulation come into play. Simply put, MHRA and the boards cannot license candidates who currently don't exist.

The study team examined demographic composition of graduate students in a limited sample of relevant degree programs.[6] The demographics of students in these programs were similar to Oregon as a whole: about 74 percent white and 26 percent racially or ethnically minoritized groups, and more diverse than the demographic makeup of practitioners in Oregon.

The study team did not have access to data to determine whether students enrolled in these programs are looking more like the Oregon population now than in the past, but national trends suggest this is possible. For example, enrollment of racially and ethnically minoritized students in graduate psychology programs grew from 27 percent in 2006-07 to 35 percent in 2016-17 according to the American Psychological Association.[7]

Enrollment that more closely matches the demographics of Oregon's population may help to diversify the professions. Even if that occurs, closing the gap in licensed professionals of color compared to the population will take time.

[There is a] lack of effective recruitment of people in diverse groups [and a] lack of support and resources for underprivileged people who are interested in joining the profession.

Asian American/Pacific Islander, female licensed professional counselor

Many of the factors presenting challenges to persons pursuing higher education are systemic and beyond the control of boards.

Female professional counselor licensure applicant of color

Our graduate programs are not necessarily recruiting LGBT people or people of color. Since you can't get into licensure unless you have a graduate degree, I think that's a place to start looking.

White, LGBTQ+, non-binary licensed professional counselor

The lack of representation of faculty of color in our graduate institutions is extremely problematic, as are opportunities for recruitment and retention of BIPOC students.

American Indian, female licensed psychologist

[6] Four universities with six relevant degree programs in Oregon reported demographic data on enrolled students for 2020-21 in their accreditation reports to the Council for the Accreditation of Counseling and Related Education Programs.

[7] Bailey, D. (2020, January 1). *Enticing new faces to the field*. American Psychological Association. https://www.apa.org/monitor/2020/01/cover-trends-new-faces

Financial concerns. Financial barriers to entry to the professions were the second most frequently cited hinderance to diversity. These include:

- The cost of education, which can result in sizable student loan debt;
- Unpaid internships; and
- Compensation constraints for registered associates whose services are not covered by private insurance.

Many participants reported that the layered financial barriers for practitioners entering the profession may be insurmountable, particularly in combination with other socioeconomic challenges that are more likely for people of color, persons with disabilities and LGBTQ+ individuals.

The cost of graduate school is really problematic for most people. If you don't have the ability to secure loans or have … a cosigner on loans, that would be really challenging for students from marginalized backgrounds or who may not have financial support ….

Biracial, female licensed psychologist

To pay off school loans, someone [in this industry] may need to work extra hours or have a second job.

White, female licensed professional counselor

We just spent two years doing [a] graduate program …. Right at the tail end, we're asked to do six months of unpaid internship. We're working up to 32 hours a week for free … and having to pay bills.

White, female professional counselor associate

If I'm qualified to work with clients while I'm being supervised, why shouldn't I be able to take insurances and work with more people?

Middle Eastern, female professional counselor associate

Working as an intern is tough because many of the insurances will not panel with us while we're an associate …. [Oregon Health Plan] will pay us. Other insurances are not doing that.

White, LGBTQ+, non-binary professional counselor associate

A pre-licensed therapist [working in private practice] will mostly see patients who are self-paying … a reduced fee. It is difficult to keep a consistent caseload and those services are yielding very low income

National mental health professional association board member, out-of-state private practice owner

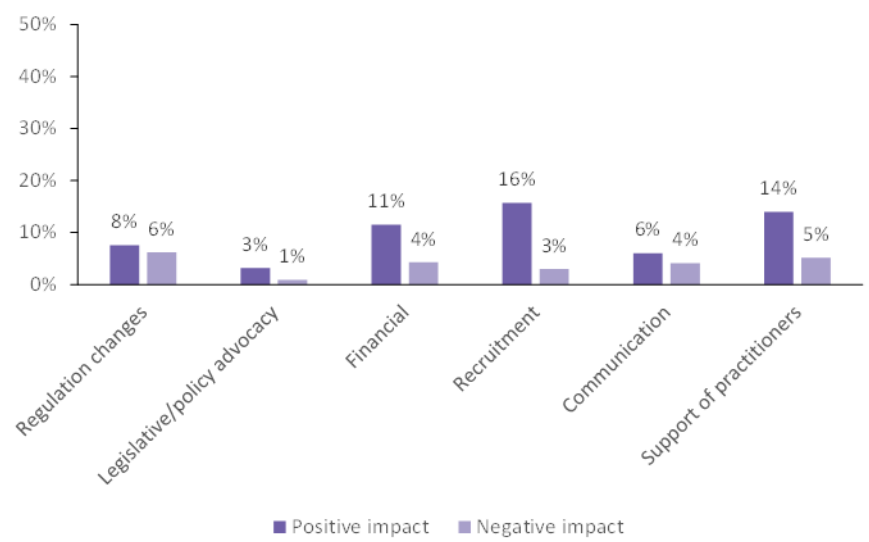
Licensing and regulation factors were much less frequently cited as barriers to diversity.

Licensing rules and processes fell among the three least frequently mentioned themes in open-ended response about hinderances to the diversity of the professions (see Figure 4). Additional analysis is provided in Appendix E.

The impact of MHRA and the boards may be overestimated based on misunderstandings of their scope.

Some comments reflected misunderstandings about the purview of MHRA and the boards. As a result, participants attributed responsibilities to the boards that are outside their scope. For example, when asked about board actions that can influence diversity, participants most frequently mentioned recruitment of students to the professions (see Figure 5).

5. Mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health professions



Note: N = 567.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

MHRA and the boards have opportunities to support diversity in the professions, acting independently or in collaboration with others.

Limited diversity in Oregon's mental health professions likely originates "upstream" from MHRA and the boards and many participants in the study were realistic about how much influence MHRA and the boards directly have on diversity of the professions.

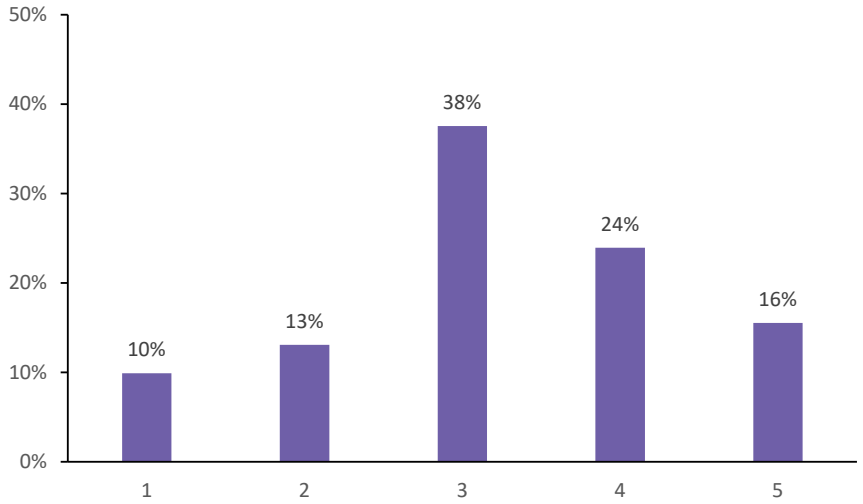
However, many participants in the study thought there was opportunity to have some influence. For example, more respondents believe the boards do have an influence on diversity in the professions (40%) than do not (23%), as shown in Figure 6. When asked about opportunities to promote diversity among Oregon mental health professions, about 33 percent suggested licensing changes.

About three times as many participants described licensing and regulation factors as potential hinderances to diversity than as supportive (see Figure 4). Professionals identified many possible ways MHRA and the boards may influence diversity that are within their purview such as regulations, communications and support (Figure 5). Participants also discussed opportunities and barriers to diversity related to licensing (see Appendix F) and complaints (Appendix G).

Keen Independent's analysis finds that disparities in the professions are not *caused* by licensing and regulation, but licensing and regulation policies and actions can passively *perpetuate or exacerbate* inequities. In some cases, MHRA and the boards can act independently on changes to support equity. In other cases, MHRA and board changes may depend on legislative action to change policies or allocate resources.

MHRA and the boards may have additional opportunities to support diversity through advocacy on issues that are external to the boards and by acting in collaboration with other organizations.

6. Ratings on a scale from 1 (very little) to 5 (very much) of MHRA and board influence on diversity in the mental health professions



Note: N = 1,688.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

SUMMARY REPORT — Recommendations

Keen Independent provides five recommendations based on results of the diversity study. Key themes behind these recommendations include the need for: (a) visible, consistent efforts to avoid exacerbating inequities and challenges facing professionals, (b) support for professionals and diversity in the professions as a means of supporting and protecting mental health consumers.

A summary of the recommendations is on the right. The balance of this report explains each overall recommendation and breaks them into individual steps.

- In some cases, the recommendations include initiatives already under consideration or in process at MHRA or the boards that could benefit from added support or resources.
- In other cases, the recommendations include ideas that may only be possible with legislative action or additional resources.
- Some of the recommendations relate to collaboration with other groups that might lead these efforts.

The recommendations are largely based on quantitative and qualitative information in Appendices A through J. The Summary Report does not fully explain all of the information collected in the study, so review of these appendices is necessary to understand the context and reasons behind these recommendations.

Also note that some of the recommendations address misunderstandings or lack of knowledge among some practitioners. Sometimes those misperceptions may be causing a lack of trust in MHRA or the boards. It is important for MHRA and the boards to better communicate their processes and to make strong statements, with corresponding visible action, about fairness, equity and support for diversity in the professions.

Summary of recommendations for MHRA and the boards:

1. Make and sustain a visible, active commitment to DEI.
2. Reconsider licensing policies and procedures to support equity.
3. Add safeguards around complaints, investigations and disciplinary actions.
4. Audit and improve communications and service.
5. Identify and to the extent possible advocate for, influence or support changes in factors external to MHRA and the boards to foster equity.

In the following pages, each recommendation is explained in detail.

1. Make and sustain a visible, active commitment to DEI

Results. MHRA and the boards are in the early stages of addressing a range of equity issues. Making and sustaining progress with limited resources and competing priorities will require long-term commitment and steady progress. One way to foster accountability is for MHRA and the boards to make public commitments to progress in these areas and to regularly update the public on their success.

Many professionals perceive the agency and boards as pursuing their mission of consumer protection as though it excludes parallel protections for professionals. Consequently, many professionals do not view MHRA and the boards as allies in fostering diversity and equity. These impressions, even if based on a lack of information, can create a negative narrative about the agency and boards that is counterproductive to their future diversity efforts. Some of the recommendations to the right are based on the following logic:

- The agency and boards exist to protect ALL consumers.
- Some consumers from historically marginalized groups want to receive services provided by professionals from similar backgrounds but may not receive services because of limited diversity in the professions.
- Therefore, protecting the interest of consumers from historically marginalized groups goes hand in hand with further supporting professionals from marginalized backgrounds and fostering greater diversity in the professions.

The recommended steps to the right also encompass training, resources, monitoring, and welcoming and responding to ideas and feedback. MHRA and the boards can do more to foster openness and inclusion, from operation of board meetings to routine communications with professionals.

Potential actions for MHRA and the boards:

A. Make a visible high-level commitment to equity.

i. Add equitable protection of professionals to agency and board mission or values.

ii. Publish DEI goals, track progress and share regular progress updates at least annually.

B. Operate boards inclusively.

i. Train staff and board members in skills that foster inclusion and belonging (e.g., inclusive meeting facilitation).

ii. Sustain opportunities for remote meeting participation by both board members and the public.

C. Align resources, monitor and make adjustments as needed.

i. Identify resource needs to achieve progress on equity and reallocate or request funding to close gaps.

ii. Monitor for the possibility of unintended consequences of equity related changes and make adjustments as needed.

D. Create systems and opportunities to welcome ideas and feedback.

i. Create opportunities to envision possible short and long-term changes that acknowledge constraints rather than being blocked by them.

ii. Create avenues for MHRA and boards to *hear from and respond* to feedback.

2. Reconsider licensing policies and procedures to support equity

Results. Most professionals who provided input to this study understood that licensing is not the primary cause of limited diversity in the mental health professions in Oregon. Even so, about one-third of open-ended comments from professionals about strategies to increase diversity suggested changes to licensing rules. Keen Independent identified several areas that warrant attention. Some of the recommendations are specifically related to potential concerns or misunderstandings from professionals that were expressed to the study team.

Criminal background declarations and checks. People of color are overrepresented in the criminal justice system in Oregon and are more likely to be negatively impacted by background questions and checks.[8]

Oregon law offers hiring protections for people with criminal records in both the public and private sectors. However, MHRA and board authority to question and consider interactions with the criminal justice system is expansive. Licensing declarations require disclosure of criminal arrests, charges or convictions even if the criminal justice system found no basis for charges or exonerated the individual.[9]

It is also possible that background questions and checks adversely impact diversity even if the boards are extremely judicious in use of the information. Some professionals may be uncertain how a licensing body would consider the information, which may discourage them from entering the professions.

Nationally, "ban the box" reforms have focused on opening employment opportunities to people with arrests or convictions. These efforts have involved regulating how and when public and private employers can consider criminal background information. "Ban the box" campaigns have also highlighted how occupational licensing background checks can create barriers to employment even in states that have adopted "fair chance" employment protections.

The National Employment Law Project recommends licensing background check questions and processes exclude long outdated information, arrests without convictions, set asides and expunged records. [10] They also recommend limiting information to what is actionable and directly relevant to the role being licensed and mandating consideration of rehabilitation or mitigating circumstances.[11]

[8] Vera Institute of Justice. (2019). *Incarceration trends in Oregon* [infographic]. https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf

[9] For example, "You must answer 'YES' even if you received a pardon, the charges were dismissed or dropped, the conviction or judgment was deferred or set aside, the records were expunged, or you entered into a pretrial diversion or deferred prosecution agreement."

[10] Rodriguez, M. and Avery, B. (2016, April 26) *Unlicensed and untapped: Removing barriers to state occupational licenses for people with records.* National Employment Law Project. http://www.nelp.org/publication/unlicensed-untapped-removing-barriers-state-occupational-licenses/

[11] Ibid.

Impairment declaration. The licensing declaration question related to "impairment" may give the impression that the boards discourage licensing of certain professionals. This question raised concerns for professionals with personal substance abuse histories, mental health issues, disabilities and neurodiversity. Vague wording and lack of context could cause some potential clinicians to opt out of the professions due to fear they will not qualify.[12]

Competency exams. Oregon requires standardized exams, one state and one national, for licensure. Evidence from related fields and for other standardized exams suggests cause for caution about validity and bias in credentialing exams. Assessment of the national exam for psychologists found evidence of bias, for example. Bias in competency exams for counselors and therapists has not been independently assessed but the National Board of Certified Counselors announced the establishment of a review committee to review exam content for potential bias. The state exam has not been evaluated for bias.

Concerns of bias and/or poor value predicting success have led some graduate programs and professional associations in related fields to drop exam requirements. Some graduate programs that have dropped the Graduate Record Examination (GRE) are evaluating results. The Boston University School of Public Health, for example, dropped the GRE admission requirement. Evaluation found that dropping the exam requirement increased diversity and did not adversely affect student performance in the program.[13] Evidence of bias in the national social work licensure exam has led the National Association of Social Workers Licensing Task Force to recommend removing the requirement for a licensure exam from proposed legislation for an interstate compact for social work.[14]

Supervised clinical experience (LPCs and LMFTs). Keen Independent evaluated supervised clinical experience requirements in a separate report, which is included following the appendices to this report. Oregon's requirements for direct client service are relatively high for counselors and therapists. Additional findings include the need to clarify Oregon's new requirement for employers to pay for supervision, the difficulty obtaining supervision from professionals from a similar demographic background or with similar client populations, and the possibility that a supervisor's lapse or violation could cause a loss of hours for the supervisee.

Financial barriers. Many professionals cited financial challenges separate from MHRA and the boards (education costs, compensation issues and insurers) as the biggest barriers. Licensing fees and payment policies may be modest by comparison, but these factors that are within MHRA and board purview may add to financial barriers for professionals from socioeconomically disadvantaged backgrounds.

[12] For example, "Do you have any condition that in any way impacts or may impair your capacity to perform the duties of a counselor or marriage and family therapist with reasonable skill and safety?"

[13] Sullivan L., Velez A., Longe N., Larese A., and Galea S. (2022). Removing the Graduate Record Examination as an admissions requirement does not impact student success. *Public Health*. 43 (1605023). doi: 10.3389/phrs.2022.1605023

[14] Memo from the Co-chairs of the National Association of Social Work Licensing Task Force. (2022, October 20). *Update on the Interstate Licensing Compact for Social Work & NASW public comment.* Socialworkers.org. www.socialworkers.org/LinkClick.aspx?fileticket=fSvAwJFwleg%3D&portalid=0

Licensing professionals from other jurisdictions. The process of obtaining licensure in Oregon may deter experienced clinicians who are licensed elsewhere from seeking a license in Oregon. Oregon has high levels of unmet mental health needs for consumers and a population of practitioners that is less diverse than is true elsewhere. Finding ways to ease the credentialing process for practitioners from out of state or outside the country could be beneficial for consumers and potentially add to the diversity of professionals licensed in the state.

License renewal and maintenance. Participants mentioned certain renewal policies and processes as possible barriers. High renewal fees in psychology may add a financial barrier for professionals with socioeconomic disadvantages. The frequency of renewal for LPCs and LMFTs, annually compared to biennially for psychology and many other boards, creates extra workload and increases the opportunity for renewals to be subject to late fees or for licenses to lapse.[15] Late renewals result in delinquent fees. When licenses lapse, professionals must reapply and cease practice until licensed or risk sanctions.

Some participants noted the opportunity for license status options to support diversity by accommodating family and medical needs without an age restriction. Currently, OBLPCT does not allow a semi-active status and OBOP only allows it for professionals who are 62 or older.

Continuing education (CE). Oregon requires that professionals meet the continuing education requirement by taking courses or undertaking other learning activities on a variety of subjects in each renewal period. Definition of qualifying CE varies between the professions.[16]

To avoid risk of activities not 'counting,' some professionals may feel limited to paid courses offered by recognized groups. Some professionals feel this limits the value of the CEs. Paid courses also have a financial impact that can add to barriers for professionals from socioeconomically disadvantaged backgrounds.

[15] MHRA is proposing a legislative concept, LC #0350, in the 2023 Legislative Session that will allow OBLPCT to change the frequency of renewals from annual to biennial.

[16] OBOP caps the hours for home study including internet and tele-courses but permits options such as reading books and articles and participating in formally organized study groups. OBLPCT does not cap home study hours but does not offer options for reading or study groups. OBLPCT counts paid supervision other than what is required to fulfill licensure or discipline requirements, but MHRA staff report that OBOP eliminated supervision as a CE option because professionals were trading supervision of each other to meet the requirement.

Potential actions for MHRA and the boards:

A. Reconsider requirements that may have inequitable impacts.

i. Reconsider the scope of required disclosures and background check information considered by the boards.

ii. Revise wording and communicate proactively online and in the portal about what is being asked, how it is viewed and how it is protected.

iii. Evaluate potential bias in the state rules and laws exam and follow/support efforts to understand and resolve issues of bias in national competency exams.

iv. Consider options to mitigate disparate impacts of exam bias (e.g., proposing lifting the statutory exam requirement).

B. Consider revised supervised clinical experience requirements.

i. Reduce direct service requirement for LPCs and LMFTs and reduce family/couple hours for LMFTs.

ii. Seek clarification on enforcement and parameters for employer obligation to pay for supervision.

iii. Support access to 'like' supervisors through on-line resources and consider supporting policy adjustments to increase access to out-of-state supervision.[17]

iv. Consider requiring or encouraging post-licensure supervision, consultation or other ongoing support.

v. Explore ways to protect supervised experience hours for registered associates from supervisor lapses or violations.

C. Consider fee modifications to support socioeconomic diversity and encourage service to underserved populations.

i. Explore sliding scale based on income or reductions or waivers for service to underserved populations.

ii. Offer opportunities to pay fees in recurring installments.

D. Facilitate interstate credentialing for services and supervision (e.g., address barriers to joining interstate compacts or identify options for smoother, faster and more flexible acceptance).

E. Reduce friction points in license renewal.

i. Reduce frequency for LPCs and LMFTs to every other year.[18]

ii. Reduce the psychologist renewal fee.[19]

iii. Offer semiactive status options for inclusivity related to family/medical circumstances.

F. Evaluate possible modifications to continuing education requirements.

i. Consider increased flexibility in topics and what "counts."

ii. Share examples of CEs approved in the past.

iii. Consider ongoing peer support/consultation or group supervision/support, whether paid or unpaid, as "counting" toward CEs.

[17] Clinical supervision by practitioners licensed outside of Oregon, but not in Oregon, would be unlicensed practice under Oregon statute.

[18] Frequency is set by statute. MHRA has a pending legislative concept to allow this change.

[19] MHRA staff note that this fee is high in part due to the reassignment of unlicensed practice cases from OBLPCT to OBOP due to an education loophole that prevents OBLPCT from acting on unlicensed practice by individuals who do not meet the educational qualifications for counseling or therapy licensure. Staff note that the costs also reflect the inability of OBOP to assess disciplinary costs.

3. Add safeguards around complaints, investigations and disciplinary actions

Results. Complaints, and therefore investigations, were more frequent for some demographic groups than others. Bias cannot be ruled out; nor can it be confirmed using available data. It is clear from the research that some practitioners have strong reservations about the fairness of complaints and investigations. MHRA and the boards should take action to address fears about complaint handling and investigations, even if some may be based on a lack of information.

The use of former law enforcement in investigations and use of "police-like" techniques (practitioners' words) are reasons some professionals gave for their distrust. This distrust focused on whether the processes would be fair and equitable for people of color.

Confusion about expectations for individuals who filed complaints ("complainants") was another area of discussion by professionals. Confusion about complaint and investigations processes was described as having a negative impact for all professionals and a potentially disparate impact for professionals from historically marginalized groups. A reason given for this disparate impact is that professionals unfamiliar with formal, legalistic procedures or unaware of how MHRA and board processes differ from the legal system may fare worse than those who are more familiar with such systems or have the benefit of legal counsel. Some professionals noted that they have no frame of reference for what to expect from the boards to help guide their decisions when they are complaint respondents.

Professionals expressed distrust and reservations about whether the boards can be counted on to be fair and consistent. Professionals view diverse representation on the boards as a safeguard but lack information about board demographics.[20] Mystery surrounding confidential situations prevents scrutiny and accountability. Lack of scrutiny and accountability can foster fear of unrecognized and unchecked bias.

Board members themselves describe cases and sanctioning decisions as complex and nuanced, sometimes involving mitigating factors. Nationally, experts note that there is little if any evidence about efficacy of disciplinary approaches, so boards are mostly operating on patterns they have previously established.

Designing and publishing intentional sanctioning reference points could help address practitioners' concerns. Reference points would benefit from being explicitly tied to the cause of the violation (ignorance, overwhelm or willful disregard) and the severity of the violation. We further recommend steps to foster transparency (within the boundaries of confidentiality) such as publishing data annually about complaints and actions.

Related to sanctions, MHRA and the boards may eventually wish to consider drawing from techniques used in restorative justice or mediation, for example, to expand options available to complainants and respondents.

[20] See Appendix A for information on efforts to recruit diverse board membership. See Appendix B for analysis of board demographics.

Potential actions for MHRA and the boards:

A. Take action to mitigate negative perceptions of use of former law enforcement.

i. Require training for MHRA investigators in clinical subject matter and investigation approaches that are less associated with policing.

ii. Prioritize clinical knowledge and experience when hiring future investigators.

B. Add and/or communicate procedures to safeguard respondent rights and well-being.

i. Explore options to "orient" respondents.

ii. Formalize procedures that prevent decisions on incomplete investigations.

iii. Establish standards for treatment of respondents in investigations.

iv. Establish a board level review process for complaints about investigation processes or techniques.

v. Consider options to prevent perceptions of conflict of interest (even if unfounded) when a respondent is a current or former board member.

vi. Reconsider the publication of disciplinary action in newsletters and/or the level of detail provided.

C. Add and/or communicate procedures to safeguard complainant rights and well-being.

i. Evaluate options for increasing protection of whistleblowers (especially registered associates).

ii. Require that staff speak to every complainant.

iii. Consider options to communicate reasons for dismissals.

D. Revise and potentially expand disciplinary action options.

i. Publish sanctioning reference points for consistency, transparency, and to reflect board disciplinary approach.

ii. Explore restorative justice, mediation or other techniques for opportunities to expand available action options.

E. Foster transparency and accountability to the extent possible.

i. Publish statistics on complaints and actions with demographic data relative to the professions overall.

ii. Publish statistics on the diversity of board membership.

iii. Publish statistics on how frequently the boards reject proposed orders by administrative law judges including explanations of the reasoning behind such decisions.

4. Audit and improve communications and service

Results. Quantitative and qualitative analyses of virtual workshop responses strongly indicate that the agency and board should expand communications and service. Current communication efforts include frequent e-newsletters, the board websites and open meetings consistent with Oregon law.

Many who provided input would like MHRA and the boards to be more informative, helpful and responsive. This theme was present in comments about licensure and renewals as well complaints and investigations (among both complainants and respondents). Some perceived an overly formal tone or generic nature of communications that did not resolve questions or address confusion. Some reported difficulties getting live support when needed or experienced delays in receiving that support. Some expressed specific concerns about language access or accommodations for persons with disabilities, neurodiversity or other challenges.

Perceived service gaps and communication challenges were especially troubling for professionals facing deadlines for action. Their experiences left some skeptical about whether professionals are treated fairly by the agency and the boards.

Comments frequently reflected lack of understanding of the mission, purview and actions of MHRA and the boards.

While service issues can impact all practitioners, they may have an outsized impact on professionals from historically marginalized groups or who need accommodations, for example for learning differences. Experiences reported by practitioners suggest that self-advocacy may be necessary to overcome barriers in the licensure process. When outcomes vary depending on the level of persistence and self-advocacy, inequities can result.

Potential actions for MHRA and the boards:

A. Evaluate and update communications and service to foster inclusion and belonging.

i. Identify and act on opportunities to communicate with professionals in ways that are welcoming, accessible, helpful, user-friendly and proactively head off issues.

ii. Set and enforce expectations for timely follow up.

iii. Ensure opportunities for live support and two-way communication.

B. Use communications to reduce common misunderstandings and friction points.

i. Evaluate options to head off common questions and enhance understanding about licensing, complaints, and information on the role and responsibility of MHRA and the boards relative to other groups.

ii. Increase the frequency and vary the methods for renewal communications to reduce lapses.

C. Modify communications for complainants and respondents.

i. Evaluate options to educate potential complainants about avenues for types of concerns (including those not actionable by the boards) and available remedies.

ii. Evaluate options to improve information for complaint respondents about the process and their rights.

D. Support language access to information currently only available in English (PDFs).

5. Identify and to the extent possible advocate for, influence or support changes in factors external to MHRA and the boards to foster equity

Results. Some key barriers to diversity and equity in the professions are beyond the purview of MHRA and the boards. These include:

- Education-related issues such as lack of diversity of students entering and graduating from relevant Oregon degree programs and financial challenges related to tuition costs, unpaid internships and student loans;
- Financial barriers such as insurance exclusions for services by registered associates, reimbursement and compensation rates and Medicare exclusion of LPC services; and
- Resources and practices to support diverse and equitable workplaces.

Many participant comments reflected belief that MHRA and the boards have some authority over degree programs, education funding, insurers or employers. They do not. MHRA and the boards have a role defined by a combination of statute and policies: licensing and regulation of professionals. Even within this purview, some parameters are set by Oregon statute, not by MHRA and the boards.

MHRA and the boards face constraints about affecting broader change through influence or advocacy. For example, the Governor's Office prohibits agencies from taking a position on any legislation other than supporting legislation the agency itself has introduced that has already been vetted and approved by the Governor's Office.

Within these limitations, MHRA and the boards should consider ways outside of licensing and regulation they can support diversity in the professions. Recommendations to consider are shown to the right.

Potential actions for MHRA and the boards:

A. Be influential by being informative.

i. Proactively publish evidence or data available to MHRA and the boards about mental health professionals to help inform the priorities and activities of education programs, employers, legislators or funders.

ii. Set and share a research agenda "wish list" to welcome possible collaborations, prompt academic interest or help guide funders.

iii. Share information about the roles, responsibilities, priorities and programs of other groups in the counseling, therapy and psychology professional ecosystem.

B. Work around the boundaries of advocacy.

i. Consider collaborations with other groups that do not depend on legislation or legislative advocacy.

ii. Inquire about processes to request approval to submit information relevant to legislation proposed by others.

Implementation

Keen Independent offers these recommendations understanding that not all may be feasible, that MHRA and the boards are not able to implement certain recommendations on their own, that resources may not be available to effectively address all of them, and that there are trade-offs concerning other parts of their mission. As noted in the discussion of study scope, Keen Independent identified potential actions MHRA and the boards might take to increase diversity, but the scope did not include vetting possible trade-offs or collecting additional stakeholder perspectives on potential policy or practice changes.

After MHRA and the boards review these recommendations with these considerations in mind, they will need to make decisions about what is most important to pursue and plan how to proceed.

Many of the recommendations proposed here will take time. MHRA and the boards are encouraged to undertake a combination of strategies that include both near-term changes that can be acted upon relatively swiftly and longer-term changes that may be more difficult but important to accomplish.

Suggested next steps:

- Communicate MHRA's and boards' commitment to diversity, equity and inclusion to stakeholders.
- Assign responsibility for the launch of a comprehensive DEI plan that considers the information in this report as well as other input from stakeholders.
- Identify steps MHRA and the boards can take near term, mid-term and long term, independently or in collaboration with others.
- Identify and act on "quick wins."
- Identify resource needs and funding solutions for priorities that require additional evaluation or investment.[21]
- Regularly report back to elected officials, industry partners, practitioners and other stakeholders.

[21] Be cautious about closing funding gaps through increased license fees which could exacerbate socioeconomic barriers in the professions.

APPENDIX A. MHRA, OBOP and OBLPCT — Introduction

Appendix A analyzes the role of diversity in the licensing, complaints and investigations process of the Oregon Board of Psychology (OBOP) and the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT). Both OBOP and OBLPCT operate under the Oregon Mental Health Regulatory Agency (MHRA). The information for this analysis is derived from official board policies and reports as well as from documents and resources referred to the study team during interviews with licensing professionals.

MHRA's Diversity and Inclusion Statement, quoted below, reflects a desire to include staff who represent the demographics of the Oregon population.[1]

> *The Mental Health Regulatory Agency is dedicated to building and maintaining a culture of inclusiveness. We believe that all forms of diversity—age, gender identity, race, sexual orientation, physical or mental ability, ethnicity, socioeconomic status, religion, military status and perspective—create immense value within the agency and helps drive our strong core commitment to public protection. We strive to create a workplace that reflects the stakeholders we serve and where everyone feels empowered to bring their full, authentic selves to work.*

Keen Independent organized information in this appendix as follows:

- Overview:
  - Purpose and principals; and
  - Structure, policies and demographics.
- Licensing, complaints and investigations:
  - Initial licensure;
  - Renewing and maintain licensure; and
  - Complaints and investigations.
- Comparative analysis of other boards:
  - Licensing and renewal of licensure; and
  - Complaints and investigations.

[1] Hill, C. (2019). *State of Oregon Mental Health Regulatory Agency: Diversity & Inclusion/ Affirmative Action Statement*. State of Oregon Mental Health Regulatory Agency: https://www.oregon.gov/oblpct/Documents/MHRA_2019-21_AA_Stmt_FINAL.pdf

A. MHRA, OBOP and OBLPCT — Overview of OBOP and OBLPCT

Overview

This section examines the mission statements, structure, jurisdiction and training of MHRA, OBOP and OBLPCT to analyze their impact on diversity and inclusion.

This section includes the following parts:

- Purpose and principals:
  - Mission statements and board composition; and
  - Code of ethics and professional conduct.
- Structure, policies and demographics:
  - Authority of the boards;
  - Appointing new members to the boards;
  - Board meetings; and
  - Demographics.

A. MHRA, OBOP and OBLPCT — Overview of OBOP and OBLPCT

Purpose and Principles

MHRA provides administrative support to OBOP and OBLPCT including financial, human resources and procedural coordination.[2] The two individual boards oversee licensing, complaint investigation and fee collection.[3]

Mission statements and board composition. MHRA, OBOP and OBLPCT are each directed by individuals appointed by the Governor. These organizations are authorized to regulate the licensed professionals within the purview of the boards and to ensure consumer protection. The mission statements and a description of board composition for MHRA, OBOP and OBLPCT are described below.

Oregon Mental Health Regulatory Agency. The Oregon Mental Health Regulatory Agency's mission is to "provide administrative and regulatory oversight" of OBOP and OBLPCT.[4] MHRA has one Executive Director who is jointly appointed by OBOP and OBLPCT, or in the case of disagreement is appointed by the Governor.[5] The current Executive Director was appointed by the OBOP and OBLPCT in 2015.[6]

Oregon Board of Psychology**.** The Oregon Board of Psychology's mission is to "promote, preserve, and protect the public health and welfare by ensuring the ethical and legal practice of psychology."

OBOP has three program areas that accomplish this mission:

- Examining new applicants;
- Issuing licenses and license renewals; and
- Ensuring consumer protection.

The nine-member OBOP includes six licensed psychologists and three members of the public appointed by the Governor for three-year terms.[7]

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[2] Oregon ORS. § 675.160 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html. See also https://www.oregon.gov/mhra/Pages/About.aspx.

[3] Mental Health Regulatory Agency. (n.d.). *About the Agency.* Oregon.gov. https://www.oregon.gov/mhra/Pages/About.aspx

[4] Ibid.

[5] Oregon ORS. § 675.178 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html

[6] Charles Hill began serving as Executive Director in March 2015 and was still in this position at the time of this report. For a summary of his appointment process and credentials see Ferder, F. (2015). Welcome, New Executive Director Charles Hill. *The Examiner,* 1. https://www.oregon.gov/psychology/Documents/Newsletter_Spring_15.pdf. "The Examiner" is the precursor to the present OBOP quarterly newsletter. For his introductory letter to OBLPCT see Hill, C. (2015). Executive Director's Report [Review of Executive Director's Report]. *OBLPCT Quarterly Newsletter, 5*(1), 1-2. https://www.oregon.gov/oblpct/Documents/Newsletter_Summer_15.pdf

[7] Board of Psychology. (n.d.). *About the Board*. Oregon.gov. https://www.oregon.gov/Psychology/pages/Board.aspx

Oregon Board of Licensed Professional Counselors and Therapists.

The Oregon Board of Licensed Professional Counselors and Therapists' mission is to "protect the public by identifying and regulating the practice of qualified mental health counselors and marriage and family therapists."

OBLPCT has the same three program areas as OBOP to accomplish this mission. The eight-member board includes three professional counselors, two marriage and family therapists, a faculty member from an accredited counselor and therapist school and two members of the public. These board members, like OBOP board members, are appointed by the Governor for three-year terms.[8]

Code of ethics and professional conduct. Both boards that are under the jurisdiction of MHRA have adopted national codes of ethics.

- OBOP adopted the 2010 American Psychological Association's Ethical Principles of Psychologists and Code of Conduct.[9]
- OBLPCT adopted the 2014 American Counseling Association Code of Ethics.[10]

[8] Board of Licensed Professional Counselors and Therapists (n.d.). *About the Board*. Oregon.gov. https://www.oregon.gov/oblpct/Pages/Board.aspx

[9] Oregon OAR. § 858-010-0075 (n.d.). https://secure.sos.state.or.us/oard/view.action?ruleNumber=858-010-0075. See also American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2003, amended effective June 1, 2010, and January 1, 2017) https://www.apa.org/ethics/code/index

[10] Oregon OAR. § 833-100-0011 (n.d.). https://secure.sos.state.or.us/oard/view.action?ruleNumber=833-100-0011. See also American Counseling Association. (2014). *2014 ACA code of ethics*. https://www.counseling.org/knowledge-center/ethics

A. MHRA, OBOP and OBLPCT — Overview of OBOP and OBLPCT

Structure, Policies and Demographics

The mission statements and national standards of ethics and professional conduct for each board, paired with the state laws and regulations, guide the jurisdiction and authority of OBOP and OBLPCT.

Authority of the boards. MHRA is authorized by the Oregon Revised Statutes to provide administrative oversight for OBOP and OBLPCT.[11] Some of the outlined duties are:

- Budgeting;
- Record keeping;
- Staffing;
- Contracting; and
- Other administrative actions to "reduce regulatory burdens without compromising regulatory standards" for OBOP and OBLPCT.[12]

The Oregon Revised Statutes authorize OBOP and OBLPCT to perform several tasks including the following:

- Adopt rules to administer the work of the board;
- Issue, renew, suspend, revoke and restore licenses;
- Establish fees; and
- Maintain an active directory of licensed individuals.[13, 14]

Regarding complaints and investigations, the boards are authorized to:

- Adopt a code of ethics (in this case, each board has adopted a national code);
- Require state or national criminal record checks;
- Perform investigations; and
- Issue subpoenas.[15]

[11] Oregon ORS. § 675.166 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html
Oregon ORS. § 675.169 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html

[12] Oregon ORS. § 675.169 (1)(g) (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html

[13] Oregon ORS. § 675.110 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html

[14] Oregon ORS. § 675.785 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html

[15] Ibid.

A. MHRA, OBOP and OBLPCT — Overview of OBOP and OBLPCT

Appointing new members to the boards. The Governor appoints all member of OBOP and OBLPCT.[16] Appointments to these two boards are only some of the over 250 appointments to boards and commissions over which the Governor has authority. The Governor's website states that these appointments are made with attention to diversity and providing appointees that are representative of the demographics of Oregon. Submitting demographic information in the application is optional.[17]

Applicants to OBOP or OBLPCT board positions must submit an online application and agree to a background check. The Governor's website states that concerning background check results or concerning unmet financial obligations are an automatic reason for denial of an application.

Neither the Governor's Executive Appointment Office or the Membership Handbook detail a standardized matrix for denial of applications based on background check results or financial reports.[18, 19] A published standardized matrix may help an individual interested in board service evaluate their eligibility as well as assure applications for board appointments are assessed fairly and without prejudice.

Appointed board members receive a per diem compensation for their service.[20] A 2021 Oregon House Bill increased the per diem compensation to "reduce systemic barriers to participation."[21] Appointed board members also receive an introductory training that includes a section on diversity and inclusion.[22]

Board meetings. Both boards meet regularly every other month and may call special meetings as needed. [23] [24] Scheduled meetings are listed on each board's website as well as meeting agendas with information on requesting disability access or interpretive services to attend upcoming meetings. Meeting minutes are published on the website.

Both OBOP and OBLPCT allow remote meeting attendance via Zoom. Oregon enacted legislation January 1, 2022, requiring public governing body meetings to offer remote methods for public attendance and participation on an ongoing basis.[25]

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[16] MHRA and the boards actively recruit board members with diversity in mind. Considerations include personal and demographic characteristics, professional areas of expertise and geographic distribution. The Governor makes final decisions and appointments. Efforts by the agency and boards to recruit diverse members may not always directly benefit the OBOP and OBLPCT. For example, MHRA staff noted two recent cases when candidates they had recruited were appointed by the Governor to other state boards instead of OBOP or OBLPCT.

[17] Office of the Oregon Governor Kate Brown. (n.d.). *Boards & Commissions*. https://www.oregon.gov/gov/Pages/board-list.aspx

[18] Ibid.

[19] Brown, K. (2015). *Membership Handbook for Boards & Commissions*. State of Oregon. https://www.oregon.gov/gov/Documents/Board%20Handbook_2-18-15.pdf

[20] Oregon OAR. § 858-010-0005 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285887

[21] HB 2992, Oregon law. C. 627 (2021) https://www.oregon.gov/gov/SiteAssets/How_To_Apply/HB-2992-FAQ.pdf

[22] State of Oregon. (2018). (New Board Member Training) *Overview of Boards, Commissions, & Small Entities*. See pages 19-20 Module 5. https://www.oregon.gov/das/HR/Documents/BC.pdf

[23] State of Oregon. (n.d.). *About the Board*. Board of Psychology: State of Oregon. https://www.oregon.gov/Psychology/pages/Board.aspx

[24] State of Oregon. (n.d.). *About the Board*. Board of Licensed Professional Counselors and Therapists: State of Oregon. https://www.oregon.gov/oblpct/Pages/Board.aspx

[25] HB 2560, Oregon ORS. § 192.670 (2021). https://oregon.public.law/statutes/ors_192.670

A. MHRA, OBOP and OBLPCT — Overview of OBOP and OBLPCT

Demographics. The Oregon Health Authority is authorized by the 2015 Oregon Senate Bill 230[26] and the Oregon Administrative Rule Chapter 409, Division 026[27] to collect and report the demographic data of health care workers. OBOP and OBLPCT are among the health care workforce regulatory boards required by this Senate Bill to report demographic data. OBOP and OBLPCT comply by including collection of these data as part of the license renewal process for each board.[28]

OBOP[29] and OBLPCT[30] each discuss membership demographics in a quarterly newsletter. The Spring 2021 issue of the OBOP newsletter reported the findings from the Oregon Health Authority 2020 Health Care Workforce Reporting Program[31] on underrepresentation of ethnically diverse health care providers relative to the actual demographics of the general population of the state. The Fall 2020 OBLPCT newsletter encouraged members to disclose their demographic data to the Oregon Health Authority as part of their renewal process (disclosure is voluntary and not mandatory for renewal).

The OBOP newsletter also explained some of the diversity of new board members by discussing the background experience and some demographic information for these members in the Summer 2021 and Spring 2021 issues. The OBLPCT newsletter included the background and diversity interests of additional new board members in its Winter 2022 issue.

OBLPCT members are listed on the website with short biographies and photos. OBOP members are listed with a name and photo only. Some aspects of diversity on the board are evident from photos, but others are not.[32] Board demographics are described in Appendix B.

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[26] Oregon State Legislature. (n.d.). *SB 230 2015 Regular Session - Oregon legislative information system* https://olis.oregonlegislature.gov/liz/2015R1/Measures/Overview/SB230

[27] *Oregon Secretary of State administrative rules*. (n.d.). Secure.sos.state.or.us. Retrieved August 18, 2022, from https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1659. See also https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Health-Care-Workforce-Reporting.aspx, and https://www.oregon.gov/oha/OEI/Pages/REALD.aspx.

[28] See the Fall 2020 OBOP newsletter and the Race, Ethnicity, Language, and Disability (REALD) Implementation program operated by the Oregon Health Authority at https://www.oregon.gov/oha/OEI/Pages/REALD.aspx. See also the Winter and Spring 2020 OBLPCT newsletter featuring the Oregon Health Authority's publishing the 2020 healthcare workforce report.

[29] Board of Psychology. (n.d.). *Newsletters: State of Oregon*. https://www.oregon.gov/psychology/pages/newsletters.aspx

[30] Board of Licensed Professional Counselors and Therapists. (n.d.). *Newsletters: State of Oregon*. https://www.oregon.gov/oblpct/Pages/newsletters.aspx

[31] Oregon Health Authority. (2021, September). *Oregon's Licensed Health Care Workforce*. https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonslicensedhealthcareworkforce/Overview?%3Aorigin=card_share_link&%3Aembed=y&%3AisGuestRedirectFromVizportal=y#1

[32] Visibility of information about board members has varied over time. MHRA staff note that changes have been made about what is shared due to safety threats against board or staff and the currently published information is subject to change as risks are assessed.

A. MHRA, OBOP and OBLPCT — Overview of OBOP and OBLPCT

Diversity and inclusion. MHRA's 2019–2021 Diversity and Inclusion and Affirmative Action Statement details its commitment to diversity and inclusion in MHRA as a workplace as well as resources that board members and licensed professionals may use to increase efforts in diversity and inclusion.[33]

This document outlines informal and formal complaint processes MHRA employees may utilize to resolve concerns of unfavorable workplace conditions. The document provides contact information for other official agencies that have authority to address these concerns. This allows employees to report to another agency if they are uncomfortable reporting to MHRA, OBOP or OBLPCT. Additional agencies include the Oregon Bureau of Labor and Industries Civil Rights Division, the Oregon Governor's Affirmative Action Office, the federal Equal Employment Opportunity Commission and the federal Department of Labor.

MHRA also outlines in this document the Agency's diversity and inclusion statement, specific goals and objectives, progress towards these goals and objectives and additional efforts by the Agency. For example, board members are also required to attend any diversity and cultural competency training required by the Governor's Office or by the State Chief Human Resource Office. These trainings may also be recommended to the general population of licensees in each board but are not required.

MHRA requires all licensees to complete four hours of continuing education in cultural competency. Psychologists must complete these four hours every two years for license renewal. LPCs and LMFTs must complete these four hours of cultural competency training every two years and must renew their license every year.[34]

[33] Hill, C. (2019). *State of Oregon Mental Health Regulatory Agency: Diversity & inclusion/ affirmative action statement*. State of Oregon Mental Health Regulatory Agency: https://www.oregon.gov/oblpct/Documents/MHRA_2019-21_AA_Stmt_FINAL.pdf

[34] Ibid.

A. MHRA, OBOP and OBLPCT — Licensing, complaints and investigations

As previously described, both OBOP and OBLPCT have authority to issue licenses and to ensure consumer protection. Psychologists are licensed by OBOP, and licensed professional counselors and licensed marriage and family therapists are licensed by OBLPCT.[35, 36]

The following section provides an overview of:

- The volume of licenses, complaints and investigations the boards administered in recent years;
- The initial licensure process;
- Requirements to renew and maintain a license; and
- The complaint and investigation process.

[35] For access to all relevant Oregon Revised Statutes and Oregon Administrative Rules pertaining to the Oregon Board of Psychology, see https://www.oregon.gov/psychology/Pages/LawsRules.aspx

[36] For access to all relevant Oregon Revised Statutes and Oregon Administrative Rules pertaining to the Oregon Board of Licensed Professional Counselors and Therapists, see https://www.oregon.gov/oblpct/Pages/LawsRules.aspx

A. MHRA, OBOP and OBLPCT — Licensing, complaints and investigations

Licensing and Complaint Volume

Licensing quantity. MHRA includes many professionals throughout Oregon, with new licensees added every year. As shown in Figure A-1, in 2021, 7,923 professionals held licenses issued by OBOP and OBLPCT and the boards issued 897 new licensees that year.[37]

Complaints and investigations quantity. Both OBOP and OBLPCT are authorized to ensure consumer protection by receiving and handling complaints. Between 2017 and 2022:

- OBOP received 287 complaints against psychologists.
- OBLPCT received 60 complaints against LMFTs and 45 complaints against marriage and family therapist associates.
- OBLPCT also received 332 complaints against LPCs as well as 180 complaints against professional counselor associates.

Appendix B of this report details the quantity of complaints and investigations processed between 2017 and 2022 including demographics about professionals who were the subject of complaints.

A-1. MHRA 2021 licensing summary

	Total licensed professionals at year end	Total new licenses issued during year
OBOP		
Psychologists	2,236	140
OBLPCT		
Licensed Professional Counselors	4,340	539
Licensed Marriage and Family Therapists	1,347	218
Subtotal	**5,687**	**757**
Grand total	**7,923**	**897**

Note: Information from OBOP Winter 2022 Newsletter and OBLPCT Winter 2022 Newsletter.
Source: Keen Independent Research.

[37] See OBOP and OBLPCT's winter 2022 newsletters.
Board of Licensed Professional Counselors and Therapists. (2022). *OBOP NEWS 2022 Winter Edition.*
https://www.oregon.gov/psychology/Documents/Newsletter_Winter_22.pdf
Oregon Board of Licensed Professional Counselors and Therapists. (2022). *OBLPCT NEWS 2022 Winter Edition*.
https://www.oregon.gov/oblpct/Documents/Newsletter_Winter_22.pdf
See also Oregon Health Authority. (2021, September). *Oregon's Licensed Health Care Workforce*. Health Care Workforce Reporting Program. https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonslicensedhealthcareworkforce/Overview?%3Aorigin=card_share_link&%3Aembed=y&%3AisGuestRedirectFromVizportal=y#1

A. MHRA, OBOP and OBLPCT — Licensing, complaints and investigations

Initial Licensure

Figure A-2 provides a summary of the requirements for initial licensure of psychologists, licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs).

Initial licensure requirements common to both boards. We begin with synthesis of requirements that are similar across OBOP and OBLCPT followed by initial licensure requirements that are specific to each board.

Licensure by Oregon. All LPCs, LMFTs and psychologists (including supervisors) who practice in Oregon must be licensed in Oregon. MHRA staff have been advised that participation in interstate compacts to permit geographic reciprocity for licensees would violate Oregon's constitution.

- OBOP does allow licensure by endorsement from states with comparable licensure requirements.[38] It also offers a visitor's permit option for temporary practice within Oregon for psychologists licensed in other states.[39]
- OBLPCT also accepts applications for "licensure by reciprocity" for individuals with comparable licenses in other jurisdictions.[40] MHRA is proposing to add a visitor's permit option for LPCs and LMFTs from other states in 2023, but this requires legislative approval.

A-2. Comparison of initial licensure for MHRA

	OBOP	OBLPCT	
	Psychologist	Licensed Professional Counselor	Licensed Marriage and Family Therapists
Education	Doctorate	Master's	Master's
Examinations			
National	Yes	Yes	Yes
State	Yes	Yes	Yes
Supervised experience			
Minimum months of post-degree experience	12	24	24
Hours during degree	1,800	400	400
Hours after degree	1,500	2,000	1,000
Hours with couples/families	0	0	1,000
Total hours	**3,300**	**2,400**	**2,400**
Fees			
Application	$ 325	$ 175	$ 175
License	0	125	125
State examination	155	0	0
Criminal record check	46	46	46
Total	**$ 526**	**$ 346**	**$ 346**
Geographic reciprocity	No	No	No

Source: Keen Independent Research.

[38] Oregon OAR. § 858-010-0017 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=219808

[39] Oregon OAR. § 858-010-0055 (n.d.). https://secure.sos.state.or.us/oard/view.action?ruleNumber=858-010-0055

[40] Oregon OAR. § 833-020-0051 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=201733

Exams. Both boards require candidates to pass the Oregon law and rules exam.[41] Candidates must also pass a national credentialing exam. The exam options differ by profession as listed to the right.

One assessment of the national exam for psychologists found evidence of bias in 2019.[42] The Association of State and Provincial Psychology Boards (ASPPB), which both designs and administers the Examination for the Professional Practice of Psychology (EPPP), disputes that the exam is discriminatory against racially minoritized professionals.[43] Recent revisions to the EPPP have also come under critique as needing validation against bias.[44]

Bias in competency exams for counselors offered by the National Board of Certified Counselors (NBCC) has not been independently assessed, but in 2021, NBCC announced the establishment of a committee to review exam content for potential bias.[45] NBCC has not published additional information about this effort.

The study team was unable to locate any evidence that the state law and rules exam has been evaluated for bias.

National exams accepted by OBOP and OBLPCT by profession are:

Psychologists

- The Association of State and Provincial Psychology Boards' Examination for the Professional Practice in Psychology (EPPP).[46]

Licensed professional counselors

- The National Board of Certified Counselors' National Counselor Exam (NCE) or National Clinical Mental Health Counselor Examination (NCMHCE); or
- Certified Rehabilitation Counselor Examination (CRCE).[47]

Licensed marriage and family therapists

- Marital and Family Therapy Exam of the Association of Marital and Family Regulatory Boards; or
- Marriage and Family Therapist Written Clinical Examination of the State of California Board of Behavioral Sciences.[48]

[41] Oregon OAR. § 858-010-0030 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=276074

[42] Sharpless, B. A. (2019). Are demographic variables associated with performance on the Examination for Professional Practice in Psychology (EPPP)? *The Journal of Psychology*, *153*(2), 161–172. https://doi.org/10.1080/00223980.2018.1504739

[43] Grusec et al. (n.d.). *EPPP myths verses reality*. Association of State and Provincial Psychology Boards. https://www.asppb.net/page/MythsvsReality

[44] Callahan, J. L., Bell, D. J., Davila, J., Johnson, S. L., Strauman, T. J., & Yee, C. M. (2020). The enhanced examination for professional practice in psychology: a viable approach? *American Psychologist*, *75*(1), 52–65. https://doi.org/10.1037/amp0000586

[45] National Board for Certified Counselors. (April 14, 2021). *Examination Sensitivity and Bias Review Committee | NBCC*. https://www.nbcc.org/resources/nccs/newsletter/examination-sensitivity-and-bias-review-committee

[46] Oregon OAR. § 858-010-0025 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=219833

[47] Board of Licensed Professional Counselors and Therapists. (2016). *Exams: State of Oregon*. Oregon.gov https://www.oregon.gov/oblpct/Pages/Exams.aspx

[48] Ibid.

Evidence from related fields and for other standardized exams suggests cause for caution about validity and bias in credentialing exams. Concerns of bias and/or poor value predicting success have led some graduate programs and professional associations in related fields to drop exam requirements. Some graduate programs that have dropped the Graduate Record Examination (GRE) are evaluating results. The Boston University School of Public Health, for example, dropped the GRE admission requirement. Evaluation found that dropping the exam requirement increased diversity and did not adversely affect student performance in the program.[49]

Similar reconsideration of exams is underway in related professions, such as social work. The Association of Social Work Boards recently reported disparities in social work exams for historically marginalized groups, especially African Americans.[50] As a result, the National Association of Social Workers Licensing Task Force has recommended removing the requirement for a licensure exam from proposed legislation for an interstate compact for social work.[51]

[49] Sullivan L., Velez A., Longe N., Larese A., and Galea S. (2022). Removing the graduate record examination as an admissions requirement does *n*ot impact student success. *Public Health*. 43 (1605023). doi: 10.3389/phrs.2022.1605023

[50] (2022). *2022 ASWB Exam Pass Rate Analysis*. Retrieved from the Association of Social Work Boards: https://www.aswb.org/exam/contributing-to-the-conversation/

[51] Memo from the Co-chairs of the National Association of Social Work Licensing Task Force (2022, October 20). *Update on the Interstate Licensing Compact for Social Work & NASW public comment.* Socialworkers.org. www.socialworkers.org/LinkClick.aspx?fileticket=fSvAwJFwleg%3D&portalid=0

A. MHRA, OBOP and OBLPCT — Licensing, complaints and investigations

Background declarations and criminal record checks. Both board processes consider fitness to practice by asking mandatory disclosure questions in the application process and by conducting criminal background checks.

Disclosure questions include whether applicants have been:

- Subject to a complaint or investigation;
- Dismissed from employment or an education program; and
- Involved in sanctions, license denial or surrender from a professional regulatory board.

Applicants must also disclose any conditions that could impair their ability to perform the duties of the profession.[52]

Licensing declarations require disclosure of involvement in any civil or criminal actions and criminal arrests, charges or convictions even if the criminal justice system found no basis for charges or exonerated the individual.[53, 54] The Character and Fitness Review Policy of the boards allow the MHRA Executive Director (or designee) to review expunged offenses.[55] If the review finds the expunged offenses to be unrelated to practice of the profession, the licensing process may continue without delay. If the review process finds the expunged offense to be relevant to practice of the profession, the application is referred to the board's consumer protection committee for review.

No predetermined list of crimes automatically disqualifies an applicant in Oregon. Applicants with criminal histories are asked to provide a complete explanation. Applicants must also inform their respective board immediately of any civil or criminal charges against them. Applicants can be fined $200 for each charge not disclosed to the boards.[56] The boards may consider information outside an individual's application including national and state databases of criminal records and professional disciplinary actions.[57]

MHRA, OBOP and OBLPCT recently modified questions associated with criminal records in the application process to arrests only within the past six months.[58]

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[52] For example, "Do you have any condition that in any way impacts or may impair your capacity to perform the duties of a counselor or marriage and family therapist with reasonable skill and safety?"

[53] For example, "You must answer 'YES' even if you received a pardon, the charges were dismissed or dropped, the conviction or judgment was deferred or set aside, the records were expunged, or you entered into a pretrial diversion or deferred prosecution agreement."

[54] MHRA staff note that requiring disclosure of all offenses, including dismissed and expunged, sidesteps pitfalls of accurate memory or confusion about offenses believed to be expunged that were not. They note that review of expunged offenses is completed by the Executive Director rather than the boards to prevent delays.

[55] MHRA (2022) Character and fitness review policy [revision adopted by OBLPCT February 2, 2022 and by OBOP on March 11, 2022.] Salem, OR: Mental Health Regulatory Agency.

[56] Oregon OAR. § 858-010-0020 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=289668

[57] Oregon OAR. § 858-010-0018 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=219818

[58] The renewal process requires disclosure of any arrests since the last application or renewal.

In addition to the common requirements, there are some initial requirements that are specific to each board.

Additional initial licensing requirements for psychologists. To become licensed as a psychologist, an applicant must have obtained a doctorate degree in psychology from an accredited program.[59] Accredited degree programs in the United States will include practicum and internship requirements sufficient to meet Oregon's requirement. Candidates whose degrees were completed at foreign universities must demonstrate they have completed a 300-hour practicum[60] and a 1,500-hour internship.[61, 62] All licensure candidates must then complete a post-doctorate supervised residency of at least 1,500 hours.[63]

Residency supervisor. The residency supervisor must be "an Oregon licensed psychologist who has been licensed for at least two years in Oregon or in a jurisdiction with licensing standards comparable to Oregon," and the supervisor and resident do not need to work physically at the same location.[64] These provisions offer a broader pool of potential supervisors for a resident who may benefit from a supervisor with experience as a member of a particular demographic group or working with clients from a particular demographic group.

Initial licensure costs. Applicants pay $526 in Oregon costs including application fee, the fee for board admission to the state jurisprudence exam and the fee for the criminal records check and fingerprinting.[65]

The cost for admission to the national exam for psychologists is $688.[66]

[59] Board of Psychology. (2010). *Apply for a license: State of Oregon*. Oregon.gov.. https://www.oregon.gov/Psychology/Pages/Apply.aspx

[60] Oregon OAR. § 858-010-0012 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=281290

[61] Oregon OAR. § 858-010-0013 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285888

[62] Accredited degree programs in the U.S. mandate these minimums.

[63] Oregon OAR. § 858-010-0036 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285889

[64] Oregon OAR. § 858-101-0036, 2b-2d (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285889

[65] Oregon OAR. § 858-030-0005. (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=264419

[66] ASPPB (n.d.). EPPP fee summary. Retrieved from https://cdn.ymaws.com/www.asppb.net/resource/resmgr/eppp_/EPPP_Fee_Summary.pdf on 2022, November 9, 2022.

Additional initial licensing requirements for counselors and therapists. To become an LPC[67] or an LMFT[68] an applicant must obtain a graduate degree, either master's or doctorate, from an accredited program.[69]

Each license requires supervised clinical experience. In addition to completing the required graduate degree, both LMFT and LPC applicants must complete 36 months of supervision and 2,400 direct client contact hours. Up to 12 months and 400 hours may be conducted before they obtained their degree.[70] For LMFTs 1,000 of these hours must be with couples or families. During this supervision, individuals must be registered as associates.[71]

Registered Associate Supervisor. Supervisors of registered associates must be Oregon licensed mental health professionals and have received 30 hours of supervision training.[72, 73] The supervisor may meet with the registered associate virtually.[74]Supervisors must be licensed mental health professionals in Oregon. A "supervisor candidate" who is a licensed LPC or LMFT may supervise registered associates while working toward becoming an "approved supervisor" on the registry, which requires three years of licensure. Supervisors not on the registry, such as professionals other than LPCs or LMFTs, for example LCSWs, must have at least three years of licensure.[75] [76] These requirements limit the pool of potential supervisors for registered associates to those currently allowed by rule to qualify as supervisors in Oregon.

[67]Oregon OAR. § 833-040-0011, 1-6. (n.d.). https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3732

[68] Oregon OAR. § 833-030-0011, 1. (n.d.). https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3733

[69] Board of Licensed Professional Counselors and Therapists. (2016). *Education: State of Oregon*. Oregon.gov. https://www.oregon.gov/oblpct/Pages/Education.aspx

[70] Board of Licensed Professional Counselors and Therapists. (2010). *Experience: State of Oregon*. Oregon.gov. https://www.oregon.gov/OBLPCT/Pages/Experience.aspx See also sections 833-040-0021 and 833-030-0021.

[71] Board of Licensed Professional Counselors and Therapists. (n.d.). *Associate Registration: State of Oregon*. Oregon.gov. https://www.oregon.gov/oblpct/Pages/Registration.aspx

[72]Oregon OAR. § 833-130-0040, 2b (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=282066

[73] Oregon OAR. § 833-130-0070 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=282068

[74] Oregon OAR. § 833-050-0081, 5. (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=282042

[75]Oregon OAR. § 833-130-0050, 1. (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=282067

[76] Oregon OAR. § 858-130-0050 (n.d.). https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3744

Initial licensure costs. Applicants pay $347 including their application fee, initial license fee, and the criminal records check and fingerprinting.[77] Unlike OBOP which charges $155 for the state exam, OBLPCT does not charge an exam fee. The cost for admission to a national exam is estimated to cost a few hundred dollars.[78]

[77] Oregon OAR. § 858-030-0005 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=264419

[78] Not all examining organizations publish prices. For example, the National Board of Certified Counselors does not publish the prices of the NCE or NCMHCE, but third-party exam prep companies indicate that the NBCC exams cost $275. The Association of Marital and Family Regulatory Boards publishes a cost of $365.

Renewing and Maintaining Licensure

Both boards require licensed professionals to renew their licenses regularly and meet continuing education requirements each renewal period. Figure A-3 summarizes the requirements to renew licenses for psychologists, LPCs and LMFTs.

Renewal process. Both boards:

- Require renewal in the licensee's birth month and open the opportunity to renew 45 days prior to the renewal month;
- Send four communications via email to addresses on file;[79]
- Offer a one-month grace period for late renewal in which a late fee is assessed but renewal is still possible and practice is not considered unlicensed;
- Treat licenses as lapsed starting in the second month following expiration (the month after the one-month grace period);
- Require professionals whose licenses have lapsed to reapply if they wish to practice and treat practice after a license has lapsed as unlicensed and subject to disciplinary action; and
- Offer a free grace period after the initial licensure date before the first renewal is due, which may range from one to 13 months depending on the proximity of the initial licensure date to the birth month.[80]

A-3. Comparison of licensure renewal for MHRA

	OBOP	OLPCT	
	Psychologists	Licensed Professional Counselors	Licensed Marriage and Family Therapists
Frequency	2 years	1 year	1 year
Continuing education			
Required hours	40 hours	40 hours (every 2 years)	40 hours (every 2 years)
Required hours in diversity related training	4 hours in ethics and laws	6 hours in ethics	6 hours in ethics
	4 hours in cultural competency	4 hours in cultural competency	4 hours in cultural competency
Fee for renewal of active license	$780	$165	$165

Source: Keen Independent Research.

[79] MHRA staff note that the boards are not required to remind licensees to renew but do so as a courtesy. Reminders occur at 45 days and 30 days prior to expiration, followed by a notice on the day they lapse and a notice after their 30 day grace period has expired.

[80] Renewal fees are paid to cover licensure for the 12 months following the licensee's birth month. Both boards offer a grace period of free licensure after initial licensure that lasts until the first renewal in the birth month of the licensee. Practitioners who are initially licensed in their birth month receive the most generous grace period, about 13 months if their initial licensure date is early in the month. Their renewal will be due at the end of their birth month the following year. Practitioners who are initially licensed late in the month prior to their birth month receive the least generous grace period, about one month of licensure free before their first renewal is due. According to MHRA staff, most other boards prorate the charge for the time period that OBOP and OBLPCT currently offer without charge.

A. MHRA, OBOP and OBLPCT — Licensing, complaints and investigations

Renewal frequency and fees. The frequency and fees for renewal are areas in which the professions have substantial differences.

- Psychologist licensees must renew every two years.[81] Psychologist renewal fees are $780 every two years (the equivalent of $390 per year).
- LMFTs and LPCs must renew every year.[82] [83] LPCs and LMFTs pay $165 for an annual renewal.

MHRA and board budgets receive no taxpayer, lottery or grant funds; they are completely funded by licensing-related fees.[84] MHRA staff note that psychology renewal fees are affected by statutory provisions that differ from those pertaining to counselors and therapists. By statute, OBLPCT can assess disciplinary costs when issuing action for violations.[85] OBOP cannot. OBOP's disciplinary costs are funded by psychologist fees.

In addition, OBLPCT refers cases to OBOP that involve unlicensed practice by individuals who do not meet the education requirements to be counselors or therapists ("the education loophole").[86] [87]

[81] Board of Psychology. (n.d.). *Renew a license: State of Oregon*. Oregon.gov. https://www.oregon.gov/psychology/pages/Renew.aspx

[82] Board of Licensed Professional Counselors and Therapists. (n.d.). *Renew a License or Registration: State of Oregon*. Oregon.gov. https://www.oregon.gov/oblpct/Pages/Renew.aspx. See also and Oregon OAR. § 833-075-0020. (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=202066

[83] MHRA and OBLPCT have identified annual renewal, required by statute, as problematic and have introduced a legislative concept for 2023 that if passed will allow two-year renewals for counselors and therapists.

[84] A small portion of the budget comes from civil penalties assessed by the boards in disciplinary actions.

[85] MHRA staff note that other boards such as the Oregon Medical Board and Oregon Board of Licensed Social Workers may assess disciplinary costs. The study team also notes that California and Minnesota boards similar to OBOP and OBPLCT are permitted to assess costs.

[86] OBLPCT cannot act on cases in which the unlicensed practitioner does not meet the education requirements of the profession, but OBOP can. Case referrals to OBOP increase costs that OBOP cannot recover by assessing disciplinary costs. MHRA and the boards have proposed legislative changes to remove the "education loophole" for OBLPCT and allow OBOP to assess disciplinary costs, which have not been passed by the legislature.

[87] Oregon ORS. § 675.825(4) (2021). https://oregon.public.law/statutes/ors_675.825

A. MHRA, OBOP and OBLPCT — Licensing, complaints and investigations

Criminal record checks and fitness determinations. Consideration of background questions and fitness to practice during renewals is similar to the initial application process previously described.

- During renewal, licensees are asked about incidents since their application or last renewal.
- LMFTs and LPCs must also submit an updated Professional Disclosure Statement.
- The boards make decisions on the licensee's fitness.[88] A licensee may appeal an adverse decision through the state Office of Administrative Hearings.[89]

Continuing education. Licensees must complete 40 continuing education credits during each two-year period.[90, 91] Each board specifies ways the continuing education requirements can be fulfilled and the topics that are mandated to be covered each period. Required topics include ethics, pain management, suicide risk assessment and cultural competency credits.[92, 93, 94]

Data collection. Licensees must complete the Oregon Health Authority Healthcare Workforce Survey and pay the fee for the survey when they renew.[95, 96] The fee is set by Oregon Health Authority. MHRA is required to administer the data collection effort and is permitted by statute to add and collect an administration fee, which they have opted not to do.

[88] Oregon OAR. 858-010-0034, 5 and 8. (Rev. 2018). https://www.oregon.gov/Psychology/Documents/CBC_OARs.pdf

[89] Oregon OAR. 125-007-0300 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=7518.

[90] Oregon OAR. § 883-080-0011 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=286438

[91] Board of Psychology. (n.d.). *Continuing education: State of Oregon*. Oregon.gov. https://www.oregon.gov/psychology/Pages/CE.aspx. See also Oregon OAR. § 858-040-0015 (n.d.). https://secure.sos.state.or.us/oard/displayDivisionRules.action;JSESSIONID_OARD=FibbSEMWapFNJnbX97icbOJQwNhQsXWSTyzIfao79XQPjfohmhFd!1243901809?selectedDivision=3998

[92] Oregon State Legislature (2001) SB 885 2001 *Regular Session – Oregon legislative information access system* https://www.oregonlegislature.gov/bills_laws/archivebills/2001_BESB885.pdf

[93] Oregon State Legislature (2021) HB 2078 2021 Regular Session – Oregon legislative information system https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2078/Introduced

[94] Oregon State Legislature (2021) *HB 2315 2021 Regular Session – Oregon legislative information system https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2315/Introduced*

[95] Board of Psychology. (n.d.). *Renew a license: State of Oregon*. Oregon.gov. https://www.oregon.gov/psychology/pages/Renew.aspx. See also Oregon OAR. § 858-010-0041, 1a, 1b and 1d (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=286442

[96] Board of Licensed Professional Counselors and Therapists. (n.d.). *Renew a license or registration: State of Oregon*. https://www.oregon.gov/oblpct/Pages/Renew.aspx

Complaints and Investigations

Both boards are authorized to receive and required to investigate complaints regarding individuals licensed by the boards. Complaints are investigated by the compliance staff of MHRA.[97]

- Complaints that are considered relevant to the respective board's jurisdiction are given a preliminary investigation to determine if a full investigation is merited.
- The individual identified in the complaint must fully cooperate with the investigation.[98]
- If the board proposes discipline, the respondent may request a hearing which is administered by an Administrative Law Judge who is independent of the board.[99]

OBOP complaints and investigations. Complaints may be filed against residents, applicants and licensees by other residents, applicants, licensees, other licensed professionals, clients, member of the public or OBOP.

OBOP may create a Consumer Protection Committee to assist in the investigation of a complaint. The committee is composed of two professional members and one public member. These individuals must abstain from the investigation if they have a conflict of interest.[100]

OBLPCT complaints and investigations. Applicants, registered associates, licensees, clients, the public and OBLPCT may file complaints against an LMFT or LPC applicant or licensee.[101]

Complainant rights and communications. The identity of complainants is confidential under Oregon law. According to MHRA staff, complainants receive two written communications.

- The first is confirmation that their complaint was received and has been assigned for investigation.
- The second is notice of any action taken. If the outcome is dismissal, the communication to the complainant is generic and does not cite a reason.[102]

[97] Board of Psychology. (n.d.). *File a complaint: State of Oregon*. Oregon.gov. https://www.oregon.gov/psychology/pages/Complaint.aspx

[98] Oregon OAR. § 833-110-0011, 4 and 5. (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=282061

[99] Board of Licensed Professional Counselors and Therapists. (n.d.). *File a complaint: State of Oregon*. Oregon.gov. https://www.oregon.gov/oblpct/Pages/Complaint.aspx. See FAQ #11: What happens if the Board initiates disciplinary action?

[100] Oregon OAR. § 858-020-0015 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=220039

[101] Oregon OAR. § 833-110-0011 (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=282061

[102] Per ORS 676.175(2), the Boards may choose to provide a summary of the reason for dismissal upon request by the complainant, but MHRA staff report that they rarely, if ever, do because of the difficult nature of explaining dismissals in ways that will be satisfying to complainants.

Confidentiality. Confidentiality requirements are defined by Oregon statute and are applicable to all professional regulatory boards.[103]

- When complaints are filed, MHRA informs respondents what has been alleged and which client(s) are alleged to have been harmed.
- As noted previously the identity of complainants is confidential under Oregon law. MHRA does not inform respondents who made the complaint and cautions respondents against making assumptions about the identity of the complainant.

The Administrative Procedures Act requires agencies to include sufficient information in the notice document, a Notice of Proposed Disciplinary Action or a Notice of Proposed Civil Penalty, before taking action on violations by a licensee, applicant, or unlicensed respondents.[104] The boards must balance the privacy interests of parties involved with the requirement to provide sufficient information.

The boards provide information on disciplinary actions taken.

- The OBOP quarterly public newsletter includes a section on respondents who have been disciplined.[105] The newsletter details the respondent's name, facts concluded in the investigation and the discipline that was enacted. These disciplines include formal reprimands, monetary civil fines and suspension of licensure.
- The OBLPCT quarterly public newsletter does not report on the board's disciplinary actions, but they do post disciplinary action cumulatively.[106] [107]
- Both OBOP and OBLPCT publish disciplinary action on their public websites.[108]

[103] Oregon ORS § 676.150; 676.175 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors676.html

[104] Oregon ORS. Ch. 183 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors183.html

[105] Board of Psychology. (n.d.). *Newsletters: State of Oregon.* Oregon.gov. Retrieved August 18, 2022, from https://www.oregon.gov/psychology/pages/newsletters.aspx

[106] Board of Licensed Professional Counselors and Therapists. (n.d.). *Newsletters*. Oregon.gov. Retrieved August 18, 2022, from https://www.oregon.gov/oblpct/Pages/newsletters.aspx

[107] Board of Licensed Professional Counselors and Therapists (November 2022). *Disciplinary report: January 2008 through November 2022*. Retrieved from https://www.oregon.gov/oblpct/Documents/Discipline_List.pdf on November 29, 2022.

[108] Board of Psychology. (n.d.). *Unlicensed practice of psychology* Oregon.gov. https://www.oregon.gov/psychology/pages/unlicensed.aspx. Board of Licensed Professional Counselors and Therapists. (n.d.). *Compliance.* Oregon.gov. *https://www.oregon.gov/oblpct/Pages/Compliance.aspx*

Safeguards in complaints and investigations. Examples of safeguards related to equity in complaints and investigations are described below. Some of the steps have already been taken by MHRA, OBOP and OBLPCT and other examples come from similar agencies in Oregon or other states.

Equitable discipline. MHRA does not have a published disciplinary matrix of maximum and minimum penalties for specific violation thresholds for both boards.[109] As an example, the California Board of Behavioral Sciences publishes a disciplinary matrix.[110] This California matrix allows professionals to understand whether their discipline is appropriate and falls within fair guidelines.

Another example is the Virginia Board of Behavioral Science which publishes a Sanctioning Reference Points Instruction Manual. This public document provides a matrix for calculating discipline for violations of policies for the boards regulating psychologists, counselors, and social workers.[111]

Respondents' options. Both OBOP[112] and OBLPCT[113] notify professionals who have become the respondent of a complaint that alleges a violation for which the board has jurisdiction and grounds to impose a sanction if substantiated.

As noted previously, when complaints are filed, MHRA informs respondents what has been alleged and which client(s) are alleged to have been harmed. MHRA does not inform respondents who made the complaint.[114]

MHRA staff view information about the allegation and clients involved as essential for the respondents to be able to defend themselves. However, some complaints filed about clinicians are vague. According to MHRA staff, when information about allegations and clients is not communicated to the respondents, MHRA does not have it. MHRA must inform respondents of complaints regardless and is required to investigate all complaints. MHRA staff note that many such complaints will eventually be dismissed because the board cannot take action on investigations that do not yield details.

The respondent has 21 days to respond to the allegation. After the investigation, if the board decides to issue a disciplinary action, the board issues a public notice to the respondent.

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[109] OBOP adopted disciplinary guidelines including types of board action and sanction ranges for different violations on 2017, November 4. This information is not accessible to professionals or the public on the agency or board website.

[110] *Uniform standards related guidelines to substance abuse and disciplinary*. See pages 14-23. (2015). https://www.bbs.ca.gov/pdf/publications/dispguid.pdf

[111] Visual Research, Inc. (2008, rev. 2016). *Sanctioning reference points instruction manual Behavioral Sciences Boards*. Virginia Department of Health Professions. https://www.dhp.virginia.gov/Psychology/guidelines/125-5.2.pdf

[112] Board of Psychology. (n.d.). *Frequently Asked Questions: File a Complaint: State of Oregon*. Oregon.gov. https://www.oregon.gov/psychology/pages/Complaint.aspx

[113] Board of Licensed Professional Counselors and Therapists. (n.d.). *Frequently asked questions: File a Complaint: State of Oregon*. Oregon.gov. https://www.oregon.gov/oblpct/Pages/Complaint.aspx

[114] Oregon ORS § 676.150; 676.175 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors676.html

In some cases, investigators may learn new information about a complaint that was not available at the time the respondent was informed of the complaint. MHRA does not have any required or standard procedure to share that new allegations or details with respondents. However, MHRA staff noted they would usually do so in the normal course of an investigation because new information may open up the possibility of new evidence to request and new potential charges. One reason MHRA staff might not inform a clinician of new allegations on an initially vague complaints is if they have insufficient time before investigation findings are presented to the board.

The respondent has 30 days from receiving a notice of proposed discipline to request a hearing with an independent administrative law judge or 60 days to request a hearing in the case an application is denied. The board is represented by an Assistant Attorney General and the respondent may self-represent or bring legal counsel.

Both OBOP and OBLPCT explain on their website pages regarding filing complaints that "public protection is the board's primary concern." However, each board also notes on the same page that the Oregon "Administrative Procedures Act guarantees due process for the accused."[115] The Oregon Administrative Procedures Act section 183.413 *Notice to parties before hearing of rights and procedures,* outlines that the accused individual in a contested case hearing may be represented by legal counsel. Further, according to this Act, the agency with authority to lead the investigation and the contested case hearing is required to provide a written statement of rights to the accused individual. This statement must include that the individual has the right to legal representation as well as recommend that the individual may have access to legal aid organizations that could assist them in the case of financial need.[116]

Following the ruling from the contested hearing, the respondent has 60 days to request a judicial review by the Court of Appeals. Alternatively, a respondent or their legal counsel may negotiate a settlement with the Assistant Attorney General. The Executive Director of MHRA represents the boards in this process. If agreement is reached about a settlement, the board must vote in public session to accept or reject a Stipulated Order that reflects the settlement terms.

[115] See question 6 in both OBOP and OBLPCT *Frequently Asked Questions: File a Complaint:* Question 6: How long does the complaint process take.

[116] Oregon Administrative Procedures Act, Oregon ORS § 183.413 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors183.html

See especially, 183.413.2d. The agency must serve the accused individual a written notice of the hearing including "a statement indicating that the party may be represented by counsel and that legal aid organizations may be able to assist a party with limited financial resources."

Respondents' rights. Prior to the Office of Administrative Hearings scheduling a hearing, MHRA sends the complaint respondent a Notice of Contested Case Rights and Procedures.[117] This notice outlines the specific Oregon Administrative Rules and Oregon Revised Statutes authorizing the hearing as well as the structure of the hearing. The complaint respondent is also informed through this notice of their rights during the hearing and the procedure for appealing the decision of the administrative law judge. MHRA will also send written notice to the complaint respondent of the nature of the allegation and the specific laws and rules that have allegedly been violated.

[117] *OBOP Notice of Contested Case Rights and Procedures*. Revised January 2020. Pursuant to Oregon ORS § 183.413(2) (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors183.html

A. MHRA, OBOP and OBLPCT — Comparative analysis of licensing

Introduction to Comparative Analysis

The following pages provide a comparative analysis of the regulations, policies and procedures of other regulatory agencies similar to MHRA, OBOP and OBLPCT. The criteria for selecting these states and agencies are described below. Keen Independent examined three aspects of each state and regulatory agency's administrative processes. These processes include the requirements for receiving initial licensure, the requirements for maintaining and renewing licensure and the handling of complaints of investigations.

Keen Independent selected the following states for comparison with MHRA. Within each state, the study team compared the regulatory agencies for psychologists, counselors and therapists to the regulations and processes of MHRA, OBOP and OBLPCT:

- Washington;
- California;
- Minnesota; and
- Massachusetts.

Keen Independent also compared the following regulatory boards within Oregon to MHRA, OBOP and OBLPCT:

- Oregon Behavior Analysis Regulatory Board;
- Oregon Medical Board (psychiatrists);
- Oregon Sexual Offense Treatment Board; and
- Oregon Board of Licensed Social Workers.

A. MHRA, OBOP and OBLPCT — Comparative analysis of licensing

Selection criteria for comparative states. Washington and California were selected because of their geographic proximity to Oregon. Minnesota and Massachusetts were both chosen because of their relatively high standing in the 2022 Mental Health America state rankings. The state-by-state rankings measure prevalence of mental illness and access to care among adults and youth. In 2022 overall rankings, Minnesota ranked tenth nationally, Massachusetts ranked first (Oregon ranked 46th nationally).[118] Minnesota was additionally chosen because of its comparable population characteristics to Oregon especially regarding urban and rural areas.[119]

Selection criteria for comparative regulatory agencies in Oregon. The four Oregon agencies were selected as they pertain to the professions administered by MHRA. The Oregon Medical Board licenses psychiatrists and the Oregon regulatory boards for Behavior Analysis, Clinical Sexual Offence Therapists and Social Workers all regulate licenses to professionals working in mental health as well as enforce consumer protection procedures.

[118] Mental Health America. (2022). *Ranking the states 2022*. Retrieved August 18, 2022, from https://mhanational.org/issues/2022/ranking-states#overall-ranking

[119] Bureau, U. C. (n.d.). *Historical population density data (1910-2020)*. Census.gov. Retrieved August 18, 2022, from https://www.census.gov/data/tables/time-series/dec/density-data-text.html

Comparison of Initial Licensure and Renewal Requirements

Keen Independent examined the requirements for psychologists and then for counselors and therapists in Oregon against those of other states. The study team then examined the four related professions in Oregon.

Psychologists. Figures A-4 and A-5 compare the requirements for initial licensure and renewals for psychologists. The requirements of the Oregon Board of Psychology are shown alongside the requirements for Washington, California, Minnesota and Massachusetts.

Oregon's initial licensure and renewal requirements are similar to the other states studied. Oregon has the same education and examination criteria and has similar post-degree experience requirements, fees and continuing education requirements.

Oregon differs notably from other states in its fee for renewal of an active psychology license. While initial licensure as a psychologist in Oregon costs $526, renewing an active psychology license costs $780. This is the largest difference between initial license fee and renewal fee of any of the other compared states.

A 2021 report by the Association of State and Provincial Psychology Boards (ASPPB) analyzed fees charged by psychology boards in the United States and Canada. This report allows the fees charged by OBOP and the other compared states to be placed into a larger geographic perspective.[120] For example, OBOP charges $155 for the Board's admission to examinations. This compares equally to the ASPPB's report that found the average among psychology boards in the U.S. and Canada to be $150. Also, OBOP charges a higher $325 licensure application fee compared to the ASPPB average of $249, but OBOP does not charge an initial licensure fee, which averages $396 among the ASPPB.

Overall, OBOP's fees for initial licensure are comparable to the other states examined in this study and for the psychology boards analyzed by the ASPPB report, but OBOP's renewal fees are higher than the average.

Notably, OBOP's $780 renewal fee is higher than the states compared in this study and is higher than the ASPPB average of $407.

As discussed in the license renewal section of this appendix, OBOP must fund the costs of investigation of complaints through its regular fees as it cannot assess disciplinary costs when issuing disciplinary action. In addition, OBLPCT refers to OBOP any cases involving unlicensed practice by individuals who do not meet the education requirements to be counselors or therapists.[121]

Some similar boards in Oregon, including OBLPCT, the Oregon Medical Board and Oregon Board of Licensed Social Workers, may assess disciplinary costs. The study team also notes that California and Minnesota boards responsible for counselor, therapist and psychologist regulation are also permitted to assess costs.

[120] (2021). In Focus 2021. In Association of State and Provincial Psychology Boards (pp. 26–30). The Center for Data and Analysis on Psychology Licensure. https://asppbcentre.org/wp-content/uploads/2022/08/ASPPB-InFocus-2021.pdf

[121] OBLPCT cannot act on cases in which the unlicensed practitioner does not meet the education requirements of the profession, but OBOP can. Case referrals to OBOP increase costs that OBOP cannot recover by assessing disciplinary costs.

A. MHRA, OBOP and OBLPCT — Comparative analysis of licensing

A-4. Comparison of initial licensure for psychologists

	Oregon	Washington	California	Minnesota	Massachusetts
Education	Doctorate	Doctorate	Doctorate	Doctorate	Doctorate
Examinations					
National	Yes	Yes	Yes	Yes	Yes
State	Yes	Yes	Yes	Yes	Yes
Supervised experience					
Minimum months of post-degree experience	12	24	30	12	60
Hours during degree	1,800	1,800	1,500	1,800	1,600
Hours after degree	1,500	1,500	1,500	1,800	1,600
Total hours	**3,300**	**3,300**	**3,000**	**3,600**	**3,200**
Fees					
Application	$ 325	$ 206	$ 50	$ 500	$ 150
License	0	0	500	0	0
State examination	155	0	285	300	0
Criminal record check	46	0	0	32	0
Total	**$ 526**	**$ 206**	**$ 835**	**$ 832**	**$ 150**
Geographic reciprocity	No	Yes	Yes	Yes	Yes

Note: The national exam required by all states in this table is the Examination for Professional Practice in Psychology (EPPP).

Source: Keen Independent Research.

A-5. Comparison of licensure renewal for psychologists

	Oregon	Washington	California	Minnesota	Massachusetts
Frequency	2 years	1 year	2 years	2 years	2 years
Continuing education					
Required hours	40 hours	60 hours (every 3 years)	36 hours	40 hours	20 hours
Required hours in diversity related training	4 hours in ethics and laws 4 hours in cultural competency	4 hours in ethics	none	4 hours on cultural competency	none
Fee for renewal of active license	$780	$226	$530	$500	$270

Note: Only continuing education credits directly related to diversity and inclusion training are included in this comparison.

Source: Keen Independent Research.

Counselors and therapists. Figures A-6 and A-7 show the requirements for receiving initial licensure and renewing licenses for counselors and therapists in comparison states.

The required supervised hours for initial licensure are somewhat lower for Oregon than the other states, and Oregon requires more hours of continuing education specifically in cultural competency and ethics than the other states.

Unlike the other comparison states that require licenses to be renewed every two years, OBLPCT requires licenses to be renewed every year.

A. MHRA, OBOP and OBLPCT — Comparative analysis of licensing

A-6. Comparison of initial licensure for counselors and therapists

	Oregon		Washington		California		Minnesota		Massachusetts	
	LPC	LMFT	LPC	LMFT	LPC	LMFT	LPC	LMFT	LMHC	LMFT
Education	Master's	Master's	Master's	Master's	Master's	Master's	Master's	Master's	Master's	Master's
Examinations										
National	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
State	Yes	Yes	No	No	Yes	Yes	No	Yes	No	No
Supervised experience										
Minimum months of post-degree experience	24	24	36	24	24	24	n/a	24	24	24
Hours during degree	400	400	0	0	0	0	700	300	700	300
Hours after degree	2,000	1,000	3,000	3,000	3,000	2,500	2,000	3,500	2,400	2,860
Hours with couples/families	0	1,000	0	500	0	500	0	500	960	500
Total hours	**2,400**	**2,400**	**3,000**	**3,500**	**3,000**	**3,000**	**2,700**	**4,300**	**4,060**	**3,660**
Fees										
Application	$ 175	$ 175	$ 111	$ 306	$ 250	$ 250	$ 150	$ 110	$ 117	$ 117
License	125	125	80	0	200	200	250	125	155	155
State examination	0	0	0	0	150	400	0	110	0	0
Criminal record check	46	46	0	0	0	0	33	33	0	0
Total	**$ 346**	**$ 346**	**$ 191**	**$ 306**	**$ 600**	**$ 850**	**$ 433**	**$ 378**	**$ 272**	**$ 272**
Geographic reciprocity	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: Keen Independent Research.

A-7. Comparison of licensure renewal for counselors and therapists

	Oregon		Washington		California		Minnesota		Massachusetts	
	LPC	LMFT	LPC	LMFT	LPC	LMFT	LPC	LMFT	MHC	LMFT
Frequency	1 year	1year	2 years	2 years	2 years	2 years	2 years	2 years	2 years	2 years
Continuing education										
Required hours	40 hours (every 2 years)	40 hours (every 2 years)	36	36	36	36	40	40	30	30
Required hours in diversity related training	6 hours in ethics 4 hours in cultural competency	6 hours in ethics 4 hours in cultural competency	6 hours in ethics and law	6 hours in ethics and law	6 hours in ethics and law	6 hours in ethics and law	4 hours in cultural competncy	3 hours in ethics 4 hours in cultural competency	none	none
Fee for renewal of active license	$165	$165	$106	$196	$200	$200	$250	$125	$155	$155

Source: Keen Independent Research.

Related professions. Figures A-8 and A-9 show the requirements for receiving initial licensure or certification and renewing licenses for related professions in Oregon. These related professions include behavior analysts, psychiatrists, clinical sexual offence therapists and social workers.

The required education, examinations and various fees of MHRA are comparable to other related mental health professionals in Oregon. Each profession except for psychologists and social workers requires license renewal every year. And every profession except for behavior analysts and clinical sexual offence therapists requires continuing education credits in cultural competency.

A. MHRA, OBOP and OBLPCT — Comparative analysis of licensing

A-8. Comparison of initial licensure or certification for related professions in Oregon

	MHRA			Behavior Analyst	Psychiatrists	Clinical Sexual Offense Therapists	Social Workers
	OBOP	LPC	LMFT				
Education	Doctorate	Master's	Master's	Master's	Doctorate	Master's	Master's
Examinations							
National	Yes	Yes	Yes	Yes	Yes	No	Yes
State	Yes	Yes	Yes	No	Yes	No	Yes
Supervised experience							
Minimum months of post-degree experience	12	24	24	N/A	N/A	72	24
Hours during degree	1,800	400	400	N/A	N/A	N/A	N/A
Hours after degree	1,500	2,000	2,000	1,500	1 year	2,060	3,500
Total hours	**3,300**	**2,400**	**2,400**	**1,500**	**0**	**2,060**	**3,500**
Fees							
Application	$ 325	$ 175	$ 175	$ 150	$ 375	$ 75	$ 150
License	0	125	125	200	486	325	260
State examination	155	0	0	0	0	0	0
Criminal record check	46	46	46	0	48	0	0
Total	**$ 526**	**$ 346**	**$ 346**	**$ 350**	**$ 909**	**$ 400**	**$ 410**
Geographic reciprocity	No	No	No	No	Yes	No	No

Note: Behavior Analysts must first be certified by the national Behavior Analyst Certification Board Inc.

Clinical sexual offense therapists must already have an active Oregon mental health professional license before applying to become a clinical sexual offense therapist and meeting the additional requirements outlined in this table. Approved mental health professional licenses include psychiatry, psychology, social workers, professional counselors and marriage and family therapists.

Source: Keen Independent Research.

A-9. Comparison of licensure renewal for related professions in Oregon

	MHRA			Behavior Analyst	Psychiatrists	Clinical Sexual Offence Therapists	Social Workers
	OBOP	LPC	LMFT				
Frequency	2 years	1 year	1 year	1 year	1 year	1 year	2 years
Continuing education							
Required hours	40	40 hours (every 2 years)	40 hours (every 2 years)	16	30	15	40
Required hours in diversity related training	4 hours in ethics and laws	6 hours in ethics	6 hours in ethics	1 hours in ethics	1 hour in cultural competency	none	6 hours in ethics
	4 hours in cultural competency	4 hours in cultural competency	4 hours in cultural competency				6 hours in cultural competency
Fee for renewal of active license	$780	$165	$165	$200	$486	$325	$286

Source: Keen Independent Research.

A. MHRA, OBOP and OBLPCT — Comparative analysis of complaint handling

Comparison of Complaints and Investigations

This section examines the complaint and investigation processes of similar boards.

Comparative states. The following is a brief overview of the complaints and investigation processes in the comparative states.

Washington. Complaints are filed with and investigated by the Department of Health. The Department determines if the complaint is above or below the threshold of violating laws and under its jurisdiction. The complaint is then heard by the Office of the Attorney General.[122]

The Department of Health provides a detailed Questions and Answers page to clearly outline the rights of the professional being investigated, the rights of the individual issuing the complaint, the jurisdiction of the Department of Health and the administrative details of the process.

California. Complaints are filed with and investigated by the Department of Consumer Affairs of the Board of Behavioral Sciences.[123] The Board of Behavioral Sciences publishes a matrix of the minimum and maximum penalty for violations.[124] This may provide a safeguard against inequitable disciplinary actions especially against diverse professionals.

Minnesota. The Minnesota Board of Marriage and Family Therapy files and investigates complaints. The board creates a Complaint Review Panel to evaluate jurisdiction. Licensees can agree to the Panel's voluntary settlement or can contest the case and it will then be heard by a State Administrative Law Judge.[125]

The Board of Psychology also files and investigates complaints through its Complaint Resolution Committee and contested voluntary settlements are heard by a State Administrative Law Judge.[126]

[122] Washington State Department of Health. (n.d.). *Health professions complaint process*. https://doh.wa.gov/licenses-permits-and-certificates/complaint-and-disciplinary-process/health-professions-complaint-process. See "What is the process?"

[123] Board of Behavioral Sciences. (n.d.). *Consumer complaints* https://www.bbs.ca.gov/consumers/consumer_complaints.html

[124] *Uniform Standards Related Guidelines to Substance Abuse and Disciplinary*. See pages 14-23. (2015). https://www.bbs.ca.gov/pdf/publications/dispguid.pdf

[125] Minnesota Board of Marriage and Family Therapy. (n.d.). *Filing a complaint.* https://mn.gov/boards/marriage-and-family/consumer-info/complaints/

[126] Minnesota Board of Psychology. (2012). *Complaints / Minnesota Board of Psychology*. https://mn.gov/boards/psychology/public/complaints/. See also Minnesota Board of Psychology. (n.d.). *Rules of Conduct*. https://mn.gov/boards/psychology/public/conduct/

Massachusetts. The Massachusetts Division of Occupational Licensure works with the boards to file and investigate all complaints and issue discipline.[127] Individuals can file a complaint through the Division of Occupational Licensure against individuals holding any of the licenses reviewed in this section.[128] The Division investigates the complaint and refer the case to the Prosecutions Unit if it meets the requirements.[129]

[127] State of Massachusetts. (June 5, 2015). *262 CMR 6.00 Disciplinary Action: Board of Allied Mental Health and Human Services* Professionals. Mass.Gov. https://www.mass.gov/doc/262-cmr-6-disciplinary-action/download and Mental Health Legal Advisors Committee. (n.d.). *Where to direct complaints about licensed mental health professionals in Massachusetts*. http://mhlac.org/wp-content/uploads/2018/10/complaints_re_mental_health_professionals.pdf

[128] State of Massachusetts. (n.d.). *File a complaint against an Occupational Board licensee.* Mass.gov. https://www.mass.gov/how-to/file-a-complaint-against-an-occupational-board-licensee

[129] State of Massachusetts. (n.d.). *Have a complaint against a licensee?* Mass.gov. (n.d.). https://www.mass.gov/service-details/have-a-complaint-against-a-licensee

Comparative Oregon agencies. Keen Independent also reviewed the complaints and investigation processes in the other Oregon agencies examined in Appendix A.

Oregon Behavior Analysis Regulatory Board. Complaints are filed with and investigated by the Health Licensing Office for both the Oregon Behavior Analysis Regulatory Board and the Oregon Sexual Offence Treatment Board.[130] The members of the Oregon Behavior Analyst Regulatory Board also participate in the investigation. If the investigation finds violations of the Oregon Revised Statues or the Oregon Administrative Rules, then the case is brought to an independent administrative law judge of the Office of Administrative Hearings.

The Health Licensing Office has a detailed page on its website of the rights and responsibilities a licensee who needs to respond to a complaint. In the event the Health Licensing Office determines the licensee should receive disciplinary action, the licensee is provided with a written explanation of their rights and the procedures for requesting a formal hearing with an independent administrative law judge. These rights and procedures are also listed on the Health Licensing Office website. [131]

Oregon Medical Board (Psychiatry Licensees). Complaints regarding a psychiatrist are filed with the Oregon Medical Board, which processes 750-850 complaints annually. The Oregon Medical Board also publishes alternative state departments with which an individual may file a complaint if they are unwilling to directly file with the Medical Board.[132]

The psychiatrist who is the subject of an investigation is provided written details of the allegation and an explanation of the investigation process.[133]

[130] Oregon Health Authority (n.d.). *How to File a Complaint: Health Licensing Office:* Oregon.gov. https://www.oregon.gov/oha/PH/HLO/Pages/File-Complaint.aspx

[131] Oregon Health Authority. (n.d.). *Complaints and Compliance: Health Licensing Office: State of Oregon*. (https://www.oregon.gov/oha/PH/HLO/Pages/Regulatory-Compliance.aspx

[132] Oregon Medical Board (n.d.). *Investigations*Oregon.gov. https://www.oregon.gov/omb/Investigations/Pages/Investigations-Overview.aspx

[133] Oregon Medical Board. (n.d.). *Information for licensees under investigation: Investigations:* Oregon.gov. https://www.oregon.gov/omb/investigations/Pages/FAQs-for-Licensees-under-Investigation.aspx

Oregon Sexual Offence Treatment Board. Because this Board is administered by the Health Licensing Office, complaints are filed and investigated by that office.[134] If the Health Licensing Office[135] completes a preliminary investigation and finds that statutes or rules have been violated, the case is brought before an independent administrative law judge from the Office of Administrative Hearings.[136]

Oregon Board of Licensed Social Workers. Complaints against an applicant or licensee are investigated by staff. The board's consumer protection committee reviews cases and makes recommendations to the full board.[137]

An assigned investigator presents findings to the board's consumer protection committee confidentially. The committee then presents the proposed discipline to the board in a public meeting for a vote. Board members who are unable to offer fair judgment are required to abstain from participation in the case.[138]

[134] Oregon Health Authority. (n.d.). *How to file a complaint: Health Licensing Office* Oregon.gov. https://www.oregon.gov/oha/PH/HLO/Pages/File-Complaint.aspx

[135] Oregon OAR § 331-850-0010. (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=260823

[136] Oregon Health Authority. (n.d.). *Complaints and Compliance: Health Licensing Office: State of Oregon*. Oregon.gov. https://www.oregon.gov/oha/PH/HLO/Pages/Regulatory-Compliance.aspx. See also Oregon Health Authority. (n.d.). *Sex Offender Treatment Board - Disciplinary Actions: Health Licensing Office: State of Oregon*. Oregon.gov. https://www.oregon.gov/oha/PH/HLO/Pages/Board-Sex-Offender-Treatment-Disciplinary-Actions.aspx

[137] Board of Licensed Social Workers. (n.d.). *File a Complaint: State of Oregon*. Oregon.gov. https://www.oregon.gov/blsw/Pages/FileAComplaint.aspx

[138] Oregon OAR § *877-040-0000* (n.d.). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=225994

APPENDIX B. Demographic Data — Introduction

Appendix B synthesizes demographic data about Oregon mental health services consumers and professionals.

This appendix is organized as follows:

- Methodology, including data sources;
- Oregon population data;
- Mental health professionals overall;
- Psychologists;
- Licensed marriage and family therapists;
- Licensed professional counselors;
- Pre-licensure pipeline demographics;
- Complaint respondents; and
- Board and staff demographics.

B. Demographic Data — Methodology

Keen Independent performed the following analyses to examine diversity within the mental health profession in Oregon:

- Aggregated data from national sources;
- Computed race and ethnicity percentages;
- Computed gender percentages; and
- Examined percentages of languages spoken among Oregon mental health professionals.

When calculating percentages of totals, we removed nonresponses from the total number of responses.

Data sources

Keen Independent obtained Census Bureau data on residents, statewide data on mental health service users and statewide data provided by the Oregon Mental Health Regulatory Agency on mental health professionals.

Oregon population. Data on the population of Oregon originated from the 2020 U.S. Census and the Oregon Office of Economic Analysis. Racial groups from which respondents could choose one or more included the following:

- American Indian or Alaska Native;
- Asian;
- Black or African American;
- Native Hawaiian or Pacific Islander; and
- White or Caucasian.

Throughout this appendix, percentages of people by racial group add to 100 percent. Hispanic/Latino is an ethnicity and thus was calculated independently of percentages for racial groups (and should not be added to the percentages for those groups).

B. Demographic Data — Methodology

Licensed mental health professionals, associates, residents and applicants. The Oregon Mental Health Regulatory Agency (MHRA) provided Keen Independent with demographic data on licensed professional counselors, marriage and family therapists and psychologists, as well as applicants and associates/residents for each of these license types, as of June 23, 2022. Demographic information included:

- Race/ethnicity, in which individuals could choose one or more of the same categories as the US Census;
- Gender identity as:
  - Female;
  - Male; or
  - Non-binary.
- City and state; and
- Languages spoken.

We also examined national data from the Bureau of Labor Statistics and combined the following subdivisions to obtain estimates of the race/ethnicity and gender of mental health professionals nationally:

- School psychologists;
- Other psychologists;
- Substance abuse and behavior disorder counselors; and
- Mental health counselors.

Race, ethnicity and gender data were not available for clinical and counseling psychologists nor marriage and family therapists.

College graduates. Keen Independent located data on psychology doctoral degree holders from the American Psychological Association.

Complaint respondents. MHRA provided Keen Independent with deidentified data on complaint respondents from the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) on July 6, 2022, and July 7, 2022, respectively.

This information included:

- Allegation category;
- License type and investigation outcome (where applicable);
- Race/ethnicity;
- Gender; and
- Languages spoken at home.

Data used the same classifications described for the licensed mental health professionals and applicant demographics. We note that the number of complaints ranged from 45 to 332 depending on license type. Although some of the racial and ethnic group raw numbers are small, we included percentages for each racial and ethnic group to provide context. However, we caution against drawing broad conclusions from such small sample sizes.

Sexual orientation was not provided in the complaints data. However, we note that we heard from several LGBTQ+-identifying individuals who had a complaint filed against them and recommend that the boards do collect this information to better understand their experiences.

B. Demographic Data — Oregon population

As many study participants mentioned (see Appendix E), Oregon has a racially exclusionary past that has shaped the demographics of the state. When Oregon was admitted to the United States, its constitution made it illegal for African Americans to reside in the state.[1] Numerous laws and policies forced Native Americans out of their ancestral lands and regulated other racial and religious minority populations.[2]

Today, Oregon is more racially diverse due to increases in-migration in recent decades. However, Oregon remains one of the least diverse states in the country with about 25 percent of its residents belonging to a racially minoritized group compared with nearly 40 percent nationwide.[3]

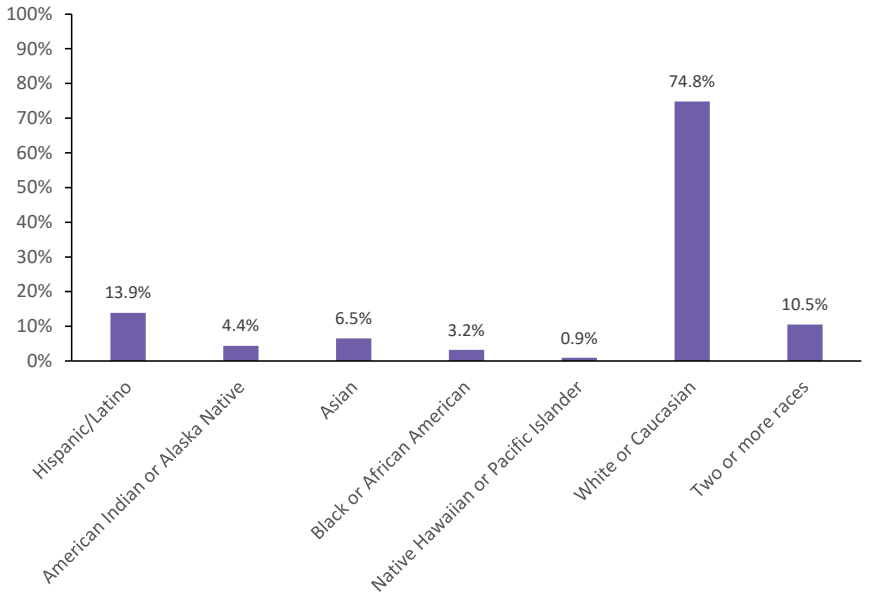
Overall Demographics

About 75 percent of Oregon residents identified as white alone. About 10 percent indicated they identified with two or more racial groups, and smaller numbers identified with other racial and ethnic groups.

Fourteen percent of residents indicated that they were ethnically Hispanic/Latino. This is less than the 19 percent of the population identifying as Hispanic or Latino in the nation.

One-half of Oregon's population is female.

B-1. Racial and ethnic groups in Oregon, 2020



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent, https://www.census.gov/library/stories/state-by-state/oregon-population-change-between-census-decade.html

[1] Fagan, S. (n.d.*). National and Oregon chronology of events*. Oregon Secretary of State. https://sos.oregon.gov/archives/exhibits/black-history/Pages/context/chronology.https://sos.oregon.gov/archives/exhibits/black-history/Pages/context/chronology.

[2] Patterson, R. (2020). Disrupt, defy, and demand: Movements toward multiculturalism at the University of Oregon, 1968-2015*, Berkeley Review of Education 9*, (2)., https://doi.org/10.5070/B892423233

[3] Vaidya, K.L. (2019). *Oregon's demographic trends*. State of Oregon Office of Economic Analysis. https://www.oregon.gov/das/OEA/Documents/OR_pop_trend2019.pdf

B. Demographic Data — Mental health service users

Oregon Mental Health Service Users

According to data 2021 from Mental Health America, Oregon had the highest rate of mental illness among adults and ranked 21st in terms of access to mental health care[4]. Nearly 9 percent of Oregonian adults reported an unmet need for mental health services in 2018 and 2019, making Oregon fourth in the country for unmet need.[5]

There are no comprehensive data available to the study team on the race and ethnicity of Oregon residents who use mental health services.

[4] Reinert, M., Nguyen, T., & Fritze, D. (2021). *The state of mental health in America*. Mental Health America. https://mhanational.org/sites/default/files/2021%20State%20of%20Mental%20Health%20in%20America_0.pdf

[5] Zhu, J. M., Howington, D., Hallett, E., Simeon, E., Amba, V., Deshmukh. A., & McConnell, K. J. (2022). *Behavioral health workforce report to the Oregon Health Authority and State Legislature*. Center for Health Systems Effectiveness. https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/Behavioral%20Health%20Workforce%20Wage%20Study%20Report-Final%20020122.pdf

B. Demographic Data — Mental health professionals overall

Keen Independent analyzed data from MRHA supplemented with information obtained from the Oregon Health Authority.

Results pertain to mental professions overall and by field (psychologist, marriage and family therapist and professional counselor). Within each section, Keen Independent presents data for racial and ethnic groups, by gender and by languages spoken at home.

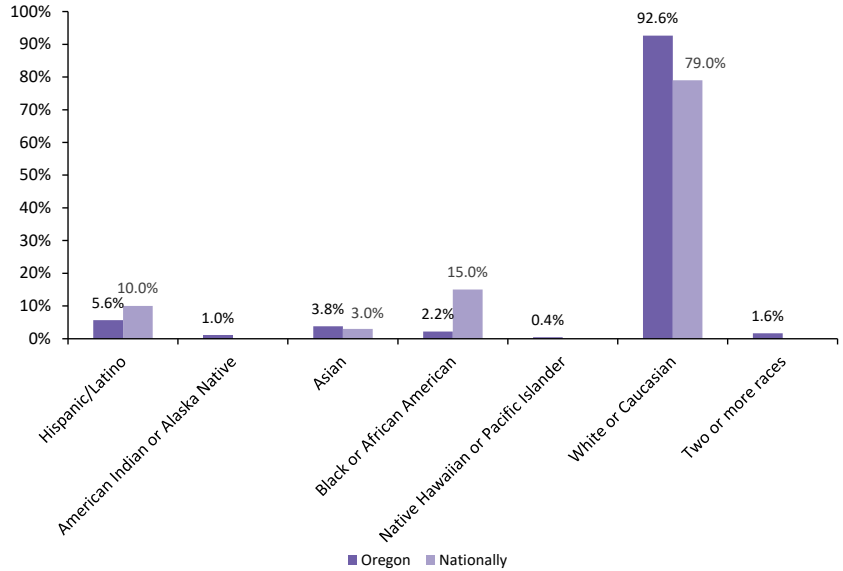
Oregon Psychologists, Licensed Professional Counselors and Licensed Marriage and Family Therapists

Overall, mental health professionals in Oregon were less racially and ethnically diverse than the population of mental health professionals in the United States.

Race and ethnicity.

Figure B-2 displays the race and ethnicity of Oregon mental health professionals compared to that of mental health professionals across the United States. About 93 percent of mental health professionals licensed in Oregon are white, much higher than for the nation based on data from the Bureau of Labor Statistics which describes a more diverse national workforce of mental health professionals. [6,7] There are proportionally nearly seven times the number of Black mental health professionals nationally compared to in Oregon. Less than 6 percent of mental health professionals in Oregon identified as Hispanic or Latino.

B-2. Race and ethnicity of all mental health licensees in Oregon compared to mental health professionals in the U.S., 2022



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency, Bureau of Labor Statistics

[6] Bureau of Labor Statistics. (2021). *Household data annual averages.* https://www.bls.gov/cps/cpsaat11.pdf

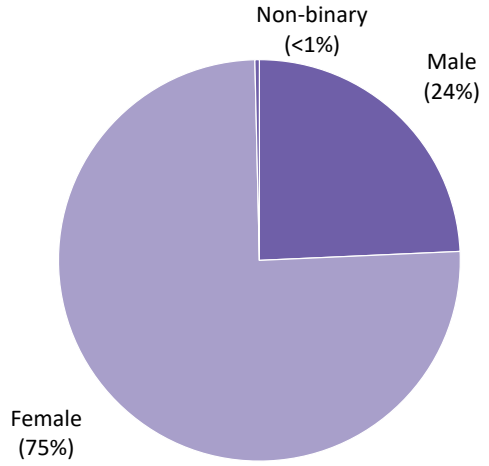
[7] BLS did not have race nor ethnicity data for clinical and counseling psychologists nor marriage and family therapists, so those groups are excluded from the total. BLS did not report percentages for American Indian or Alaska Native nor Native American or Pacific Islander, so only MHRA data for those two categories appears in Figure B-2.

B. Demographic Data — Mental health professionals overall

Gender. Three-quarters of all mental health professionals in Oregon reported their gender as female (see Figure B-3). These results are similar to the nation.[8,9]

Languages spoken. About 6 percent of licensed mental health professionals in Oregon speak Spanish at home. This was slightly less than for all people in the state (nearly 9% based on U.S. Census data).

B-3. Gender of all mental health licensees in Oregon, 2022



Note: One percent of all licensees did not indicate their gender.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

[8] Fielding, S. (2022, June 18). These women pivoted to mental health work—because of the pandemic. *Washington Post*. https://www.washingtonpost.com/lifestyle/2022/06/18/women-mental-health-career-pandemic-pivot/

[9] Using data from BLS data we combined from several categories of workers, as described in the data sources subsection.

B. Demographic Data — Psychologists

In this subsection, Keen Independent presents results of the demographic analysis of licensed psychologists. We included the few individuals licensed as Psychologist Associate, which is an obsolete license type but contains masters-level practitioners who completed their licensure requirements (the Psychology Residents are included in a subsequent section focused on the mental health practitioner pipeline).

Psychologist and Psychologist Associate Race/Ethnicity, Gender and Languages

In terms of race/ethnicity, gender and languages spoken, psychologists and psychologist associates in Oregon differed from other mental health professionals.

Race and ethnicity. Figure B-4 compares the share of psychologists and psychologist associates licensed in Oregon to the racial and ethnic characteristics of the Oregon population.

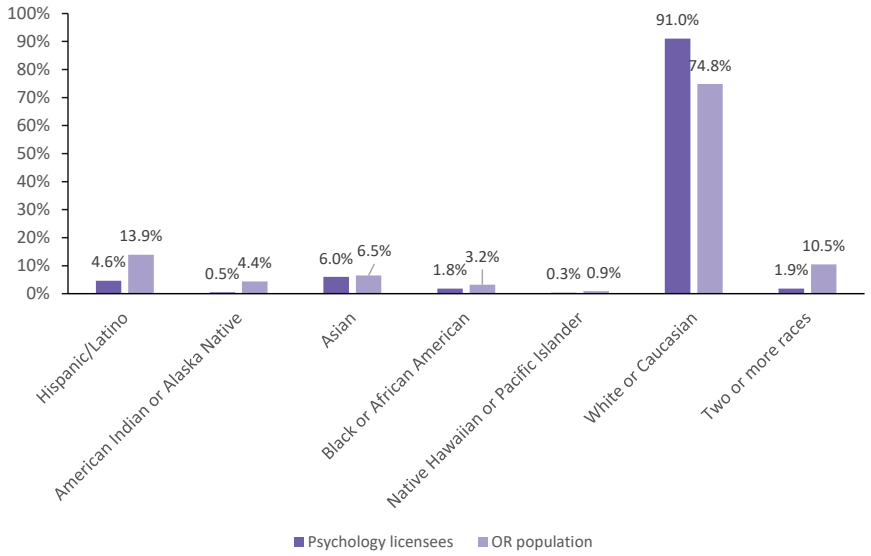
In Oregon, over 90 percent of psychologists and psychologist associates identified as white, far greater than found for the Oregon population. Nearly 9 percent of psychologists and psychologist associates reported they were Asian American, which generally matches the share of Oregon's population who are Asian American.

Turning to ethnicity, about 5 percent of psychologists and psychologist associates in Oregon indicated they were Hispanic or Latino, lower than the Latino share of the Oregon population.

These percentages are rough estimates given the large proportion of psychologists and psychologist associates who chose not to report their race/ethnicity. (This analysis assumes that the share of professionals in each racial/ethnic group are the same for those not giving their race/ethnicity as those who did.)

Using Census data, the American Psychological Association found that 83 percent of psychologists in the United States were white.[10]

B-4. Race and ethnicity of psychologist and psychologist associate licensees in Oregon, 2022, compared to Oregon population, 2020



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

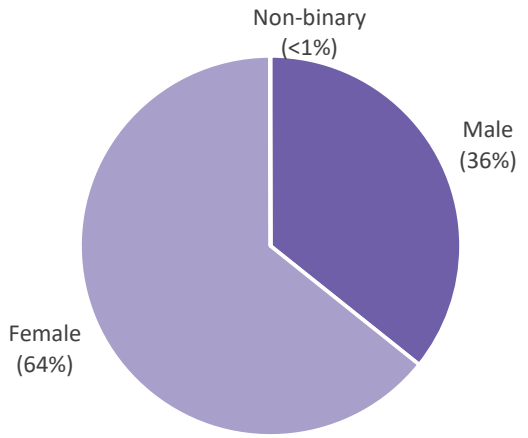
[10] Lin, L. & Ginsberg, A. (2021, May 11). American Psychological Association uses ACS data to identify need for mental health services, education, and training. *United States Census Bureau.* https://www.census.gov/programs-surveys/acs/about/acs-data-stories/psychologists.html

B. Demographic Data — Psychologists

Gender. Psychologists and psychologist associates had the largest proportion of male-licensees at 36 percent. This is in line with national trends that show psychology as a more male discipline within the mental health field.

Languages spoken. About 6 percent of psychologists and psychologist associates licensed in Oregon speak Spanish.

B-5. Gender of psychologist and psychologist associate licensees in Oregon, 2022



Note: One percent of psychologists did not indicate their gender.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Marriage and family therapists (LMFTs)

Results of the study team's demographic analysis of licensed marriage and family therapists appear in the following subsection.

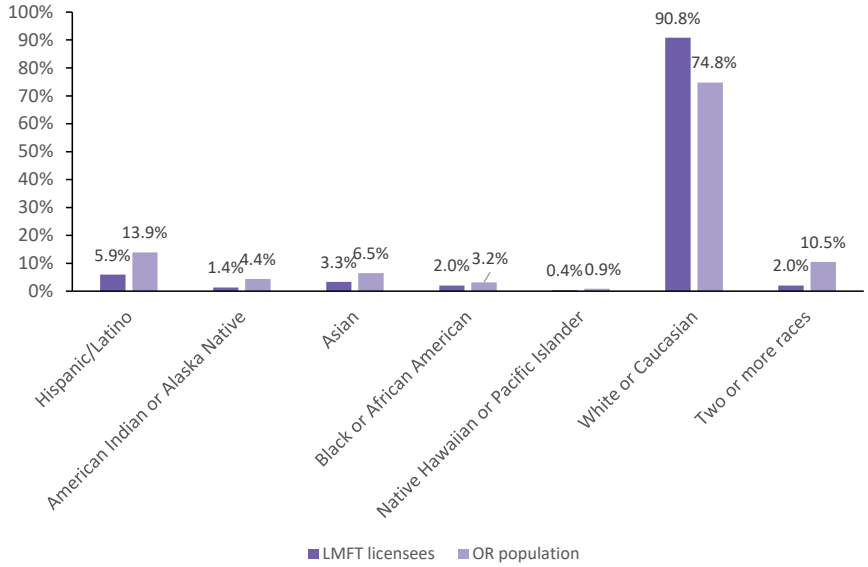
LMFT Race/Ethnicity, Gender and Languages

The racial and ethnic demographics of marriage and family therapists looks most similar to those of all licensed mental health professionals in Oregon. There was substantially less racial and ethnic diversity LMFTs when compared with the overall Oregon population.

Race and ethnicity. More than 90 percent of marriage and family therapists licensed in Oregon are white. About 3 percent of Oregon licensed therapists are Asian American.[11]

Separately examining ethnicity, professionals who identify as Hispanic/Latino comprise 6 percent of LMFTs. However, Hispanic- and Latino-identifying residents make up nearly 14 percent of the Oregon population.

B-6. Race and ethnicity of marriage and family therapist licensees in Oregon, 2022, compared to Oregon population, 2020



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

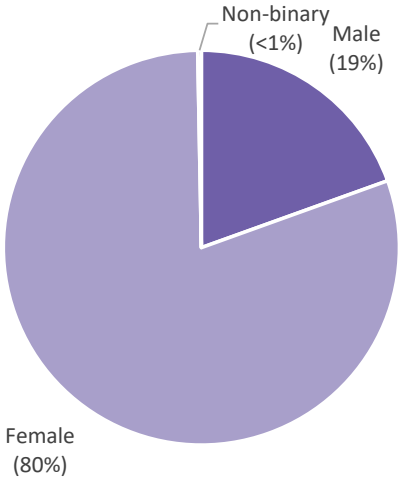
[11] The racial and ethnic group percentages reported here are based on data received from MHRA. Data from the Oregon Health Authority in 2021 indicate that the diversity of counselors and therapists in Oregon overall has improved in recent years.

B. Demographic Data — Marriage and family therapists (LMFTs)

Gender. Eighty percent of marriage and family therapists in Oregon reported their gender as female, the highest percentage among mental health professionals. This is the same as for the country as whole.[12]

Languages spoken. About 5 percent of LMFTs speak Spanish.

B-7. Gender of marriage and family therapist licensees in Oregon, 2022



Note: One percent of LMFTs did not indicate their gender.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

[12] Babayan, M. (2015). CAMFT's 2012 demographic survey: A snapshot of the "typical" California MFT. *The Therapist, 27*(5), 56-63. https://www.camft.org/Portals/0/PDFs/Demographic-surveys/2015_demographic_survey.pdf?ver=2019-06-23-164118-007

B. Demographic Data — Professional counselors (LPCs)

Keen Independent concludes this subsection of mental health professional demographics with the results for licensed professional counselors licensed in Oregon.

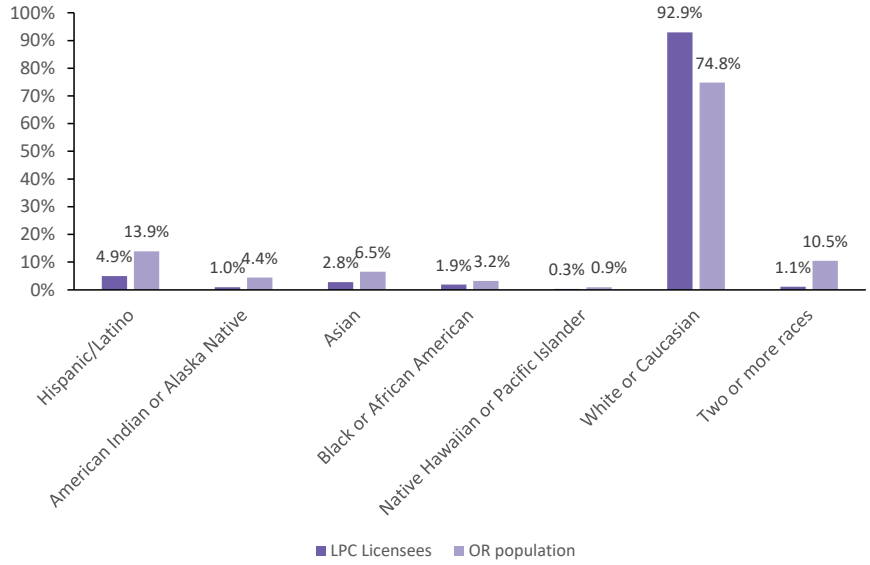
LPC Race/Ethnicity, Gender and Languages

According to data that MHRA provided for this study, professional counselor licensees are the least racially/ethnically diverse of the licensed mental health professionals in Oregon. Gender identity demographics are more similar to other Oregon mental health professionals.

Race and ethnicity. White practitioners account for 93 percent of professional counselors, almost 20 percentage points higher than found for the Oregon population. Representation of racial minorities and Hispanic/Latinos among professional counselors is lower than for other mental health professions licensed by MHRA.

Among people of color, Hispanic/Latino professional counselors are the largest group (5%) but are substantially underrepresented compared to the proportion of the overall Oregon population who identifies as Hispanic/Latino (14%).

B-8. Race and ethnicity of professional counselor licensees in Oregon, 2022, compared to Oregon population, 2020



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

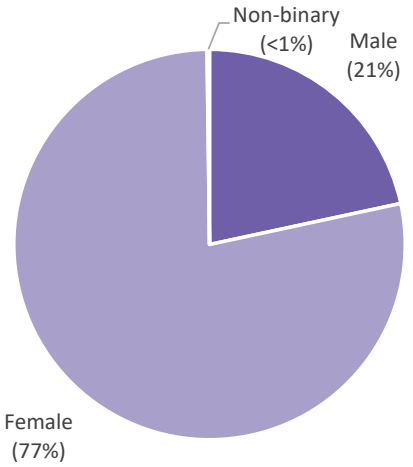
Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Professional counselors (LPCs)

Gender. About 77 percent of LPCs are female, about the same as the nation.

Languages spoken. Similar to other mental health professionals in Oregon, about 5 percent of LPCs speak Spanish.

B-9. Gender of professional counselor licensees in Oregon, 2022



Note: Two percent of LPCs did not indicate their gender.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Pipeline

The following sections examine available demographic data for college graduates, registered associates and residents.

Education of Mental Health Professionals

Using publicly available information, Keen Independent presents the following demographic analysis of the educational pipeline of mental health professionals.

Education of marriage and family therapists and licensed professional counselors. For licensure as a marriage and family therapist or a professional counselor, applicants must have graduated from a counseling program accredited by either the:

- Council for Accreditation of Counseling and Related Educational Programs (CACREP);
- Commission on Accreditation for Marriage and Family Therapy (COAMFTE); or
- Council on Rehabilitation Education (CORE).

OBPLCT also accepts degrees from regionally accredited programs and foreign degree programs that meet specific course requirements.

More than 1,000 programs across the country are accredited by one or more of the programmatic accrediting organizations and programs range from school and rehabilitation counseling to family sciences. The wide variety of and decentralized nature of these degree programs makes it difficult to locate aggregate demographic information on graduates.

The study team examined demographic composition of graduate students in a limited sample of relevant degree programs.[13] The demographics of students in these programs were similar to Oregon as a whole: about 74 percent white and 26 percent racially or ethnically minoritized groups, and more diverse than the demographic makeup of practitioners in Oregon.

The study team did not have access to data to determine whether students enrolled in these programs are looking more like the Oregon population now than in the past, but national trends suggest this is possible.

[13] Four universities with six relevant degree programs in Oregon reported demographic data on enrolled students for 2020-21 in their accreditation reports to the Council for the Accreditation of Counseling and Related Education Programs.

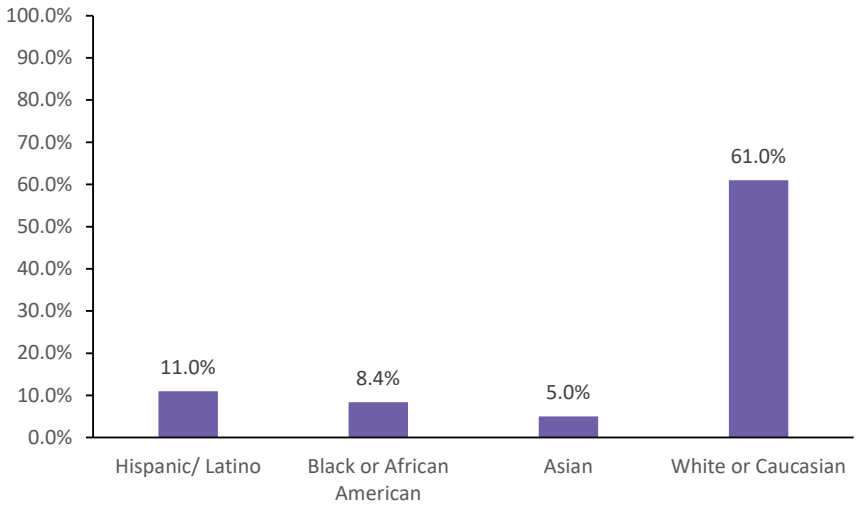
Education of Psychologists. OBOP educational standards for obtaining a psychologist license are more narrowly defined. Applicants must have graduated from a program accredited by the American Psychological Association (APA), the Canadian Psychological Association (CPA) and regionally accredited and foreign programs that meet specified coursework criteria. In Oregon, there are six APA-accredited programs:

- George Fox University (clinical PsyD)
- University of Oregon
  - Clinical PhD
  - Counseling PhD
  - School PhD
- Pacific University
  - Clinical PhD
  - Clinical PsyD

According to an APA report, a total of 3,795 graduates were awarded doctorates in health service psychology subfields across the United States in 2017, with clinical psychology as the most popular degree at 37 percent. Of all clinical psychology graduates, 78 percent were women and 64 percent were non-Hispanic white.[14] The report did not provide a racial and ethnic breakdown of health service psychology doctoral degree graduates, but Figure B-10 shows the breakdown for all psychology doctorate degree graduates.

Keen Independent did not identify data for graduates in Oregon.

B-10. Race/ethnicity of psychology doctoral degree graduates in the U.S., 2017



Note: APA data did not include percentages for graduates identifying as American Indian or Native Alaskan, Native Hawaiian or Pacific Islander, nor two or more races, so percentages do not add to 100 percent.

Source: Keen Independent Research, apa.org.

Enrollment of racially and ethnically minoritized students in graduate psychology programs grew from 27 percent in 2006-07 to 35 percent in 2016-17 according to the American Psychological Association.[15]

[14] American Psychological Association. (2019). *2008 – 2017 Masters and doctoral degrees awarded in psychology*. https://www.apa.org/workforce/publications/2017-postsecondary-data/report.pdf

[15] Bailey, D. (2020, January 1). *Enticing new faces to the field*. American Psychological Association. https://www.apa.org/monitor/2020/01/cover-trends-new-faces

B. Demographic Data — Pipeline

In addition to new graduates, the pipeline of mental health professionals includes registered associates and residents of various license types.

- For prospective licensees who have their educational credentials, OBLPCT offers a Registered Associate application method in which applicants are required to submit a proposed plan to complete the requisite hours of supervision required for licensure.

- Prospective psychology licensees must complete a post-doctoral residency to qualify for licensure. These individuals working toward full licensure are registered under OBOP as residents.

Psychology Residents and Associate Residents

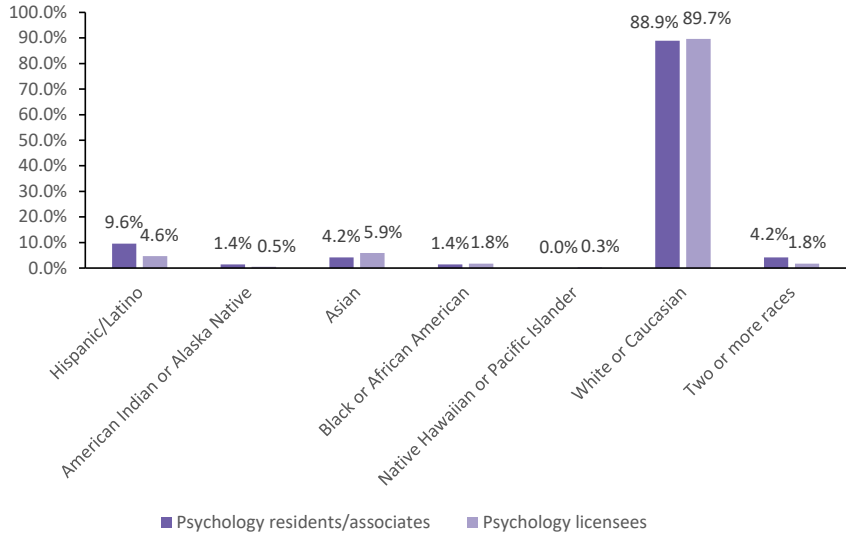
Since OBOP has an option for associate resident, the number of whom are small, we present combined demographic information for psychologist residents and psychologist associate residents. Since raw numbers for languages spoken at home are very small, we omit those results.

Race and ethnicity. Psychology associates and residents are slightly more racially diverse than their licensed counterparts. Similar percentages of psychology associates and residents and their licensed counterparts were white. Asian Americans comprised a slightly smaller share of psychology associates than licensed psychologists.

Keen Independent separately examined ethnicity. About 10 percent of associates and residents were Hispanic or Latino compared to less than 5 percent of licensees. The pipeline of psychologists shows substantially greater representation of Hispanic and Latino associates and residents than found for psychologists licensed in Oregon.

As with other graphs, Figure B-11 results for ethnicity (Hispanic/Latino) should not be combined with results by race (all other groups).

B-11. Race and ethnicity of psychology associates and residents compared to psychologist licensees in Oregon, 2022



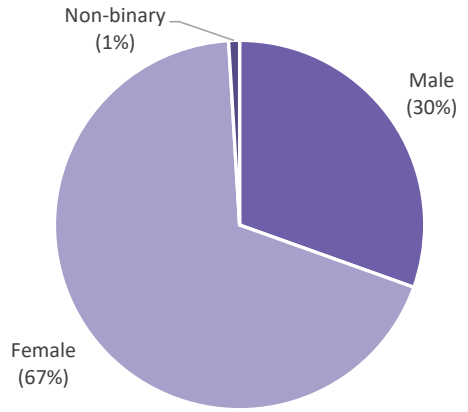
Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Pipeline

Gender demographics. Men comprise a smaller share of psychology associates and residents in Oregon than that of licensed psychologists (30 percent compared to 36 percent, respectively). Figure B-12 shows data on gender identity for psychology associates and residents.

B-12. Gender of psychology associates and residents in Oregon, 2022



Note: Seven percent of psychology associates did not indicate their gender.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Pipeline

The study team analyzed the race, ethnicity and gender of marriage and family therapist associates compared to licensed marriage and family therapists.

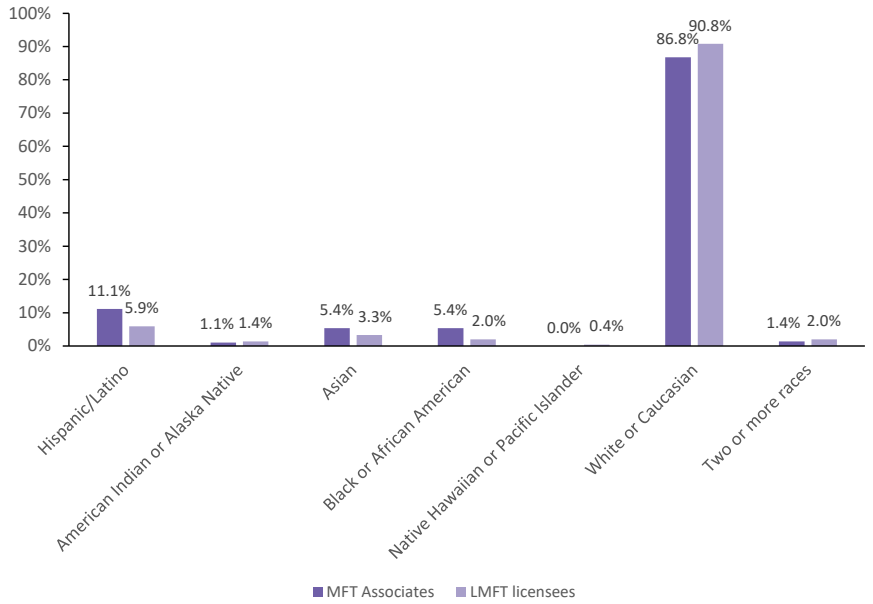
Marriage and Family Therapist Associates

According to data that MHRA provided for this study, MFT associates are the most racially/ethnically diverse of the license and associate types.

Race and ethnicity. Relatively fewer MFT associates are white than their licensed counterparts. About 5 percent of MFT associates are Asian American and 5 percent are African American, each higher than found for MFT licensees in Oregon.

Also, a greater share of MFT associates identify as Hispanic or Latino (11%) than found for MFT licensees (6%), as shown in Figure B-13.

B-13. Race and ethnicity of MFT associates in Oregon, 2022



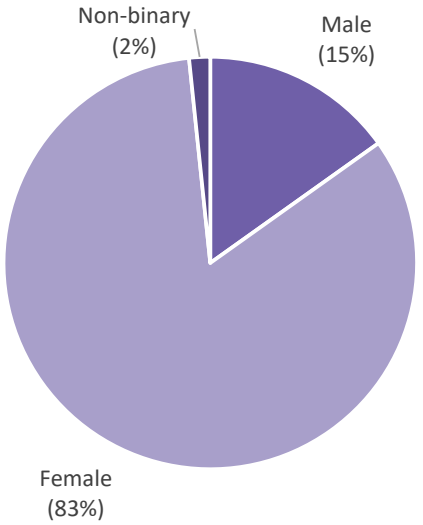
Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Pipeline

Gender. Compared to their licensed counterparts, relatively more MFT associates identify as female (83% compared to 80%) and somewhat more identify as non-binary (2% compared to 1%).

B-14. Gender of MFT associates in Oregon, 2022



Note: Less than 1 percent of MFT associates did not indicate their gender identity.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Pipeline

Keen Independent concludes the demographic analysis of associates in this section with professional counselor associates. We present results for race, ethnicity and gender.

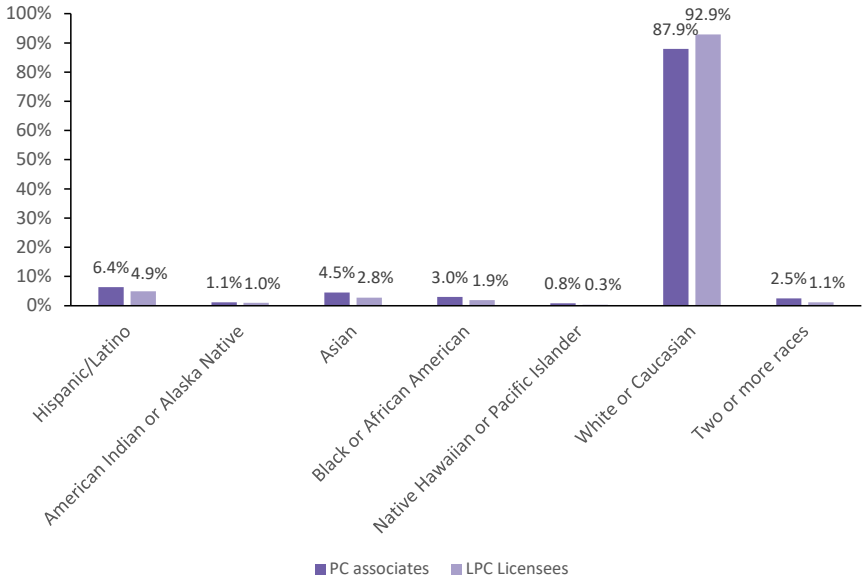
Professional Counselor Associates

Similar to marriage and family therapist associates, professional counselor associates are also more diverse than their fully licensed counterparts (LPCs).

Race and ethnicity. Whereas 93 percent of LPC licensees identified themselves as non-Hispanic white, 88 percent of professional counselor associates were white.

Hispanic/Latino associates were 6 percent of all professional counselor associates compared to just under 5 percent of LPCs.

B-15. Race and ethnicity of professional counselor associates in Oregon, 2022



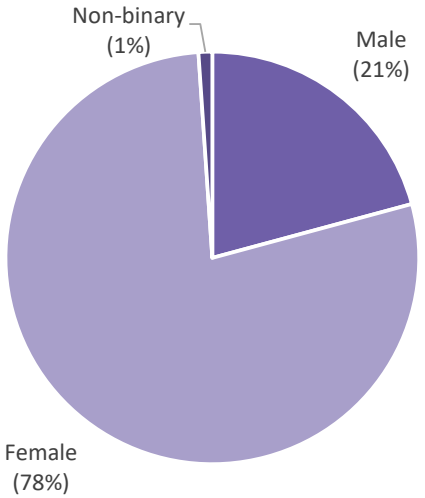
Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Pipeline

Gender. The gender makeup of professional counselor associates (78% women) is similar to licensed professional counselors (77% are women).

B-16. Gender of professional counselor associates in Oregon, 2022



Note: Less than one percent of professional counselor associates did not indicate their gender.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Keen Independent received anonymized data containing top-level information on 960 complaints and investigations received against mental health professionals from OBOP and OBPLCT. Not all complaint respondents provided race/ethnicity information, so Keen Independent applied the results for complaint respondents who reported that information to all complaint respondents of that license type. This means that small differences in results could be due to random chance.

Psychologists

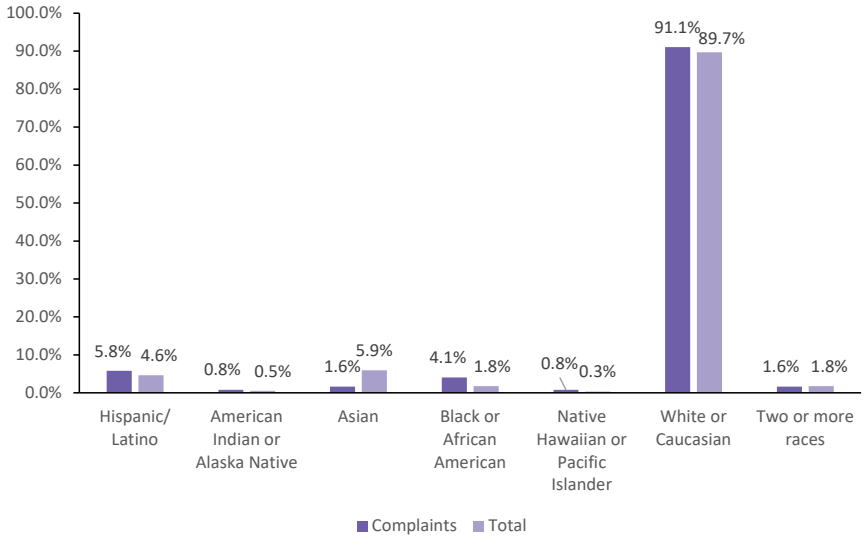
Between December 2017 and June 2022, the Oregon Board of Psychology received 287 complaints, 46 percent of which were dismissed (most commonly because the complaint was found to lack merit). Of the investigated complaints, unprofessional conduct and failure to avoid harm were the most common allegation types. Of the cases that led to a sanction in the data we reviewed, the most common outcome was reprimand or censure. Only six cases resulted in revocation or voluntary surrender of license (two females and four males; no other demographic identifiers were provided).

Eighty-five percent of complaints were filed against licensed psychologists and the remaining were filed against psychologist associates (1%), residents (2%) and temporary psychologist permit holders (7%; generally do not hold permits at the time of complaint). Sixteen complaints (6%) were not categorized by license type.

Because the number of complaints for psychologist associates, residents and temporary psychologist permit holders was relatively small, this analysis focuses on the 243 complaints for licensed psychologists. Assuming that each case filed was against a different licensee (which may not be the case since multiple complaints can be filed against a licensee and complaints data do not indicate if cases are linked to the same clinician), just under 11 percent of psychologists had a complaint filed against them.

Race and ethnicity of psychologist licensees. Figure B-17 provides the racial and ethnic demographics of psychologist licensees against whom complaints were filed. Of those for whom racial and/or ethnic information was provided, the vast majority were white. Slightly larger shares of Hispanic/Latino and Black psychologists were represented in complaints compared to the overall percentage in the population.

B-17. Race and ethnicity of psychologist complaint respondents, Dec. 2017–June 2022, compared to psychology licensees in Oregon, 2022



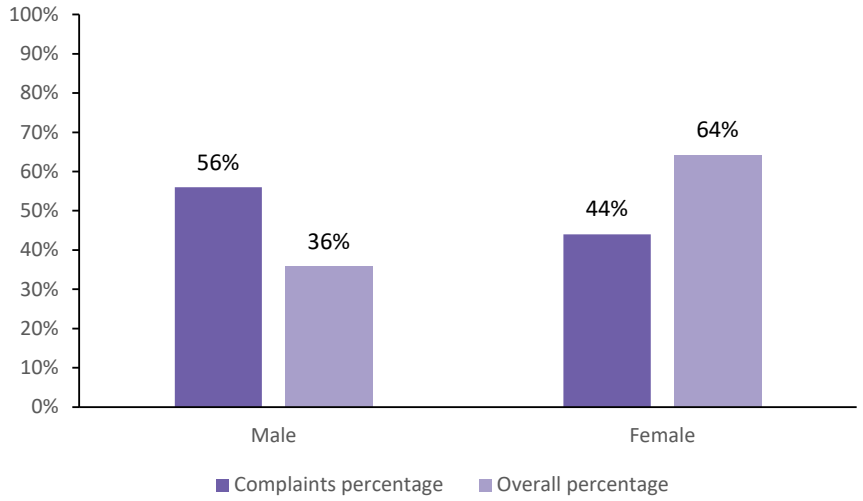
Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Gender of psychologist licensees. All psychologist complaint respondents provided a gender identity and 54 percent selected male. Male psychologists account for a larger share of complaints and investigations than expected based on the share of psychologists who are men (36%).

B-18. Gender of psychologist complaint respondents, Dec. 2017–May 2022, compared to psychology licensees in Oregon. 2022



Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

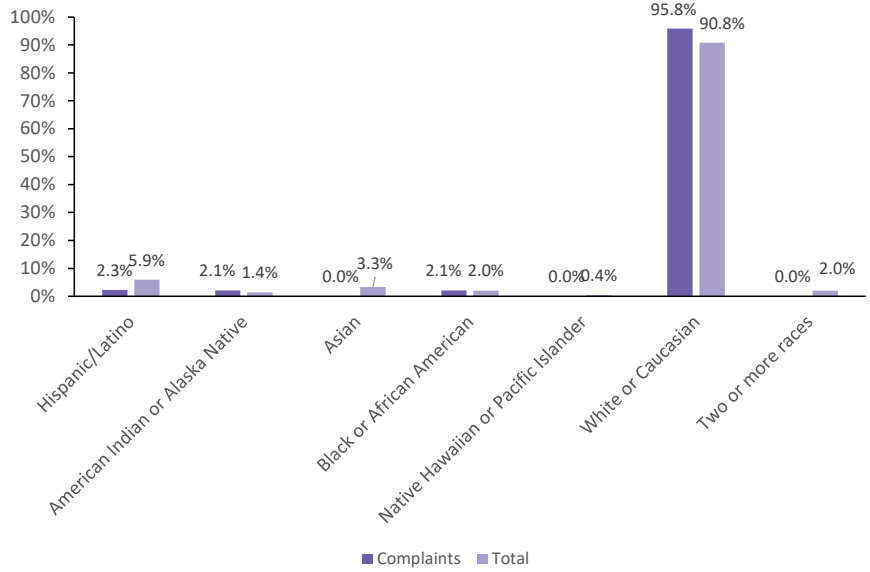
Keen Independent continues the demographic analysis of complaint respondents with marriage and family therapists and associates.

Marriage and Family Therapists

Keen Independent analyzed 60 complaints made against LMFTs and 45 complaints made against MFT associates between January 2017 and June 2022. The most common allegations were unprofessional conduct and failure to avoid harm. As with cases investigated on behalf of OBOP, the most common outcome for an investigation on behalf of OBPLCT is dismissal due to the finding that the complaint lacked merit. In the data Keen Independent reviewed, about 26 percent of cases against LMFT and MFT associates were dismissed. The most common outcomes of cases that resulted in sanctions were civil penalties and the cost of the investigation. Just one license was revoked because of an investigation.

Race and ethnicity of marriage and family therapist licensees. Figure B-19 provides the racial and ethnic demographics of LMFTs against whom complaints were filed. Nearly 96 percent of LMFTs for whom racial/ethnic information was provided are white, slightly more than expected based on the share of licensees who are white.

B-19. Race and ethnicity of LMFT complaint respondents, Jan. 2017–June 2022, compared to all LMFTs in Oregon. 2022



Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding. Nonresponse/decline to answer accounted for 20 percent of the total number of LMFT complaint respondents.

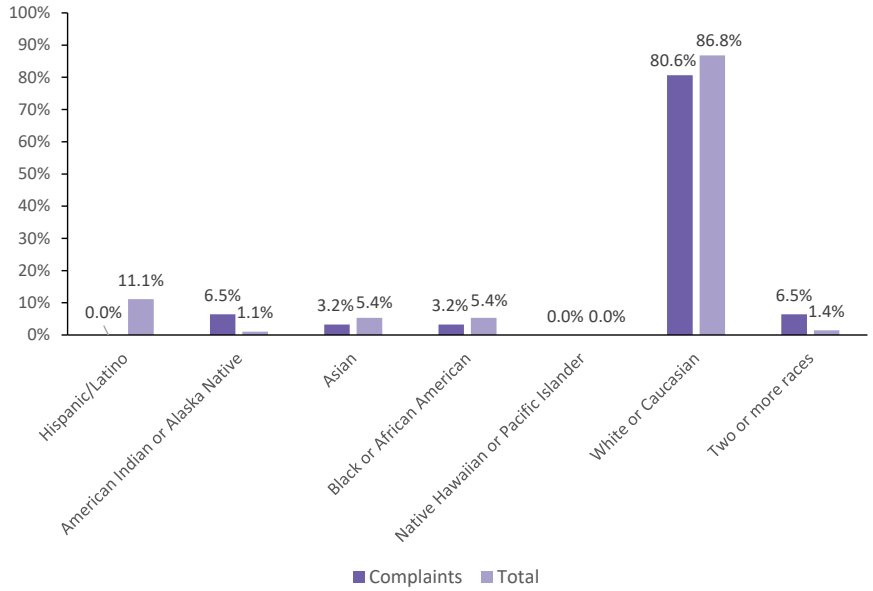
Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Race and ethnicity of marriage and family therapist licensees. The share of complaints filed against MFT associates who are American Indian or Alaska Native (almost 7%) exceeded what would be expected based on the relative number of MFT associates who are American Indian or Alaska Native (1%).

Relatively fewer complaints were filed against Hispanic MFT associates (0%) compared with the share of those professionals who are Latino (11) and white MFT associates (81%) compared to their overall share of all MFT associates (87%).

B-20. Race and ethnicity of MFT associate complaint respondents, Jan. 2017–June 2022, compared to all MFT associates in Oregon. 2022



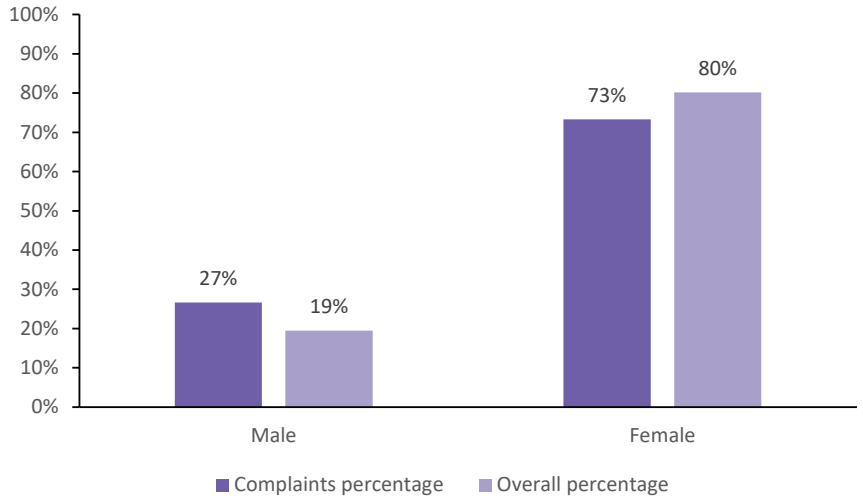
Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Gender of marriage and family therapist licensees. Of LMFT complaint respondents for whom a gender was provided, 27 percent indicated that they were male. This is higher than the overall percentage of MFT license holders who are male (19%).

B-21. Gender of LMFT complaint respondents, Jan. 2017–June 2022, compared to all LMFTs in Oregon, 2022

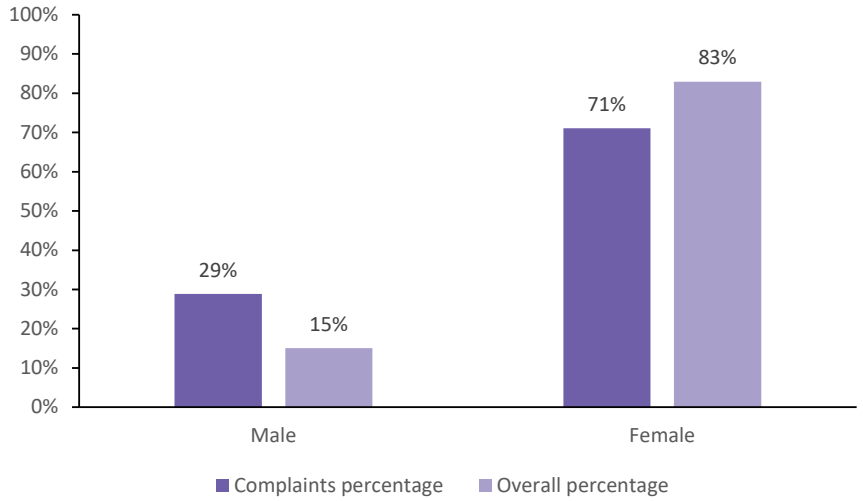


Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Gender of marriage and family therapist associates. As with other mental health professionals in Oregon, men comprised a higher share of MFT associates who were the subject of complaints (29%) than their share of MFT associates (15%).

B-22. Gender of MFT associate complaint respondents, Jan. 2017–June 2022, compared to all MFT associates in Oregon, 2022



Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Professional counselor and professional counselor associate complaint respondent demographics are examined below.

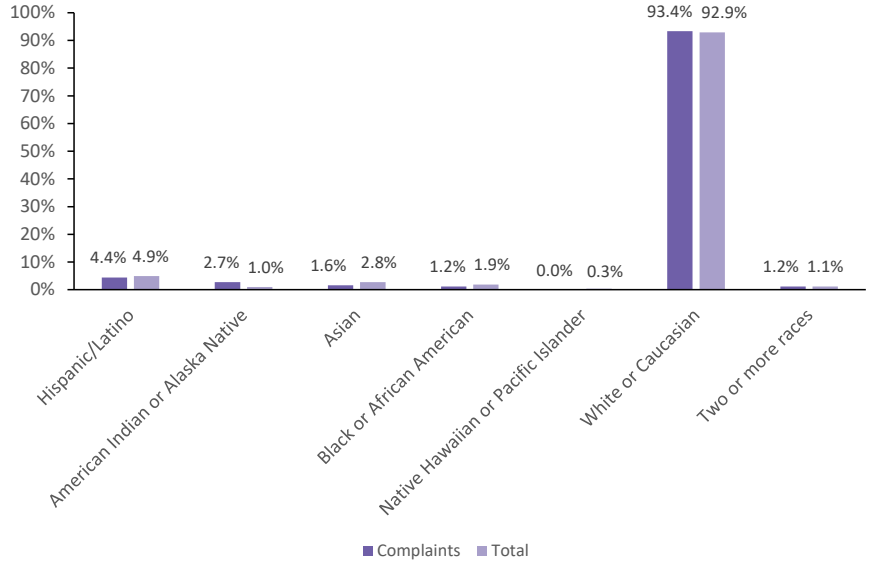
Professional Counselors

Between January 2017 and June 2022, the Oregon Board of Licensed Professional Counselors and Therapists received 332 complaints made against LPCs and 180 complaints made against professional counselor associates based on data Keen Independent was provided for this analysis. Just under 28 percent of these cases were dismissed.

The most common allegations were also unprofessional conduct and failure to avoid harm. Of the cases that led to sanction, the most common outcomes were civil penalties, letters of reprimand and the cost of the investigation itself. Just six licenses were revoked as a result of an investigation (four women and two men).

Race and ethnicity demographics of professional counselor licensees. Figure B-23 provides the racial and ethnic demographics of LPCs against whom complaints were filed compared to all Oregon LPCs. For each racial or ethnic group, the representation among complaints was about the same as the share of LPCs in a group.

B-23. Race and ethnicity of LPC complaint respondents, Jan. 2017–June 2022, compared to all LPCs in Oregon, 2022



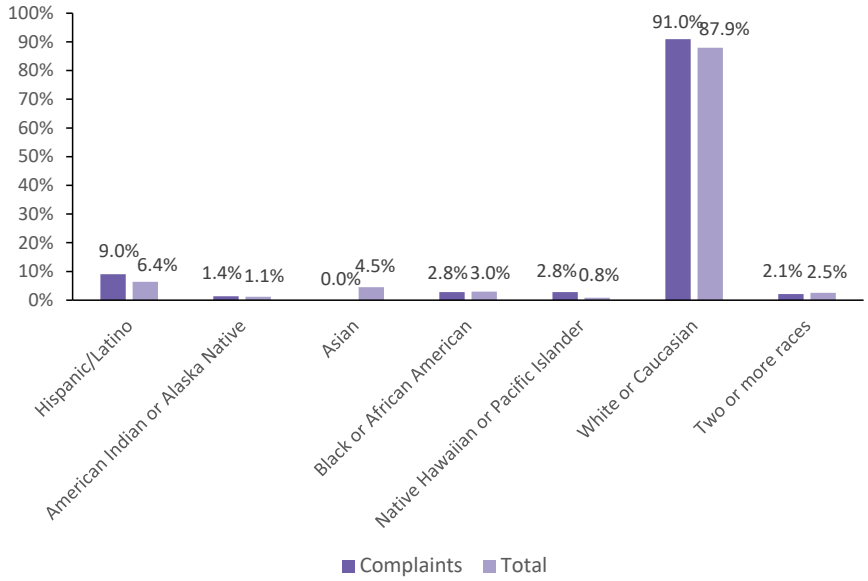
Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 percent with rounding. Nonresponse/decline to answer accounted for 22.9 percent of the total number of LPC complaint respondents.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Race and ethnicity demographics of professional counselor associates. White professional counselor associates accounted for 91 percent of complaint respondents compared to 88 percent overall. Hispanic or Latino-identifying professional counselor associates were potentially slightly overrepresented among complaint respondents (9% compared to 6% overall).

B-24. Race and ethnicity of PC associate complaint respondents, Jan. 2017–June 2022, compared to all PC associates in Oregon, 2022



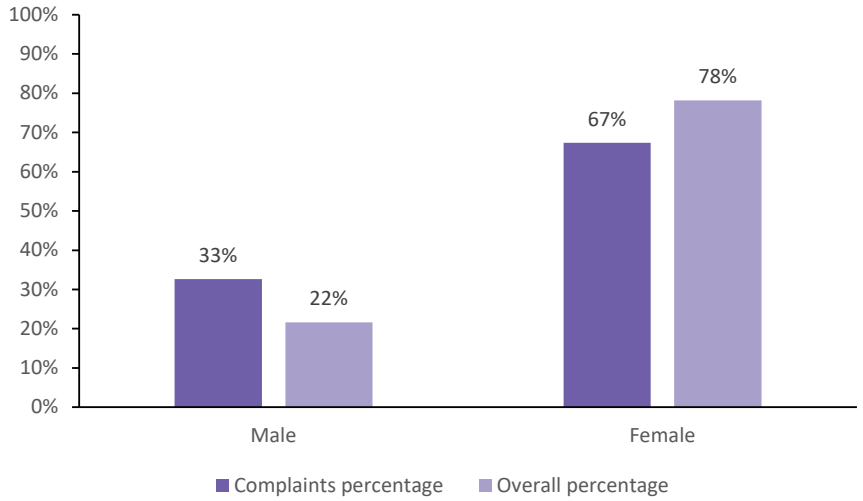
Note: Hispanic/Latino ethnicity is a separate category from the racial group categories. Racial groups add up to roughly 100 with rounding. Nonresponse/decline to answer accounted for 20 percent of professional counselor associate respondents.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Complaint respondents

Gender of professional counselor licensees. Of LPC complaint respondents for whom a gender was provided, 33 percent indicated that they were male. This is higher than the overall percentage of LPC license holders who are men (22%).

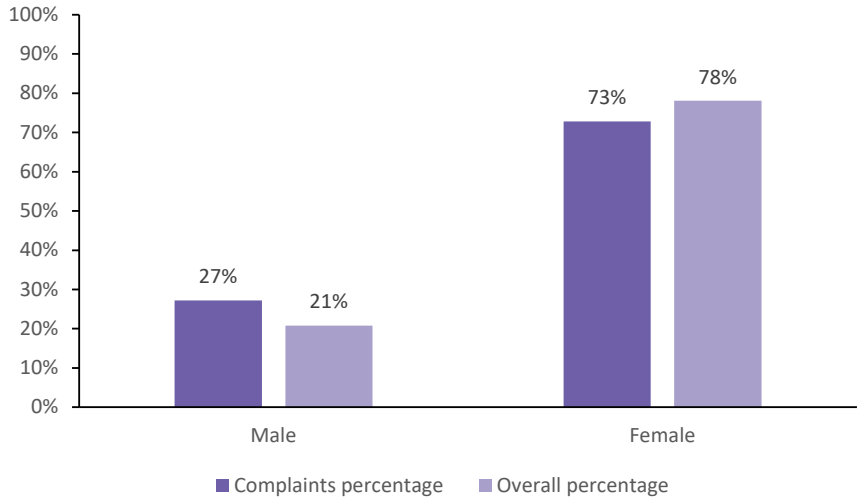
B-25. Gender of LPC complaint respondents, Jan. 2017–June 2022, compared to all LPCs in Oregon, 2022



Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

Gender of professional counselor associates. Men were also overrepresented in complaints against professional counselor associates, as shown in Figure B-26.

B-26. Gender of professional counselor associate complaint respondents, Jan. 2017–June 2022, compared to all PC associates in Oregon, 2022



Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

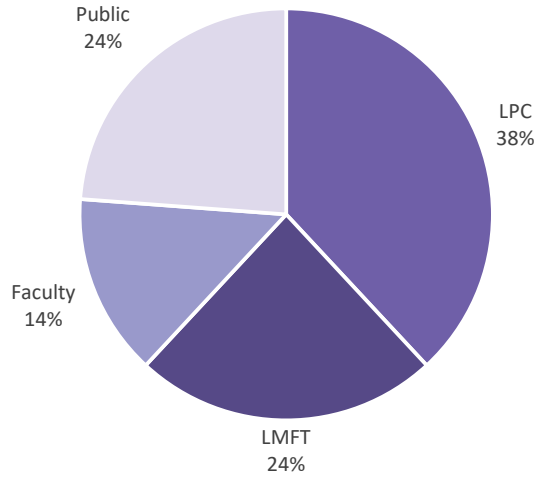
B. Demographic Data — Board and staff demographics

To contextualize the representation of professionals of different demographics in leadership positions, Keen Independent examined the license affiliation, gender, race/ethnicity and sexual orientation of members of the Oregon Board of Licensed Professional Counselors and Therapists, the Board of Psychology and staff of the Mental Health Regulatory Agency.

Board of Licensed Professional Counselors and Therapists (OBLPCT)

Keen Independent received demographic information from MHRA on 21 OBLPCT board members who served in 2015 or later. Makeup of the board by background, professional counselor, marriage and family therapist, faculty member or member of the public is outlined in Oregon Revised Statute (see Appendix A). Accordingly, the largest proportion of board members were LPC licensees.

B-27. Makeup of OBLPCT, 2015-2022

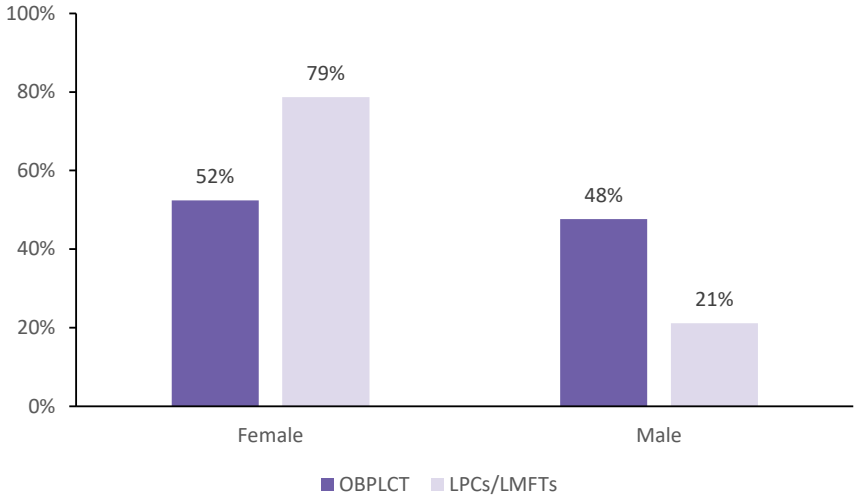


Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Board and staff demographics

Gender. Compared to the population of LPCs and LMFTs overall, members of OBLPCT are less female and more male. Figure B-28 displays the comparison of gender between OBLPCT and the licensees it regulates. We note that we omitted non-binary gender from the bar chart because less than half a percent of LPCs and LMFTs were non-binary and no board members were non-binary.

B-28. Gender of OBLPCT members compared to LPCs and LMFTs, 2015-2022

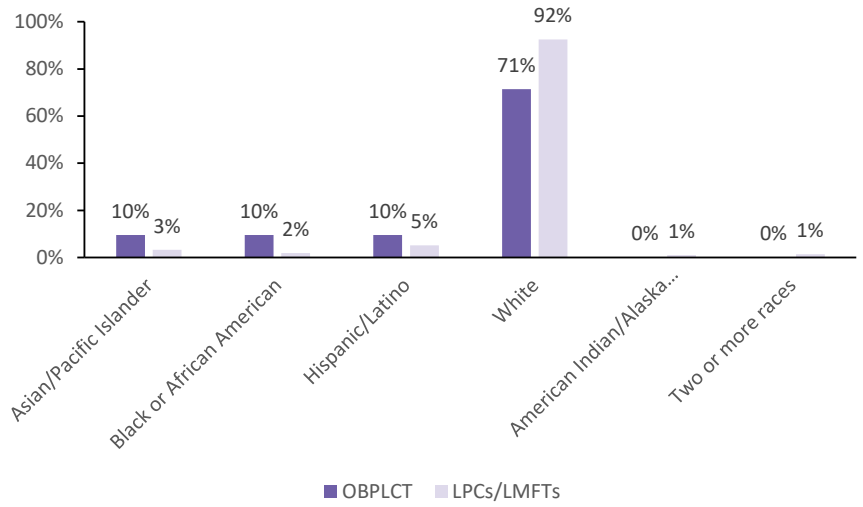


Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Board and staff demographics

Race and ethnicity. OBLPCT was less white and more racially diverse than the Oregon population of LPCs and LMFTs. Figure B-29 displays the comparison of racial and ethnic groups between the board and the practitioners it regulates.

B-29. Race/ethnicity of OBLPCT members compared to PCs and LMFTs, 2015-2022



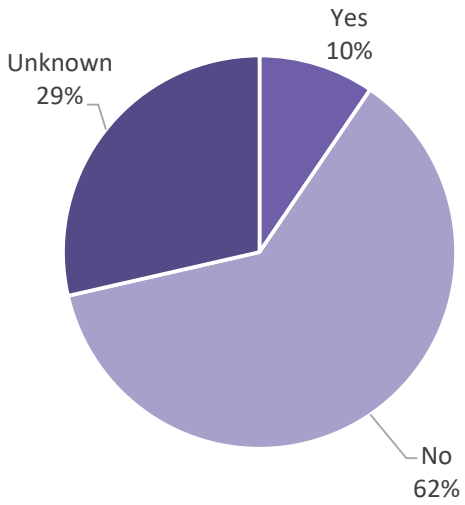
Note: Asian and Native Hawaiian/Pacific Islander were combined categories in the board data but separate categories in the practitioner data. We combined the categories into Asian/Pacific Islander here for ease of comparison.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Board and staff demographics

LGBTQ+ status. Ten percent of OBLPCT members indicated they were LGBTQ+. Information regarding the LGBTQ+ status among LPCs and LMFTs was not available from the contact lists the study team analyzed. However, of the 1,326 LPCs and LMFTs who participated in the virtual workshop[16], nearly 18 percent were LGBTQ+.

B-30. LGBTQ+ status of OBLPCT members, 2015-2022



Note: Numbers add to more than 100 percent due to rounding.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

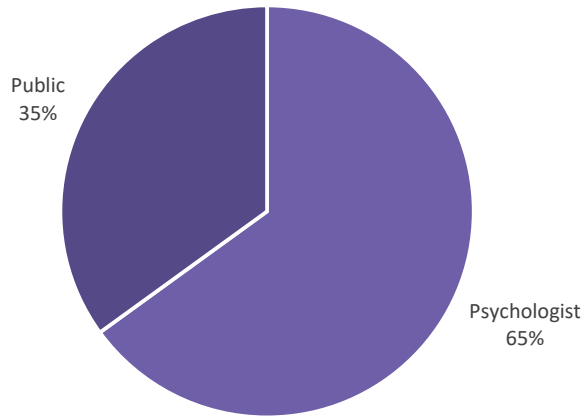
[16] A virtual workshop is similar in format to an online survey but contains more open-ended questions to encourage thoughtful responses. Keen Independent administered a virtual workshop to Oregon mental health professionals and received 1,793 responses. More information on the virtual workshop is available in Appendix C.

B. Demographic Data — Board and staff demographics

Board of Psychology (OBOP)

The study team analyzed demographic information of 20 individuals who served on OBOP in 2015 or later. Nearly two-thirds of OBOP members are psychologist licensees. The remainder are members of the public, as required by Oregon Revised Statute (see Appendix A).

B-31. Makeup of OBOP, 2015-2022

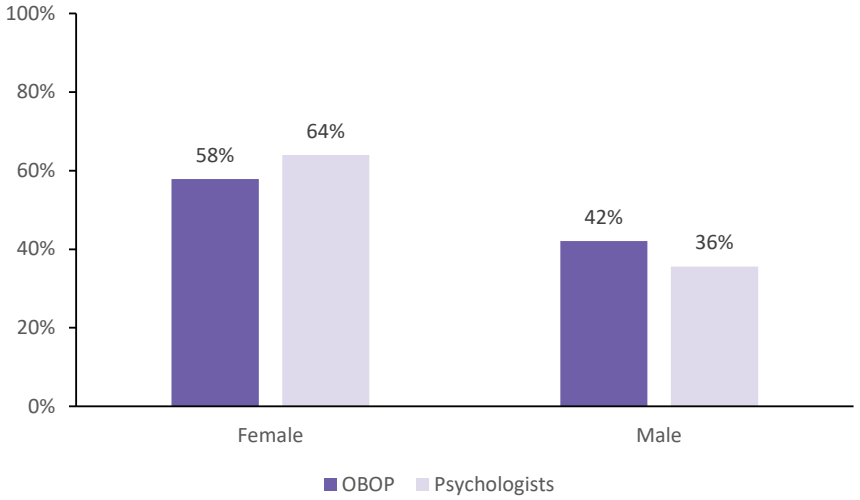


Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Board and staff demographics

Gender. Members of OBOP somewhat mirror the gender makeup of psychologists overall in Oregon. About 58 percent of OBOP is female and about 64 percent of the population of Oregon psychologists is female. Figure B-32 displays this comparison. We omitted non-binary from the bar chart because no OBOP members were non-binary and less than one one-hundredth of a percent of psychologists were non-binary.

B-32. Gender of OBOP members compared to psychologists

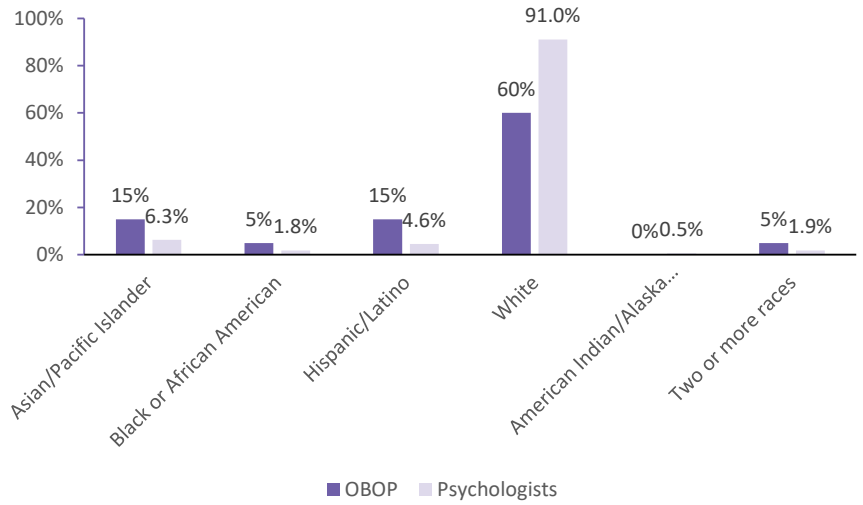


Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Board and staff demographics

Race and ethnicity. Compared to psychologists in Oregon overall, OBOP members were substantially less white (60% compared to 91% overall) and more racially and ethnically diverse.

B-33. Race/ethnicity of OBLPCT members compared to psychologists



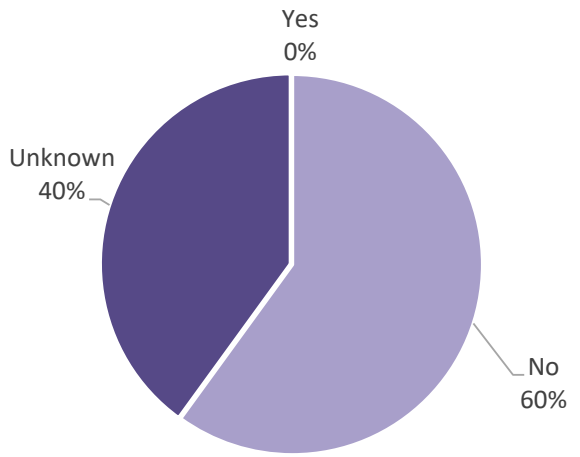
Note: Asian and Native Hawaiian/Pacific Islander were combined categories in the board data but separate categories in the practitioner data. We combined the categories into Asian/Pacific Islander here for ease of comparison.

Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

B. Demographic Data — Board and staff demographics

LGBTQ+. Data on the LGBTQ+ population of psychologists was not available for comparison, but no members of OBOP were LGBTQ+. Of the 351 psychologists who participated in the virtual workshop, slightly over 16 percent were LGBTQ+.

B-34. LGBTQ+ status of OPOB members



Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

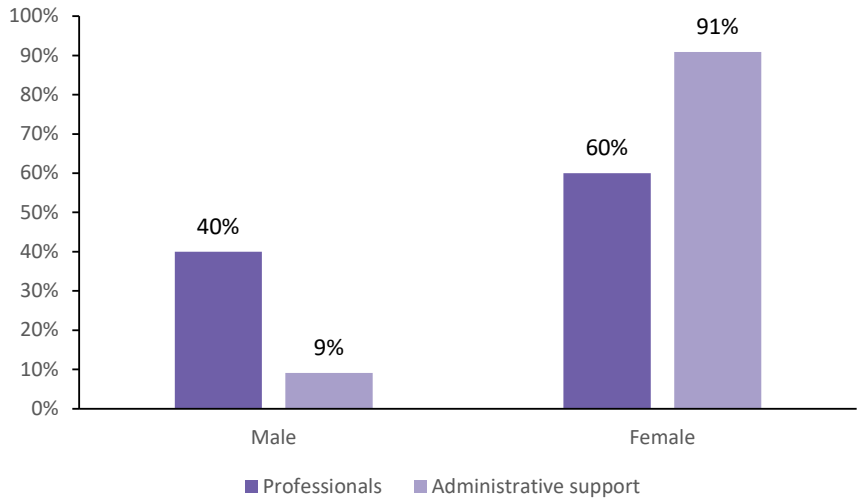
B. Demographic Data — Board and staff demographics

Mental Health Regulatory Agency

Based on information from the MHRA 2021-23 Diversity & Inclusion/Affirmative Action Plan, Keen Independent presents race/ethnicity and gender information for the MHRA staff of 16 people[17]. MHRA segmented their demographic information into job types, which include Administrative Services and Professionals.

Gender. As percentages, the MHRA Administrative Services staff is more female than the staff of Professionals. However, we note that these numbers are small, as 11 staff members are considered Administrative Services staff and 5 are considered Professionals.

B-35. Gender of MHRA staff by job type, 2020



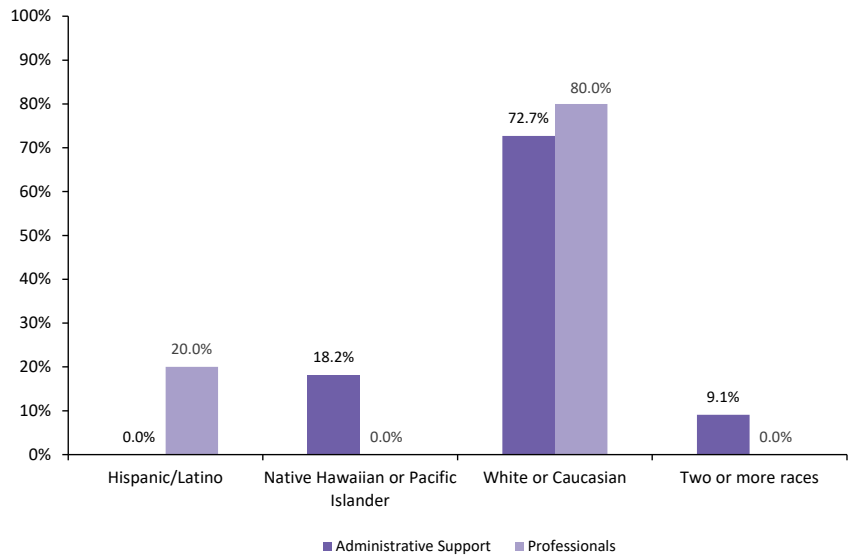
Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

[17] Information on LGBTQ+ status of MHRA staff was not available.

B. Demographic Data — Board and staff demographics

Race and ethnicity. Aligning with the overall trends in the state, the MHRA staff is majority white. Three Administrative Services staff and one Professional staff identify as non-white.

B-36. Race and ethnicity of MHRA staff by job type, 2020



Source: Keen Independent Research from Oregon Mental Health Regulatory Agency.

APPENDIX C. Methodology

To provide the Oregon Mental Health Regulatory Agency (MHRA) with diverse perspectives on equity in the counseling, marriage and family therapy and psychology professions, Keen Independent conducted extensive outreach and data collection.

External stakeholder outreach focused on licensed professional counselors, marriage and family therapists and psychologists, as well as applicants and associates/residents in Oregon. Participants included practitioners in various stages of the licensure process across a wide variety of demographic groups. Keen Independent also received input from practitioners with experience serving in leadership roles for professional associations or as members of the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) or the Oregon Board of Psychology (OBOP).

Appendix C describes the methods we used to collect this feedback and presents an overview of results from our virtual workshop with practitioners (a survey-like research method).

This appendix primarily focuses on external stakeholder research methods used in gathering and analyzing input from Oregon practitioners. As described later in this appendix, in-depth interviews also included internal MHRA stakeholders and other state and national contacts drawn from outside Oregon's counseling, marriage and family therapy and psychology professions.

Organization of this Appendix

This appendix presents:

- Virtual workshop;
- In-depth interviews;
- Focus groups; and
- Analysis of feedback.

C. Methodology

Purpose of Quantitative Analyses

Quantitative analysis in this report is used in two ways. First, we use percentages to describe populations (e.g., the demographics of Oregon mental health professionals compared to the demographics of Oregon or of all mental health professionals nationally). Second, we use total numbers and percentages to describe the virtual workshop participants and responses.

We do not use tests of statistical significance in this report for two primary reasons.

- The demographic data on mental health professionals in Oregon that we analyzed are for the entire population. As statistical significance tests are performed on sample data, not population data, they are not needed here.
- Keen Independent was not seeking to generalize virtual workshop results from subgroup responses.

Using Qualitative Analysis to Understand Experiences

When conducting research about underrepresented demographic groups in an industry, numbers of potential participants from those groups will naturally be small. Qualitative analysis provides a meaningful way to understand the experiences reported by people in underrepresented groups, which is the primary method Keen Independent used to analyze results.

C. Methodology —Virtual workshop

Keen Independent used a virtual workshop to collect feedback from mental health practitioners.

Keen Independent uses the term "virtual workshop" to refer to an asynchronous survey-like instrument that participants can complete on their own schedule that prompts them to think deeply about the topics covered. Rather than focus on yes/no survey questions, the virtual workshop asked practitioners for narratives that described their experiences and observations.

Virtual Workshop Recruitment

Virtual workshop participants were recruited via direct emails to professionals subject to licensing by OBLPCT and OBOP. Emails went to 8,109 professionals under OBLPCT and 2,494 professionals under OBOP. The study team received a total of 1,793 responses to the virtual workshop, which represents about 17 percent of all mental health professionals under the two boards. This provides confidence that any quantified results for all respondents are very close to what would have been found if the entire population of mental health practitioners in Oregon had participated (responses are accurate within about +/- 2 percentage points at the 95 percent confidence level).

Virtual Workshop Protocol

Participants were provided a link to the virtual workshop in the recruitment email and could complete the instrument at their leisure at any time during the three weeks the virtual workshop was open. The virtual workshop was open from July 11, 2022, to August 1, 2022. Following the initial invitation, two subsequent reminders were sent via MHRA's email listservs to encourage more participation.

Email invitations and introductory text for the virtual workshop explained that answers would be reported in aggregate and would not be attributed to individual participants. Participants could complete the virtual workshop without providing their names or contact information. At the close of the survey, participants who indicated willingness to participate in follow up research were asked to provide their names and contact information for outreach purposes only.

Virtual Workshop Questions

The virtual workshop contained a few questions using one to five Likert scales but the bulk of the information we gleaned from the study came from open-ended questions by design.

In addition to questions about affiliation, license type, years of experience and experience as an employer, educator, clinical supervisor, patient advocate or board member, Keen Independent asked about the following:

- Factors that influence the diversity of the mental health profession;
- How much influence regulatory boards have on the diversity of the mental health profession;
- How well the boards protect consumers from marginalized backgrounds;
- How equitably the boards treat diverse mental health professionals;
- How equitable the license attainment, renewal and investigations processes are;
- Strategies for and barriers to making the mental health profession more diverse; and
- Participant demographics, including location, race/ethnicity, gender identity, sexual orientation, age, disability status and veteran status.

Race and ethnicity categories. Keen Independent used the following categories for race and ethnicity and asked participants to select all that apply to them:

- Black or African American;
- Asian American or Pacific Islander;
- Hispanic American;
- American Indian;
- Non-Hispanic white; and
- Other (describe).

Gender identity categories. In addition to asking if the participant identified as transgender in a separate question, the study team used the following categories for gender identity:

- Female;
- Non-binary;
- Male; and
- Self-describe.

Sexual orientation categories. The study team used the following categories for sexual orientation:

- Heterosexual or straight;
- Gay or lesbian;
- Bisexual; and
- Self-describe.

C. Methodology — In-depth interviews

Keen Independent conducted interviews to understand ways in which different audiences perceived the mental health regulatory process from an equity standpoint. We developed interview guides with slight differences between them for different types of interviews as follows:

- Mental health practitioners in Oregon (i.e., professional counselors, marriage and family therapists and psychologists);
- National mental health regulatory, policy or professional advocacy group contacts;
- Regulatory contacts for similar professions in Oregon and for counselors, therapists and psychologists in other states; and
- Internal MHRA stakeholders.

Mental health practitioner guides included variations for leaders of Oregon professional associations and professionals with experience on the Oregon Board of Psychology or the Oregon Board of Licensed Professional Counselors and Therapists.

In-Depth Interview Recruitment

Oregon mental health practitioners were primarily recruited from respondents to the virtual workshop who indicated they would like to participate in additional research. Some interviews that took place prior to the virtual workshop were recruited from contact lists provided by MHRA. National and other regulatory contacts were actively recruited via direct contact.

C-1. Number of interviews by type

Interviews	Count
Oregon counselors and therapists	27
Oregon psychologists	19
National contacts	5
Other state regulatory agency contacts	3
Internal MHRA contacts	3
Other	3
Total	**60**

Note: Other interviews included individuals not licensed by OBLPCT or OBOP such as out-of-state practitioners and professionals or students in related fields.

Unique interview participants total 63 individuals. Some interviews included more than one person. One person was interviewed on two occasions on different topics.

Source: Keen Independent Research

C. Methodology — In-depth interviews

Interview Protocol

Keen Independent used interview guides for semi-structured interviews, meaning that our predetermined interview questions guided the discussion, but interviewers asked follow-up questions and probed when necessary to deepen understanding or clarify the comment. Each interview was scheduled for about one hour and the majority took the full hour.

Interviews were recorded and participants were informed their comments would be used in aggregate and reported without identifying information. The interviewer completed a background information sheet on each practitioner who participated in an interview to capture their affiliation, license type (if applicable), years of experience, location, race/ethnicity, gender and any other salient demographic characteristics they wished to share that would help contextualize their experiences.

Interview questions prompted participants to consider how equitable the Oregon licensure process is for mental health professionals at three key junctures (initial licensure, license maintenance and renewal, and complaints and investigations). We also asked broader questions about factors that affect diversity in the mental health profession, what may hinder efforts to increase diversity in the mental health profession and awareness of any successful efforts in Oregon or elsewhere that have increased diversity in the mental health profession.

Interviews with regulatory agency contacts for similar professions in Oregon and for counselors, therapists and psychologists in other states prompted participants to consider how equitable licensure, renewal and investigations are in their respective fields. These interviews also explored efforts to ensure equitable processes and increase diversity in their professions. National contact interviews covered similar subjects.

C. Methodology — Focus groups

To generate more discussion around some of the themes emerging from early interviews and virtual workshop responses, Keen Independent conducted four focus groups.

Focus Group Recruitment and Grouping

Participants were mental health practitioners in Oregon who indicated in the virtual workshop that they would like to participate in additional research. We sought to segment the focus groups by salient demographic markers, so we specifically reached out to virtual workshop participants who identified themselves as persons of color, LGBTQ+ or both.

Two focus groups were designed to hear from practitioners of color, one was composed of LGBTQ+ practitioners and one that combined practitioners of color and LGBTQ+ practitioners.

Groups also included seven total individuals who identified as having neurodiversity or a disability.

Figure C-2 displays the number of focus groups attendees by group and the percentage of those attendees who identified as individuals with disabilities.

C-2. Number of focus group attendees by group

Group	Demographic	Participant count
1.	Practitioners of color	5
2.	LGBTQ+ practitioners	4
3.	Combined	6
4.	Practitioners of color	3

Note: Combined group included practitioners of color and LGBTQ+ practitioners.
Source: Keen Independent Research.

Focus Group Questions

In each focus group, Keen Independent asked participants to consider:

- What would help more diverse individuals enter the field of mental health;
- How participants might redesign the licensing and complaints processes to promote equity; and
- How the Oregon licensing boards do and could communicate that they care about the diversity of practitioners.

Focus Group Protocol

Focus group sessions, all of which occurred on Zoom, were scheduled for 55 minutes.

C. Methodology — Methods to analyze feedback

Keen Independent utilized both qualitative and quantitative methods to analyze the information from the virtual workshop, interviews and focus groups. Our approach is described below.

Virtual Workshop Analysis

Because the virtual workshop contained ranking questions and open-ended questions, Keen Independent used both quantitative and qualitative methods to analyze feedback.

Qualitative analysis. The study team developed codes to synthesize the large volume of qualitative responses to the virtual workshop.

Study team members coded responses on open-ended questions about the following topics:

- Factors that affect diversity in Oregon's mental health professions;
- The influence of MHRA, OBOP and OBLPCT on the diversity of Oregon's mental health professions;
- Ways MHRA, OBOP and OBLPCT may affect diversity when mental health professionals are entering the industry and attaining licensure;
- Ways MHRA, OBOP and OBLPCT may affect diversity when handling complaints and investigations; and
- Strategies or policies that would help increase diversity and equity among mental health professionals in Oregon.

Study team members created a list of codes for each of the above questions and then applied the codes to each open-ended response. Each code could be positive or negative. Comments that discussed more than one topic or both positive and negative aspects of the same issue could receive more than one code. As a result, total numbers of coded responses do not add up to the total number of responses to each question.

Study team members also reviewed open-ended responses to virtual workshop questions for themes and highlighted quotes that illustrated each theme.

Quantitative virtual workshop analysis. After team members coded the qualitative open-ended responses, we computed the frequency of coded response. We examined question responses using demographic information we collected from the virtual workshop participants to see if meaningful differences among groups of practitioners emerged.

Five of the virtual workshop questions prompted respondents to rank their agreement with a statement on a one to five scale. We also computed an average score for each of those questions.

Interview and Focus Group Analysis

Following the completion of an interview or focus group session, Keen Independent reviewed each transcript to identify themes and highlight quotes relevant to themes. The team then reviewed themes and highlighted quotes, selecting representative comments for inclusion in the qualitative analysis appendices.

APPENDIX D. Virtual Workshop

Practitioners licensed and regulated by the Oregon Mental Health Regulatory Agency (MHRA), the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) provided input via responses to a virtual workshop (similar to a survey, with more opportunity for open-ended comments).

This appendix summarizes virtual workshop participation and rating question results by profession, license type and demographic characteristics.[1] More detailed information from the virtual workshops is presented in Appendices E-J.

Note: The virtual workshop asked participants to indicate if they have experience as employers, educators, clinical supervisors, patient advocates and members of the professional boards. We do not separately analyze response for these segments. These questions allowed us to monitor for potential gaps in participation and provided context for understanding participant perspectives in our qualitative analysis reported in Appendices E-J.

Appendix Overview

This appendix is organized as follows:

- Participant demographics;
- Protecting consumers and practitioners;
- Factors that affect diversity in the mental health professions;
- Board influence on diversity in the mental health professions;
- Board support/hindrance of diversity when entering the industry;
- Board support/hindrance of diversity when renewing licenses;
- Board support/hindrance of diversity during complaints and investigations process; and
- Strategies for increasing diversity and equity.

[1] A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

D. Virtual Workshop — Participants

Participant Demographics

Overall, the virtual workshop had 1,793 participants. Throughout this appendix, we compare the virtual workshop participants to the population, which refers to the total number of licensed mental health professionals in Oregon based on data from MHRA. We note that not all questions in the virtual workshop were required and provide sample size information for each individual question.

Tables on the following pages present major demographic characteristics of the sample including:

- License type;
- Race and ethnicity;
- Gender identity;
- Sexual orientation; and
- Age distribution.

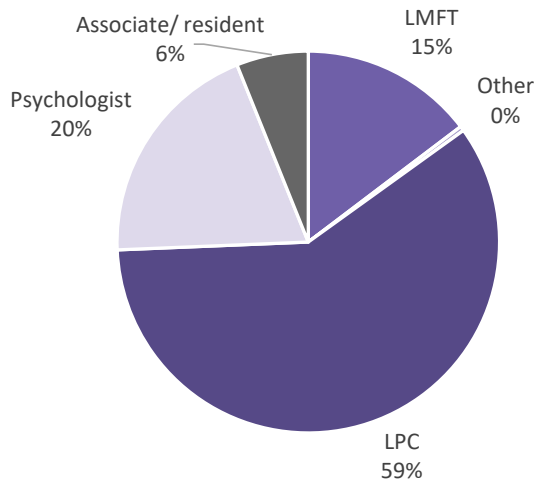
Virtual workshop participants also reported the following characteristics:

- 47 percent Portland-based;
- 14 percent persons with disabilities;
- 8 percent English as a second language speakers
- 5 percent veterans; and
- 3 percent transgender.

D. Virtual Workshop — Participants

License type. LPCs are overrepresented in the sample (59% in the sample compared to 45% of the practitioner population) and registered associates are underrepresented (6% compared to 18% overall).

D-1. Virtual workshop participants by license type



Note: N = 1,793.

Associate/resident category includes all license types, as associate numbers were too small to disaggregate.

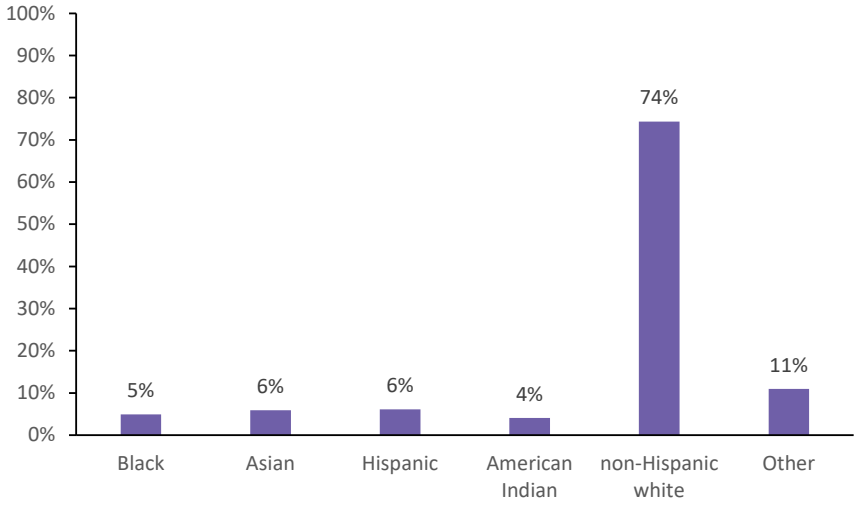
Source: Keen Independent Research.

D. Virtual Workshop — Participants

Race and ethnicity. The virtual workshop sample is substantially more diverse than the overall population of mental health professionals in Oregon. Whereas nearly 93 percent of all mental health professionals identified as white, 74 percent of the virtual workshop sample identified as white. All racially minoritized groups were overrepresented in the virtual workshop sample.

The "other" category does not exist in the data Keen Independent was provided, but in the virtual workshop data, that category captured individuals who identified as bi/multiracial, ethnically Jewish and Middle Eastern, among other identities. Participants were allowed to select more than one racial/ethnic group and many individuals who identified as multiracial selected the "other" option.

D-2. Race and ethnicity of virtual workshop participants



Note: N = 1,793.

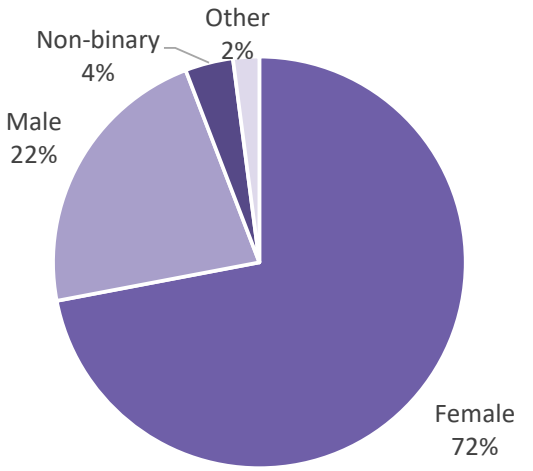
Respondents could select more than one racial/ethnic group, so numbers add up to more than 100 percent.

Source: Keen Independent Research.

D. Virtual Workshop — Participants

Gender identity. Non-binary practitioners were overrepresented in the virtual workshop sample (4% compared to less than 1% in the population). Male and female practitioners were slightly underrepresented compared to the population (22% in the virtual workshop and 24% overall for males; 72% in the virtual workshop and 75% overall for females).

D-3. Gender identity of virtual workshop participants



Note: N = 1,793.

Two percent of respondents did not provide a gender identity.

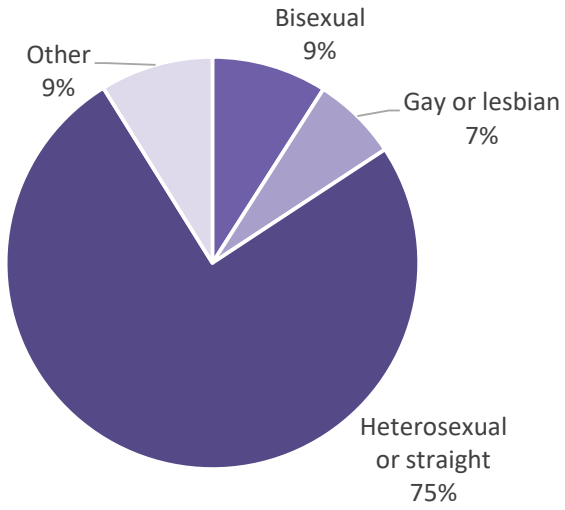
The "Other" category included a wide range of responses that together do not provide any actionable information.

Source: Keen Independent Research.

D. Virtual Workshop — Participants

Sexual orientation. Sexual orientation was not provided in the data Keen Independent received on all licensees, so a comparison of the virtual workshop sample to the population is not possible.

D-4. Sexual orientation of virtual workshop participants



Note: N = 1,793.

Four percent of respondents did not indicate their sexual orientation.

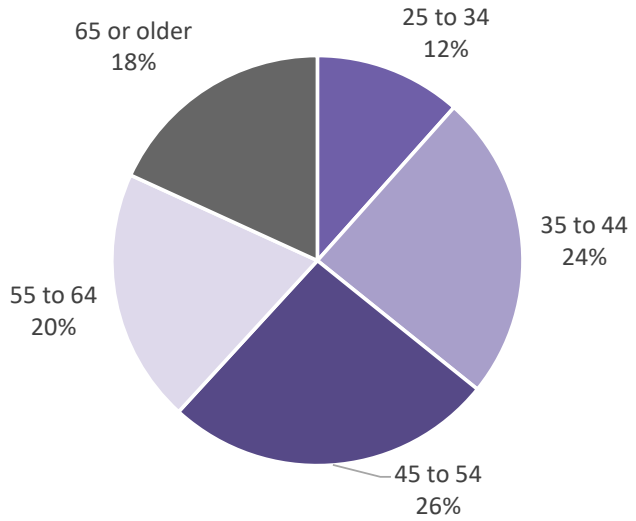
The "Other" category included a wide range of responses that together do not provide any actionable information.

Source: Keen Independent Research.

D. Virtual Workshop — Participants

Age distribution. The largest age group among respondents was 45 to 54 at 26 percent. For all licensees in Oregon, 35 to 44 is the largest age group at 31 percent with 45 to 55 as the second largest group (24%)[2]. All other age groups were slightly oversampled (by 1% to 3%) in the virtual workshop compared to the overall population of licensees.

D-5. Age groups of virtual workshop participants



Note: N = 1,793.
Three percent of respondents did not indicate their age group.
A 20-24 option was included, but no respondents selected it.

Source: Keen Independent Research.

[2] Keen Independent requested age data to make this comparison in November 2022, whereas the other data that references all licensees were requested and received in June. Thus, the age data includes individuals who were newly licensed and excludes individuals whose licenses expired between June 2022 and November 2022. We compared gender and race between these data sets and there are no significant changes in demographics.

D. Virtual Workshop — Results

Keen Independent presents a brief summary of responses to virtual workshop questions. We note the qualitative questions for which we applied quantitative coding and provide the percentage of times that each code appeared in the total number of responses.

Because numbers of responses from participants in certain subgroups were small for analysis purposes, we created a people of color subgroup (containing participants identified as Black or African American, Asian American or Pacific Islander, Hispanic or Latino, American Indian or Alaska Native and multiracial) and an LGBTQ+ subgroup (containing participants identified as non-binary, trans, bisexual and gay or lesbian).

Protecting Consumers and Equitable Treatment of Practitioners

The virtual workshop contained four questions asking respondents to indicate how well they thought the regulatory board for their profession protected the public and equitably treated practitioners.

Overall, practitioners rated the mental health regulatory boards' protection of consumers and equitable treatment professionals as slightly better than average (a score of '3' represents that boards do an average job protecting consumers and professionals). Ratings for the questions that asked participants how well boards protected consumers and equitably treated professionals from marginalized backgrounds were, on average, lower than rankings for the questions that did not mention consumers or professionals from marginalized or diverse backgrounds.

Of all subgroups we examined, LGBTQ+ respondents provided the lowest ratings for all four questions regarding protection of consumers and equitable treatment of practitioners. For more detailed analyses of ratings of consumer protection and equitable treatment of practitioners by demographic subgroup, please see Appendix H.

D-6. Average ratings for board protection of mental health service consumers and mental health professionals

Question	Average rating
How well do regulatory boards protect consumers?	3.66
How well do regulatory boards protect consumers from marginalized backgrounds?	3.22
How equitably do regulatory boards treat mental health professionals?	3.44
How equitably do regulatory boards treat diverse mental health professionals?	3.37

Note: A rating of '1' indicated a response of 'very poorly' and a rating of '5' indicated a response of 'very well.'

Source: Keen Independent Research.

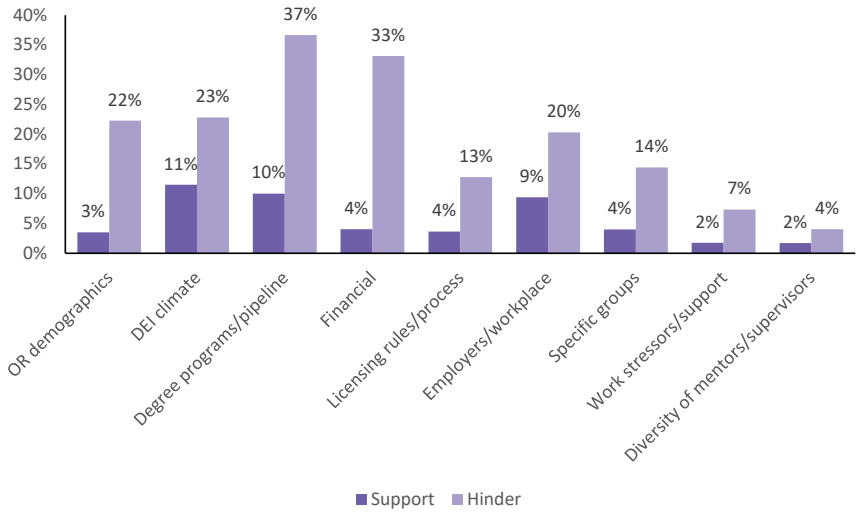
Factors that Affect Diversity in the Mental Health Profession

The first open-ended question of the virtual workshop prompted respondents to consider the factors that affect diversity in the mental health profession broadly. The study team applied the following codes to this response:

- Oregon demographics (the population makeup of Oregon);
- DEI (diversity, equity and inclusion) climate in Oregon (receptiveness to issues concerning diversity, equity and inclusion);
- Degree program/pipeline (availability of graduates from relevant programs and factors related to degree programs);
- Financial (costs and compensation related issues);
- Licensing rules/process (process and requirements for attaining and maintaining a license);
- Employers/workplace (factors related to employers or workplaces);
- Specific groups (support of or bias about a named group of individuals, e.g., gay practitioners);
- Workplace supports/stressors (general employment supports or stressors); and
- Diversity of mentors/supervisors (availability of mentors or supervisors with non-dominant identities).

Eighty-four percent of respondents provided a comment for this question and Figure D-7 illustrates the proportion of the available responses that contained each code.

D-7. Factors that affect diversity in the mental health profession



Note: N = 1,487.

Participants' responses could contain more than one code, so percentages do not add up to 100 percent.

Source: Keen Independent Research.

D. Virtual Workshop — Results

Negative factors were cited far more often than positive factors, which is expected when surveying practitioners about their profession. The most cited factor that negatively impacted diversity was the dearth of diverse candidates entering the mental health profession in Oregon (degree programs/pipeline; 37%), followed closely by financial barriers to education and licensure (33%). The most cited positive factor was Oregon's attitude toward diversity, equity and inclusion (DEI climate; 11%).

More than half of non-binary and transgender respondents cited the top two negative factors influencing diversity (degree/pipeline and finances). Additionally, people of color cited issues with employers or in the workplace more often than any other subgroup.

Licensing rules and processes were cited relatively infrequently, either in a positive or negative manner, compared to other factors. Among all respondents, licensing rules and processes were the fourth most mentioned factor that supports diversity at just under 4 percent. Around 13 percent of responses to this question indicated that licensing rules hinder diversity, making it the third least cited negative factor.

More detailed analyses of factors that support and hinder diversity of the mental health profession in Oregon are available in Appendix E.

Board Influence on Diversity in the Mental Health Profession

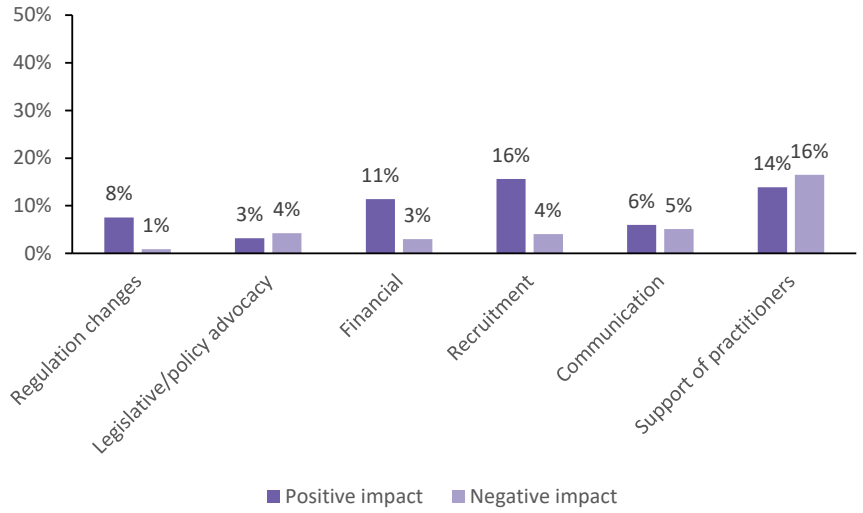
When asked to rate board influence on diversity in the mental health profession on a scale of one to five, respondents had an average rating of 3.48, indicating that the boards have moderate influence over diversity.

The study team applied the following codes to the open-ended comments submitted with this question:

- Regulation changes (directly changing rules around licensing);
- Legislative/policy advocacy (advocating for changes that could affect mental health practitioners);
- Financial (costs and compensation related issues);
- Recruitment (active encouragement of university students and professionals from other states to pursue Oregon licensure);
- Communication (information from agency/boards to practitioners); and
- Support of practitioners (providing guidance throughout the licensure process).

Recruitment was the most cited positive impact (16%) and support of practitioners was the most cited negative impact (16%). Of all subgroups we examined, LGBTQ+ respondents cited financial support and recruitment most frequently as positive factors under board control that would impact diversity. Appendix E contains more detailed analyses of board influence on diversity by subgroup.

D-8. Board influences over diversity in the mental health field



Note: N = 570.

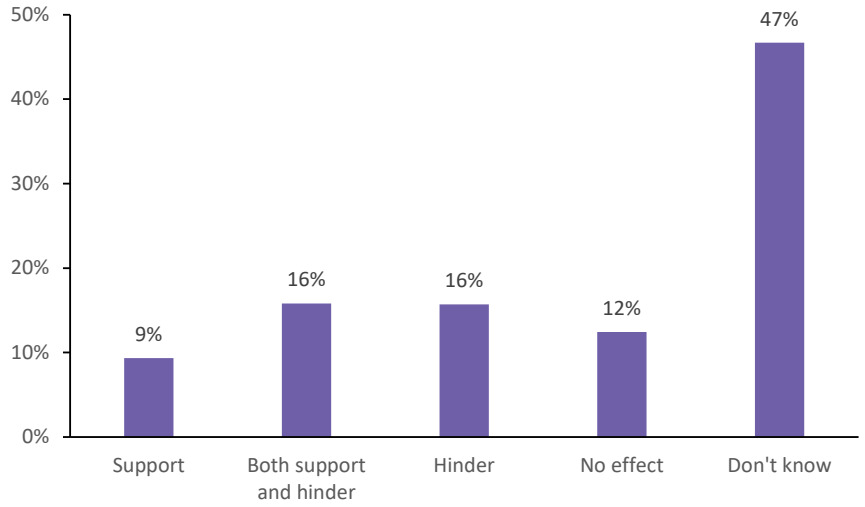
Participants' responses could contain more than one code, so percentages do not add up to 100 percent.

Source: Keen Independent Research.

Board Support/Hindrance of Diversity When Entering the Industry

Of respondents who provided an answer for whether the boards support or hinder diversity when professionals are entering the industry, just under half indicated that they did not know and another 12 percent indicated that the boards have no effect. Nine percent said the boards support diversity, equity and inclusion at this stage.

D-9. Whether boards impact the diversity of mental health professionals entering the industry



Note: N = 1,763.

Source: Keen Independent Research.

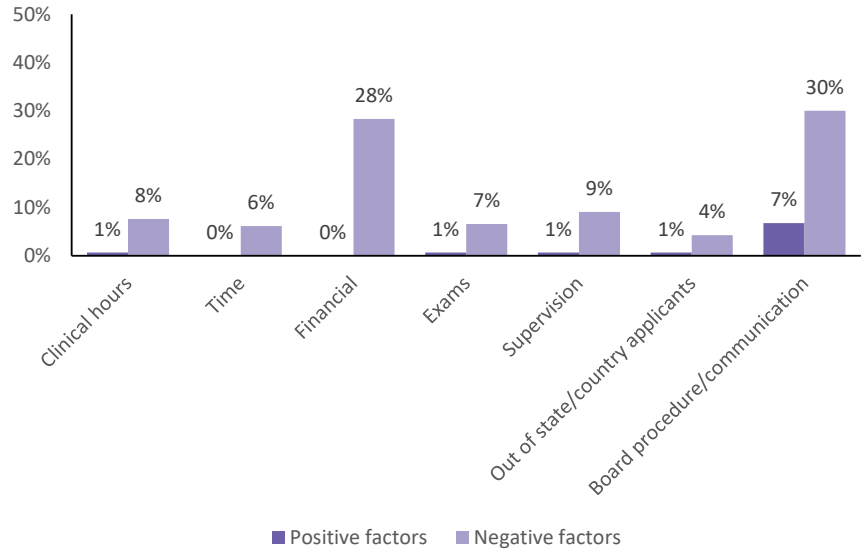
D. Virtual Workshop — Results

The study team applied the following codes to the follow-up question that asked respondents to provide examples of ways in which the regulatory boards support or hinder diversity when professionals enter the industry and attain licensure:

- Clinical hours;
- Time (e.g., how long the process of licensure takes);
- Financial (e.g., cost of licensure);
- Exam;
- Supervision;
- Out of state or country applicants; and
- Board procedures or communication (e.g., how accessible the boards are and how information is communicated to applicants).

The most cited negative impacts the boards have were financial (28%) and procedural or communications difficulties perceived by respondents (30%). However, 7 percent of respondents cited board procedures and communications as a positive factor. Four percent of responses from LMFTs indicated that licensing rules related to foreign or out of state applicants were a positive way boards could support diversity when professionals enter the industry. LGBTQ+ participants cited financial concerns and board procedures and communication as negative factors impacting diversity the most frequently. Appendix F contains more detailed analyses of responses by subgroup.

D-10. Examples of board supports/hindrances to mental health professionals entering the industry



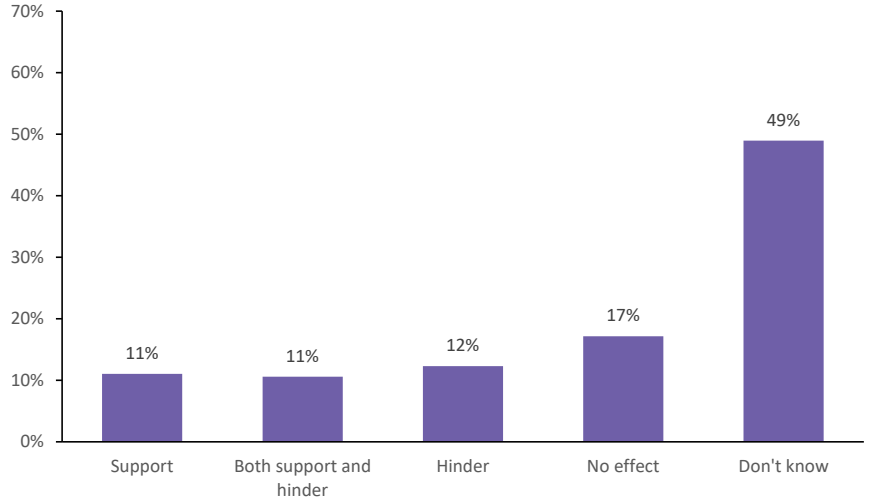
Note: N = 473.
Participants' responses could contain more than one code, so percentages do not add up to 100 percent.

Source: Keen Independent Research.

Board Support/Hindrance of Diversity When Renewing a License

When asked about whether the boards support or hinder diversity when professionals are renewing and maintaining their licenses, 49 percent of respondents indicated that they did not know. Of the remaining participant responses, no effect was the highest at 17 percent.

D-11. How boards impact the diversity of mental health professionals renewing and maintaining licenses



Note: N = 1,684.

Source: Keen Independent Research.

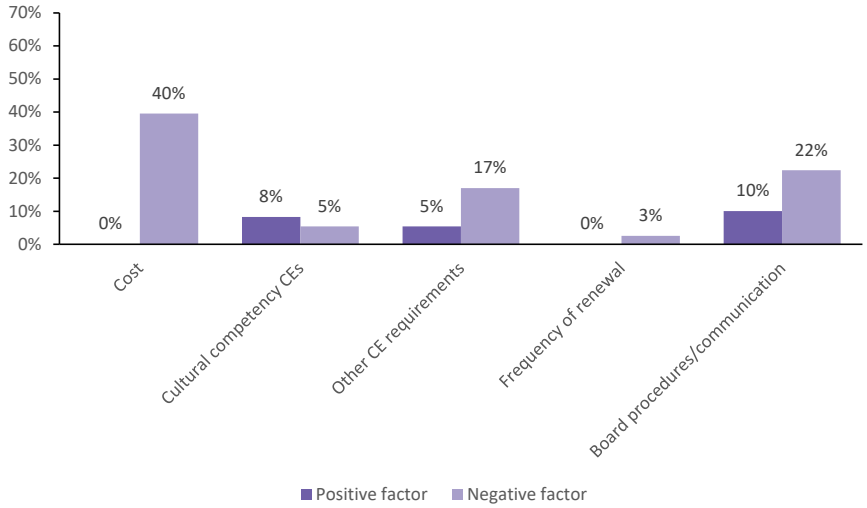
D. Virtual Workshop — Results

The next question that probed for examples of how the boards support or hinder diversity when mental health professionals are maintaining and renewing their licenses was coded for themes as follows:

- Cost;
- Cultural competency continuing education (CE) units;
- Other CE requirements;
- Frequency of renewal; and
- Board procedures or communication (e.g., how accessible the boards are and how information is communicated to applicants).

The most cited negative factor was the cost of renewal at 40 percent. Board procedures and communication was the second most cited negative factor and the most cited positive factor under board control that influences diversity during the renewal process. Responses from LGBTQ+ participants cited cost as a negative factor impacting diversity the most compared to responses from other subgroups. Appendix F contains more detailed analyses of factors that influence diversity during license renewal by demographic groups.

D-12. Examples of board supports/hindrances to mental health professionals renewing their licenses



Note: N = 389.

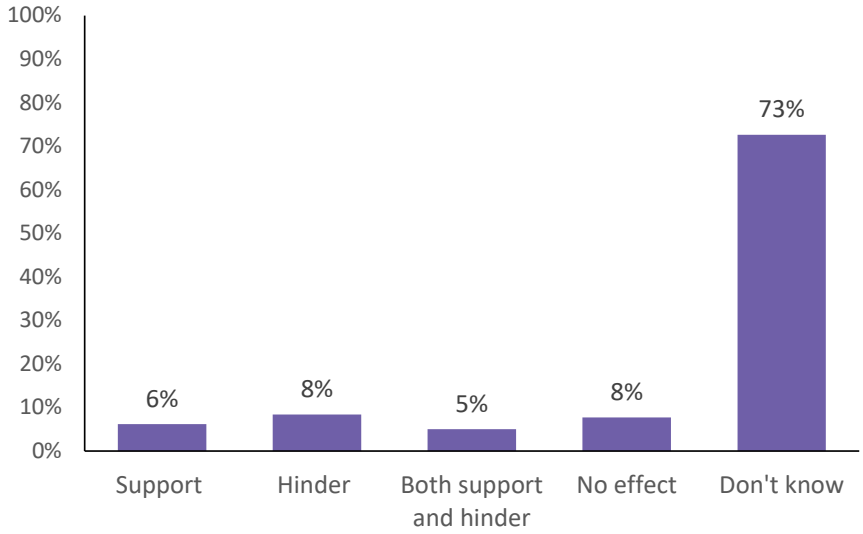
Participants' responses could contain more than one code, so percentages do not add up to 100 percent.

Source: Keen Independent Research.

Board Support/Hindrance of Diversity During Complaints and Investigations Process

Sixty-seven percent of respondents indicated that they did not know whether the boards supported or hindered diversity during the complaints and investigations process. Roughly even numbers of participants indicated that the boards hinder and have no influence over diversity during complaints and investigations.

D-13. How boards impact the diversity of mental health professionals during the complaints/investigation process



Note: N = 1,656.

Source: Keen Independent Research.

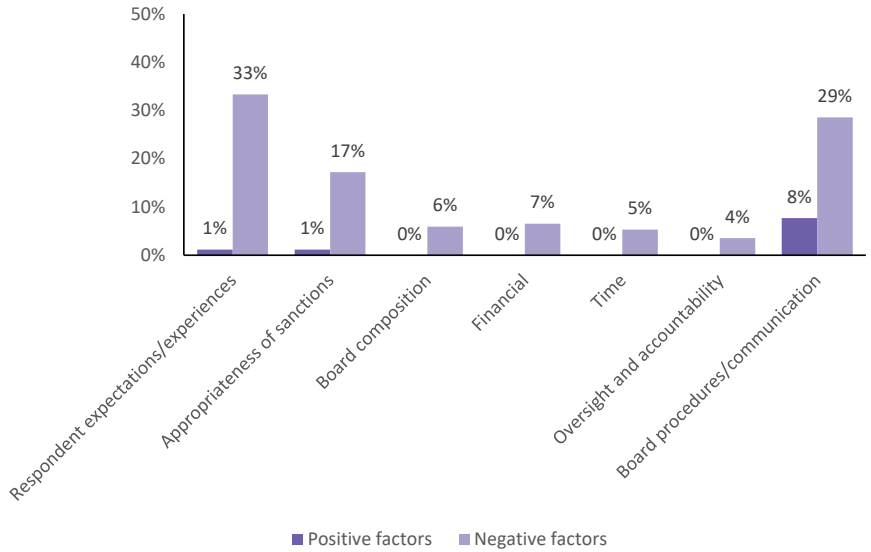
D. Virtual Workshop — Results

Keen Independent applied codes to the follow-up question asking for examples of how the board supports or hinders the diversity of mental health professionals during the complaints and investigations process.

- Respondent expectations/experiences (e.g., consideration of complaint respondents' perspectives);
- Appropriateness of sanction (e.g., extent to which the determined sanctions fit the accusation);
- Board composition (e.g., how experiences of the board due to their identities may influence outcomes);
- Financial (e.g., monetary cost of hiring a lawyer, missing work to address a complaint, fines, etc.);
- Time (e.g., how long the complaints process takes);
- Oversight and accountability (e.g., checks and balances on the complaints and investigations process); and
- Board procedures/communication (e.g., how accessible the boards are and how information is communicated to complaint respondents).

The most frequent hindrances identified among those who responded were the lack of consideration for the complaint respondent and their experience of the process (33%), and the board's procedures and/or communication during the investigation (29%). LGBTQ+ participants cited appropriateness of sanctions as a hinderance higher than any other subgroup. More detailed analyses of factors that influence diversity during complaints and investigations appear in Appendix G.

D-14. Examples of board supports/hindrances to mental health professionals involved in complaints/investigation process



Note: N = 168.
Participants' responses could contain more than one code, so percentages do not add up to 100 percent.

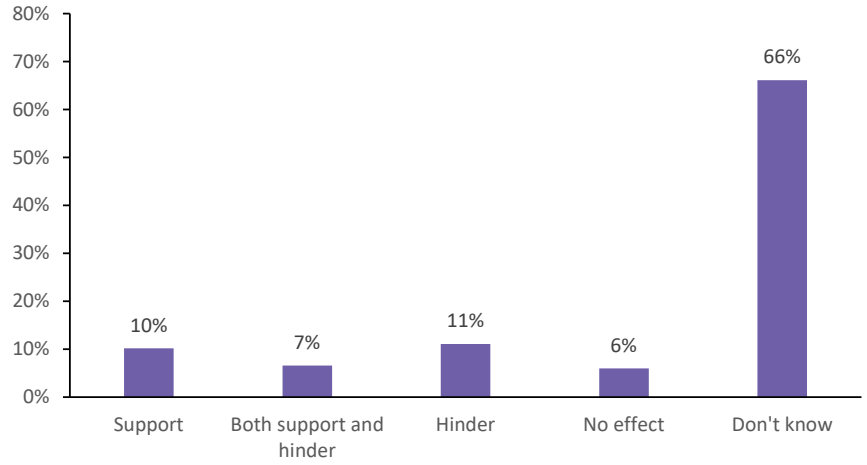
Source: Keen Independent Research.

Strategies for Increasing Diversity and Equity

Virtual workshop participants were asked to indicate how the diversity of their respective licensing board affects DEI in the mental health profession overall. Figure D-15 displays the distribution of these responses. As with other questions asking how much influence the board has over diversity related to various stages, the majority of respondents indicated that they did not know. Slightly more respondents felt board diversity hindered diversity compared to supported diversity.

Appendix I has more information on participants' impressions of how board diversity impacts diversity in the mental health profession.

D-15. How diversity of boards impact the diversity of mental health professionals overall



Note: N = 1,651

Source: Keen Independent Research.

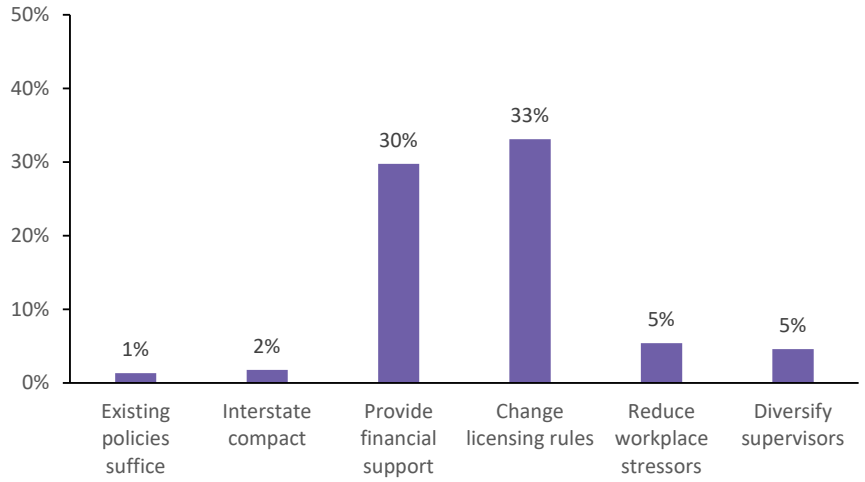
D. Virtual Workshop — Results

The final open-ended question that Keen Independent coded asked respondents to suggest strategies for increasing diversity and equity in the mental health profession. We applied the following codes:

- Existing policies suffice;
- Interstate compact;
- Provide financial support;
- Change licensing rules;
- Reduce workplace stressors; and
- Diversify supervisors.

About 33 percent of respondents indicated that a change to the licensing rules would increase diversity in the mental health profession. The second most recommended strategy among respondents was to provide prospective licensees with financial support, both throughout their degree program and during the licensing process. These top two responses were consistent throughout the subgroups we examined. More detailed analyses are available in Appendix J.

D-16. Strategies for increasing diversity and equity in the mental health profession



Note: N = 1,106.

Participants' responses could contain more than one code, so percentages do not add up to 100 percent.

Source: Keen Independent Research.

APPENDIX E. Factors Affecting Diversity

This appendix synthesizes feedback from mental health professionals about factors that might impact diversity and equity in Oregon's professional counselor, marriage and family therapy and psychologist professions.

Practitioners licensed and regulated by the Oregon Mental Health Regulatory Agency (MHRA), the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) provided input via interviews, focus groups and responses to a virtual workshop (similar to a survey, with more opportunity for open-ended comments).

Information in this appendix includes:

- Quantitative analysis of virtual workshop responses regarding factors that support or hinder diversity[1];
- Quantitative analysis of virtual workshop responses regarding the extent to which the agency and boards impact diversity and ways they might do so; and
- Qualitative analysis of factors that practitioners believe support or hinder diversity in the professions.

Sample comments from research participants throughout this appendix are drawn from the virtual workshop as well as from focus groups and interviews. In some cases, participants also emailed the study team with comments.

Comments are not attributed to individual participants and identifying information is excluded from this report consistent with efforts to protect participant confidentiality.

Throughout our qualitative analysis of participant perspectives, we include comments even if they do not explicitly name an impact on diversity or equity. Often challenges that are widespread may have an amplified impact for individuals from marginalized groups and those who are underrepresented in a profession. We also note that most comments are drawn from responses to questions about diversity and equity, so participants may have assumed the connection was implicit in their answers.

[1] A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Frequently Cited Factors

Virtual workshop participants were asked for an open-ended response to the question, "What factors have affected the diversity of the mental health profession now and over time?"

The study team analyzed and coded the responses with the following codes:

- Oregon demographics (the population makeup of Oregon);
- DEI climate in Oregon (receptiveness to issues concerning diversity, equity and inclusion);
- Degree program/pipeline (availability of graduates from relevant programs and factors related to degree programs);
- Financial (costs and compensation related issues);
- Licensing rules/process (process and requirements for attaining and maintaining a license);
- Employers/workplace (factors related to employers or workplaces);
- Specific groups (support of or bias about a named group of individuals, e.g., gay practitioners);
- Workplace supports/stressors (general employment supports or stressors); and
- Diversity of mentors/supervisors (availability of mentors or supervisors with non-dominant identities).

Each response was coded as either positive or negative. Thus, codes were applied to reflect factors that have supported diversity. Codes were separately applied to reflect factors that have hindered diversity. When responses included more than one factor, they received multiple codes. As a result, the total number of codes reported may exceed 1,793, the total number of participants who participated in the virtual workshop (note that not all respondents provided a response to be coded for every question).

Respondents cited factors that have hindered diversity at more than three times the rate of factors that have supported diversity.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Overall results. Figure E-1 shows frequently cited factors that support and hinder diversity.

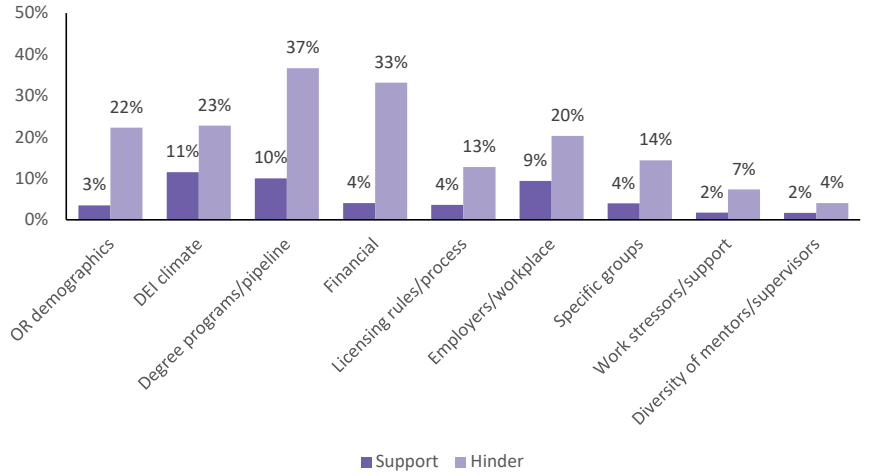
The most frequently cited supportive factors were the climate and attitudes toward diversity, equity and inclusion (DEI) in Oregon (11%) and degree programs and pipeline (10%).

Degree programs and pipeline was also the most frequently cited factors that hinders diversity (37%), followed closely by financial concerns (33%).

Results by profession. The study team examined differences in response by profession, which includes licensed marriage and family therapists (LMFTs), licensed professional counselors (LPCs) and psychologists (of which 222, 870 and 291, respectively, provided a comment for this question).

The three groups did not differ substantially from one another in terms of the ways they ranked the positive and negative factors influencing diversity in the mental health field except that LMFTs positively cited employers/workplace as highly as degree programs (both 12%) and psychologists cited Oregon demographics as a negative factor more often (26%).

E-1. All respondents — factors mentioned that support or hinder diversity in the mental health professions



Note: N = 1,487.
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Frequently Cited Factors by Demographic Groups

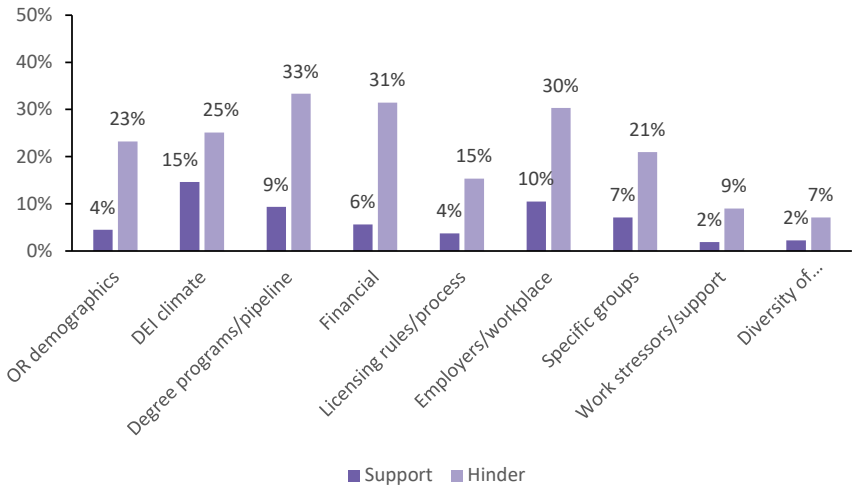
The study team examined differences in response by historically marginalized groups.

People of color. Due to the relatively small raw numbers of each racial and ethnic group among participants, we combined participants who identified as Asian American or Pacific Islander, Black or African American, Hispanic or Latino, American Indian or Alaska Native or multiracial into one group.

In general, people of color cited positive factors influencing diversity at lower rates than negative factors compared to respondents overall.

Like participants overall, people of color cited degree programs and pipeline issues as the most common hindrance to diversity (33%) and financial issues as a close second (31%). People of color were also more likely than respondents overall to cite workplace issues and issues related to specific marginalized groups as factors that hinder diversity. We note that the most frequently cited hindrance to diversity by Black or African American and Asian American or Pacific Islander participants were issues in the workplace, but this factor was not as frequently cited by Hispanic/Latino or American Indian/Alaska Native participants.

E-2. People of color — factors mentioned that support or hinder diversity in the mental health professions



Note: N = 267.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

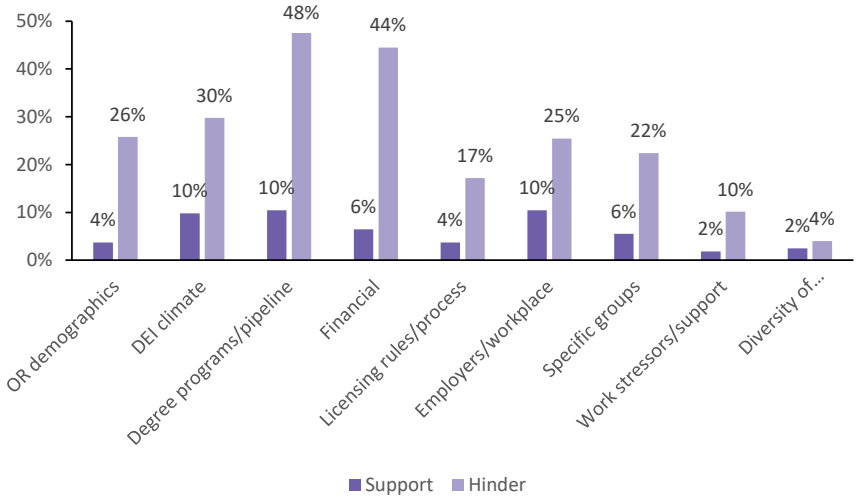
E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

LGBTQ+ professionals. Due to the relatively small number of individuals in some groups, the study team combined individuals who identified as gay, lesbian, bisexual, transgender and non-binary into one LGBTQ+ group.

Similar to people of color, LGBTQ+ participants cited negative factors influencing diversity more than positive factors when compared to respondents overall.

LGBTQ+ professionals were more likely than the overall respondents to report degree programs and pipeline issues (48% compared to 37% overall) and financial issues (44% compared to 33% overall) as barriers to diversity in the profession.

E-3. LGBTQ+ participants — factors mentioned that support or hinder diversity in the mental health professions



Note: N = 326.

Participants' responses could contain more than one code, so percentages do not add up to 100.

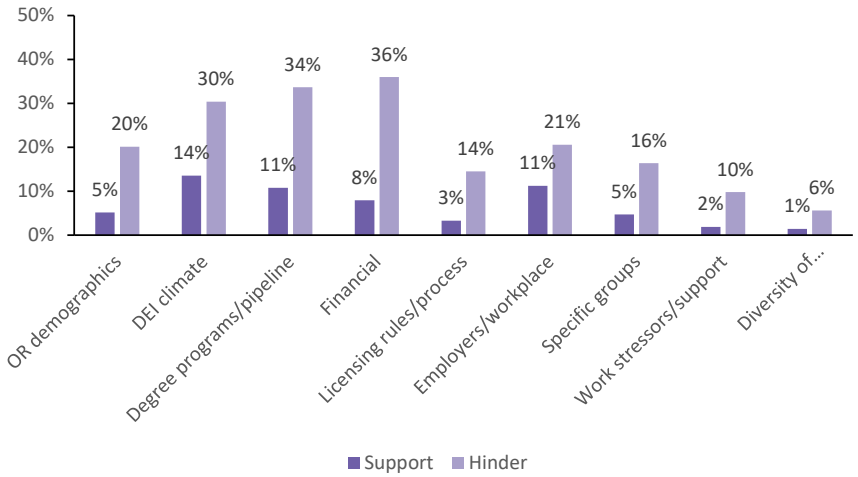
Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Professionals with disabilities. Figure E-4 displays factors virtual workshop participants with disabilities cited as supporting or hindering diversity in mental health. Participants with disabilities cited the DEI climate in Oregon as a hindrance to diversity at a higher rate (30%) than any other demographic group we examined. Similar to responses from people of color, a large proportion of participants with disabilities cited financial concerns as a negative factor affecting diversity. (Among all respondents, the most cited negative factor was degree program and pipeline issues.)

Additional analysis by demographic groups. The study team found responses from persons who spoke languages other than English at home and veterans to be like overall responses. We also examined responses to this question by age and note that the two most cited factors overall (degree programs/pipeline and financial issues) became less cited with older participant groups.

E-4. Participants with disabilities — factors mentioned that support or hinder diversity in the mental health professions



Note: N = 214.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

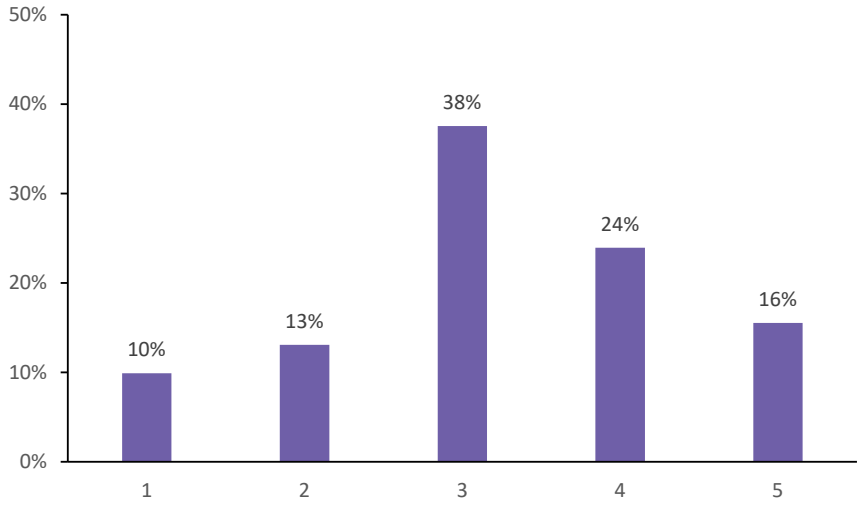
E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

OMHRA, OBOP and OBLPCT Impact on Diversity

As noted in analysis of the previous question, respondents cited many factors that support and hinder diversity in the professions more frequently than MHRA, OBOP and OBLPCT related topics.

When asked to rate how much the boards (i.e., MHRA, OBOP and OBLPCT) can influence diversity in the mental health profession on a scale of one to five (one indicated "very little" and five indicated "very much"), respondents had an average rating of 3.48. More respondents reported that the boards do have an influence (40% rated this question a 4 or 5) than reported that boards do not have an influence (23% rated this question a 1 or 2).

E-5. All respondents — ratings of how much influence MHRA, OBOP and OBLPCT have on diversity in the mental health professions



Note: N = 1,688.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Factors Attributed to MHRA, OBOP and OBLPCT

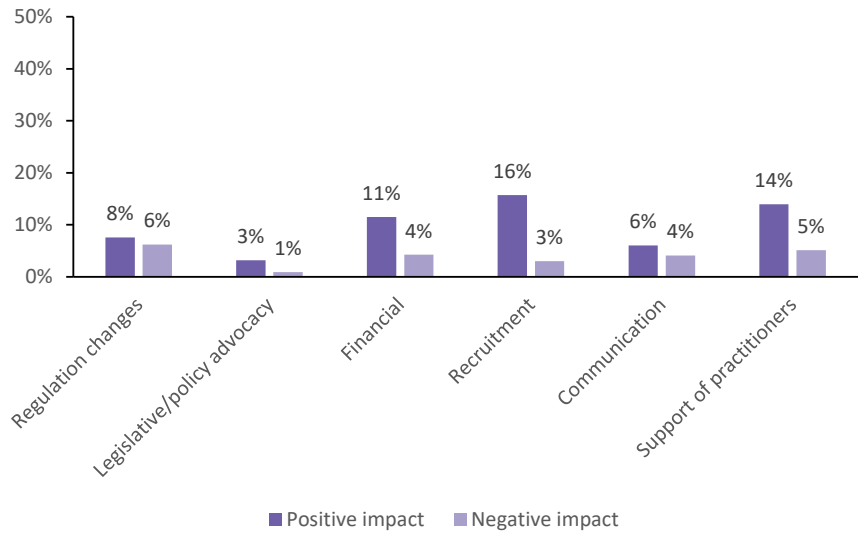
Participants were asked to comment on how they thought boards can impact diversity of the mental health professions in Oregon. The study team applied the following codes to the open-ended comments:

- Regulation changes (directly changing rules around licensing);
- Legislative/policy advocacy (advocating for changes that could affect mental health practitioners);
- Financial (costs and compensation related issues);
- Recruitment (active encouragement of university students and professionals from other states to pursue Oregon licensure);
- Communication (information from agency/boards to practitioners); and
- Support of practitioners (providing guidance throughout the licensure process).

Responses were coded as positive, indicating something that the boards currently do or could do to support diversity, or negative, indicating something that the boards do not do to support diversity. Figure E-6 shows the types of factors attributed to the agency and boards.

Recruitment (16%) and support of practitioners (14%) were the most highly cited positive factors that affect diversity under the control of the boards and agency. Negative impacts the boards could (or do) have on diversity were cited far less than positive impacts. The most highly cited negative impact was regulation changes (6%).

E-6. All respondents — mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health professions



Note: N = 567.

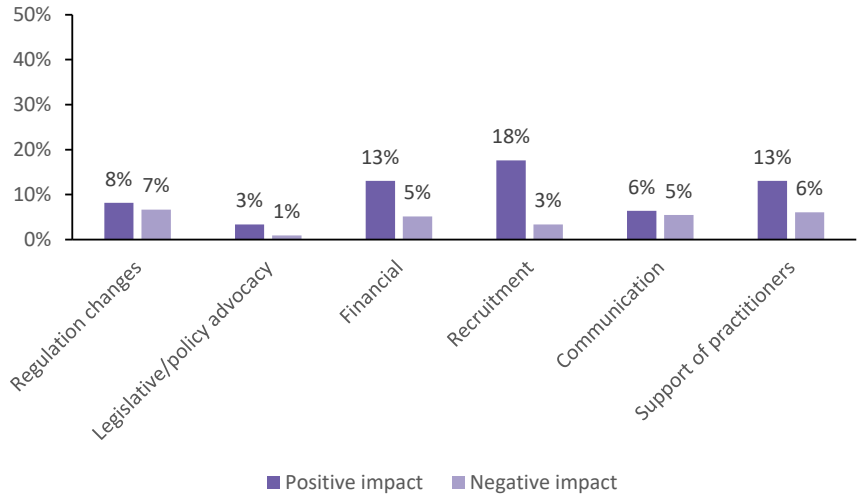
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). LPCs were less likely than all respondents to cite support of practitioners as a factor the boards can influence that has a negative impact on diversity (6% compared to 16% overall).

E-7. LPCs — mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health professions



Note: N = 330.

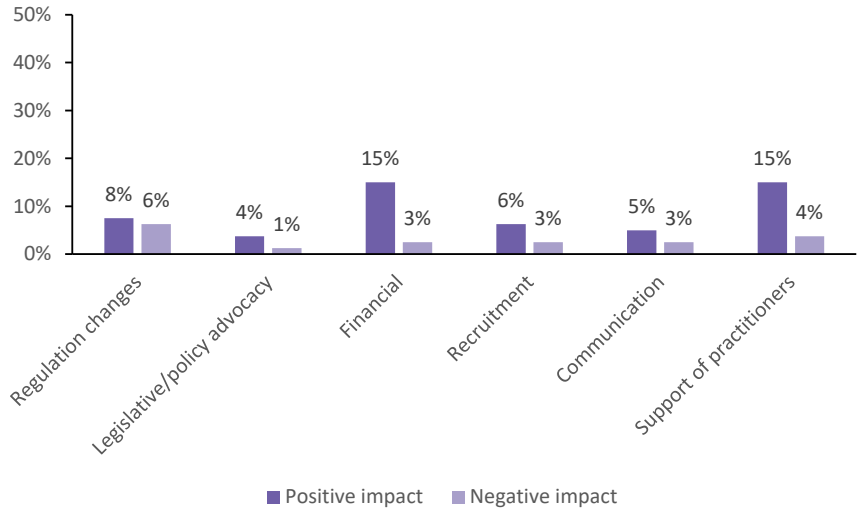
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Marriage and Family Therapists (LMFTs). Similar to LPCs, LMFTs were less likely to cite support of practitioners as a negative influence the boards can have on diversity. The top two ways in which LMFTs indicated boards could positively influence diversity in the mental health profession in Oregon were financially and through support of practitioners (both 15%). LMFTs were least likely of the three professions to cite recruitment as a positive way in which the boards impact diversity.

E-8. LMFTs — mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health professions



Note: N = 80.

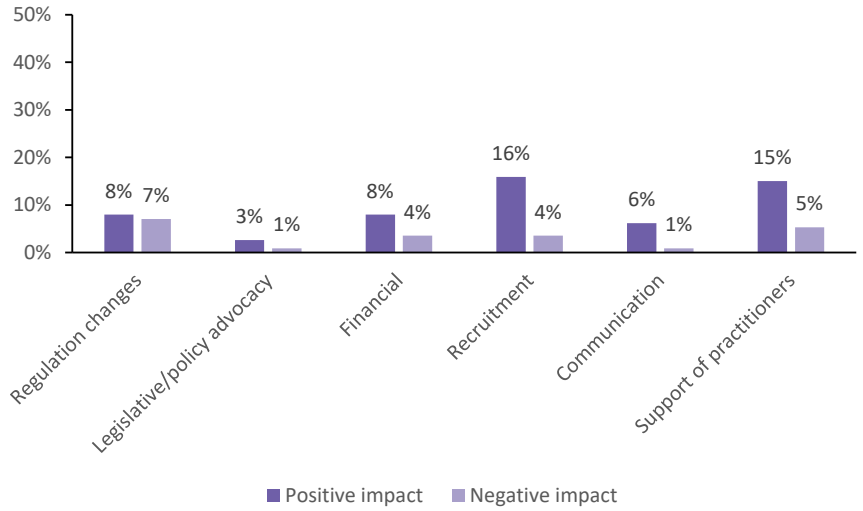
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Psychologists. Psychologists cited recruitment (16%) and support of practitioners (15%) as the top ways the boards could positively influence diversity in the mental health profession in Oregon.

E-9. Psychologists — mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health professions



Note: N = 113.

Participants' responses could contain more than one code, so percentages do not add up to 100.

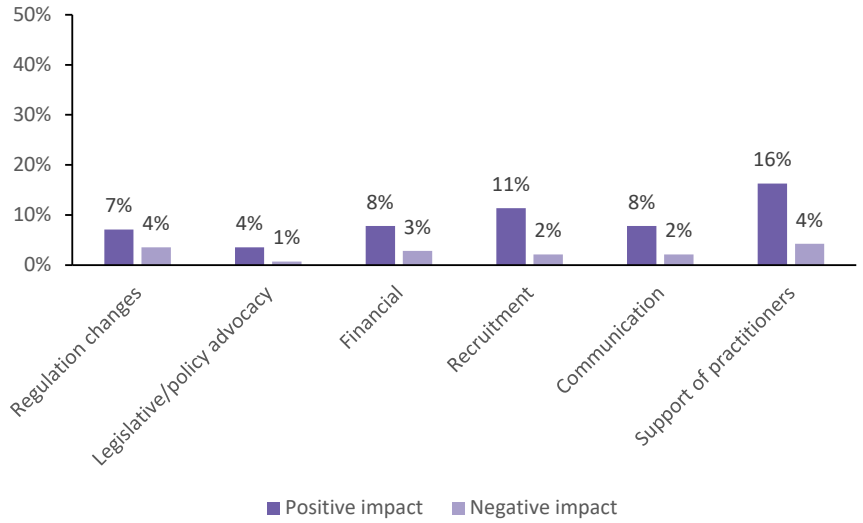
Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

People of color. Keen Independent combined participants who identified as Asian American or Pacific Islander, Black or African American, Hispanic or Latino, American Indian or Alaska Native and multiracial into one group of people of color.

Of all subgroups, people of color cited support of practitioners most as a factor under board control that could positively affect diversity (16%).

E-10. People of color — mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health professions



Note: N = 115.

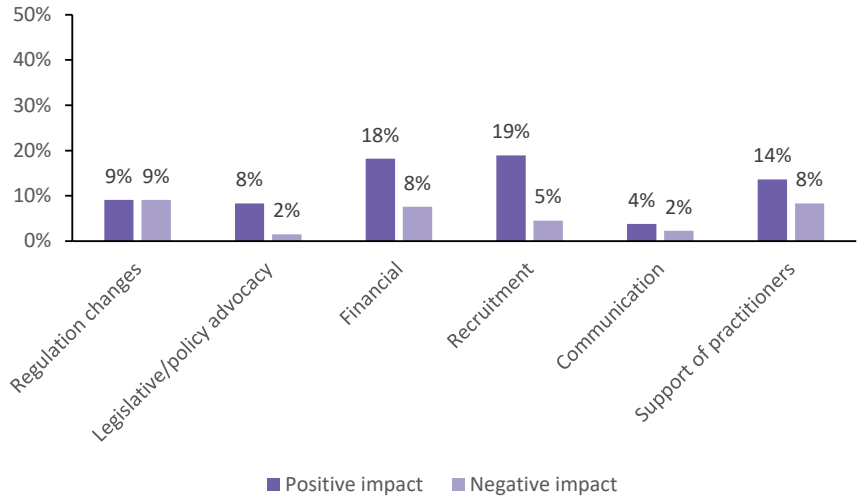
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

LGBTQ+ participants. LGBTQ+ participants cited financial support and recruitment more frequently than any other subgroups in terms of positive factors under board control that would impact diversity.

E-11. LGBTQ+ participants — mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health field



Note: N = 132.

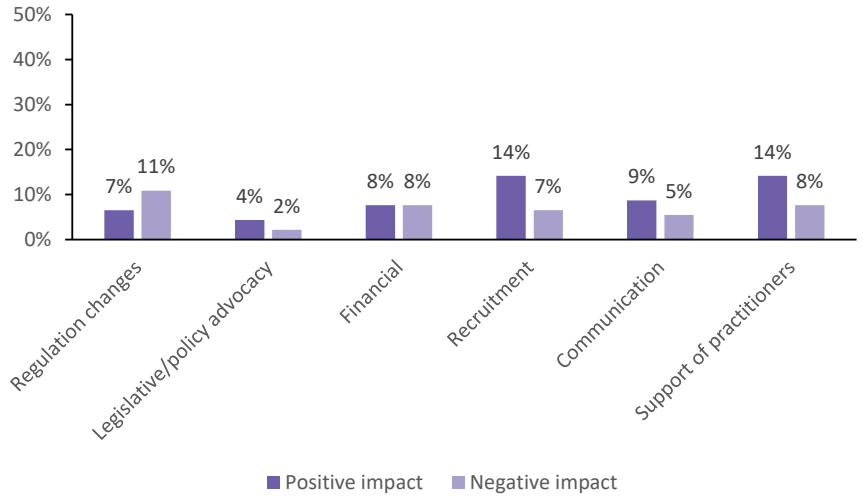
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Quantitative analysis of virtual workshop responses

Professionals with disabilities. About 11 percent of participants with disabilities identified regulation changes as a negative impact the boards could have on diversity (compared to 1% for all respondents).

E-12. Participants with disabilities — mentions of MHRA, OBOP and OBLPCT influences on diversity in the mental health field



Note: N = 92.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

E. Factors Affecting Diversity — Participant perspectives

Other appendices discuss participant perspectives on licensing, complaints and investigations, equitable protection of mental health consumers and clinicians and board composition. The remainder of this appendix will provide qualitative analysis and examples of frequently cited factors affecting diversity of the professions apart from MHRA, OBOP and OBLPCT specifically.

This analysis draws on comments submitted through the virtual workshop as well as interviews and focus groups with mental health professionals.

Examples of comments are provided for each topic.

Findings are organized by theme as follows:

- Oregon demographics and reputation;
- Oregon's climate for diversity, equity and inclusion (DEI);
- Mental health classifications of sexual orientation and gender identity variations as disorders;
- Career interest and attractiveness;
- Degree programs and educational/career pipeline;
- Financial challenges;
- Role models, mentors and supervisors;
- Employers and colleagues; and
- Professional stressors and burnout.

E. Factors Affecting Diversity — Participant perspectives

Oregon Demographics and Reputation

Many study participants mentioned Oregon's racially exclusionary past as a factor shaping current demographics and reputation of the state. As described in Appendix B, when Oregon was admitted to the United States, its constitution made it illegal for African Americans to reside in the state.[2] Other policies forced Native Americans out of their ancestral lands and regulated other racial and religious minority populations.[3]

Participants linked Oregon's history to current demographics in the state and described Oregon's demographics as a major constraint on the diversity of the mental health professions in Oregon today. Participants also cited current presence of racism and white supremacy in the state and limited support for practitioners of color as factors that adversely affect the diversity of the mental health workforce.

… Oregon has a reputation for being very homogeneously white and unwelcome to diverse people. This can be a deterrent for diverse folks to decide to move to or stay in Oregon.

Female psychologist resident of color

The lack of diversity of the profession is, in general, not a top-down problem but rather an outcome of state history and current/ongoing trends in education. Why would someone want to stay in Oregon if they could attend school in another state and then build a life in a community where there is already more diversity?

White, female licensed marriage and family therapist

State demographics are 90% white. No matter how much they advocate for diversity, you can't overcome demographics.

White, male licensed professional counselor

Some of the main barriers … are due to the history of the state in terms of discrimination and racism, the ongoing impacts of white supremacy within education systems and lawmaking, as well as Oregon being a predominantly white state.

White, LGBTQ+, female licensed professional counselor

Outside of Portland and Eugene, most of the state is Caucasian. In exploring grant opportunities for hiring more diverse staff, the struggle has been to even get applicants ….

White, male licensed professional counselor

A therapist who was on our [elected body] — [the] first person of color on [that group] — all the racism drove her out of there.

Multiracial, female licensed professional counselor

A woman who attended the same graduate program as I did moved to Portland around 2010. She is African American and did not stay in the city much more than a year due to experiencing overt racism in the city and in her workplaces.

White, female licensed professional counselor

[2] Fagan, S. (n.d.*). National and Oregon chronology of events*. Oregon Secretary of State. https://sos.oregon.gov/archives/exhibits/black-history/Pages/context/chronology.aspx

[3] Patterson, R. (2020). Disrupt, defy, and demand: Movements toward multiculturalism at the University of Oregon, 1968-2015*, Berkeley Review of Education 9*, (2). https://doi.org/10.5070/B89242323

E. Factors Affecting Diversity — Participant perspectives

Discrimination abounds throughout Oregon, especially among power brokers such as directors, CEOs, law enforcement, school board members, etc. This renders POCs [and] disabled providers especially vulnerable to false reports, harassment, improper investigations, job and licensure loss and extraordinarily high stress.

Biracial, female licensed professional counselor

Part of it is that Oregon is not that diverse racially. There is still a strong presence of white supremacy in the rural parts of Oregon, which makes it a less attractive place for diverse peoples.

White, female licensed psychologist

Due to the overall significant lack of diversity in Oregon, it can be challenging for BIPOC (Black, Indigenous and people of color) to explore the mental, emotional, physical, and social health of clients when the general environment rarely seeks to understand how bio-socio-cultural factors affect the wellness of BIPOC mental health professionals.

Multiracial licensed professional counselor applicant

E. Factors Affecting Diversity — Participant perspectives

Oregon's Climate for DEI

As previously discussed, participants cited Oregon's history, population demographics and incidents of racism as barriers to diversity. Oregon's climate for diversity, equity and inclusion (DEI) was also often cited as a hinderance. However, many participants spoke of Oregon's awareness of and receptivity to efforts to support diversity, equity and inclusion as positive factors.

Positive aspects of Oregon's climate for DEI. Some noted the change in Oregon over time and receptivity to DEI issues. Many who mentioned Oregon's climate for DEI point out the acceptance of LGBTQ + individuals as a positive factor.

Compared to [the] history [of Oregon], there is [now] more awareness and openness to enact change to systems and resources for the ideal of equal opportunity and access.

Biracial, male licensed psychologist

I was drawn to come to Oregon after finishing graduate school due to the political environment, which makes me feel safer as a queer person of color. I know that many of my diverse peers came here for similar reasons.

Biracial, LGBTQ+ licensed professional counselor

We are good here in terms of LGBTQ diversity.

White, LGBTQ+, female licensed psychologist

On the positive side, Oregon is known as a state that is welcoming to gender and sexual minorities which can attract more LGBTQ+ mental health professionals.

Female psychologist resident of color

E. Factors Affecting Diversity — Participant perspectives

Oregon's climate for DEI as a hinderance. Those who mentioned Oregon's climate for DEI as a hinderance to diversity described the DEI climate as superficial, divisive or ineffective in bringing about change.

Something I noticed very specifically about Portland … is that there's a lot of desire to be more diverse …. But when it actually comes down to it … people just kind of disappear. It's like a poof of smoke.

African American licensed psychologist

There is a lot of focus on diversity … but what actually welcomes families to stay and feel comfortable in the area is being missed. This includes attracting and retaining diverse clinicians, who do not end up feeling a sense of belonging or inclusion because racial and ethnic issues are brought up in a divisive fashion that makes the environment uncomfortable.

Biracial, female licensed marriage and family therapist

Jews are not generally invited under the tent of diversity, equity, and inclusion …. But we get labeled with all sorts of conspiracy [theories saying] we're more powerful than our numbers show …. We don't exist in the DEI world. We get lumped into mainstream white culture, which is incredibly offensive to me because I've been discriminated against, harassed and bullied all my life for being a Jew.

Jewish, male licensed professional counselor

We pride ourselves as being very liberal or radical, [but] I don't think we have—as a general population—the racial awareness that maybe we think we have. We have more difficulty retaining people of color, either as faculty or clinicians, because of that blind spot [and] that lack of real, clear, concerted effort to transform the center of how we work and what we do.

White, female licensed marriage and family therapist

Mental Health Classifications of Sexual Orientation and Gender Identity Variations as Disorders

Some participants described a welcoming environment in Oregon for LGBTQ+ community members as noted in prior discussion of Oregon's climate for DEI.

Others described challenges for LGBTQ+ clinicians connected to the mental health field's long-standing diagnostic categories related to sexual orientation and gender identity.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association pathologized LGBTQ+ individuals as "sexual deviants" until the early 1970s.[4] Updated diagnoses used over the subsequent decades such as "sexual disorder" and "sexual orientation distress" continued to define sexual orientations other than heterosexuality as mental disorders.[5] Critics of these diagnoses argued that sexual orientation should not be treated as a mental disorder and that interventions with LGBTQ+ clients should focus instead on supporting mental health impacts resulting from external factors such as lack of acceptance in families and communities, discrimination and violence.

Diagnostic classifications that defined sexual orientations other than heterosexuality as treatable mental health conditions persisted until the publication of DSM-5, just nine years ago.[6]

DSM-5 includes a diagnostic category of "gender dysphoria" which has drawn criticism from some LGBTQ+ rights organizations for continuing to place gender variation in a disease framework rather than an identity framework.[7] Notably, clinicians who identified as transgender reported professional challenges related to their gender identity.

For a long time, the LGBT community was not included [in the profession]. It was actually a diagnosis and seen as something that could be cured. So … a long-standing history of oppression keeps those … disenfranchised communities unable to jump through the barriers and hoops to be a licensed practitioner.

African American, female licensed professional counselor

The DSM hasn't kept pace [on sexual orientation or gender] ….

Licensed professional counselor applicant of color

Transphobic clinical peers in the community [are] making it unsafe to network [or] collaborate ….

LGBTQ+, non-binary licensed professional counselor

When I advertised my trans support group to other therapists [who said they see LGBTQ+ clients], I had two returned with remarks stating that I should 'go to hell' ….

LGBTQ+ mental health professional

[4] Cabaj, R. (n.d). *Working with LGBTQ patients*. American Psychiatric Association. https://psychiatry.org/psychiatrists/diversity/education/best-practice-highlights/working-with-lgbtq-patients

[5] Ibid.

[6] Ibid.

[7] Whalen, K. (n.d). *(In)Validating transgender identities: Progress and trouble in the DSM-5*. National LGBTQ Task Force. https://www.thetaskforce.org/invalidating-transgender-identities-progress-and-trouble-in-the-dsm-5/

E. Factors Affecting Diversity — Participant perspectives

Career Interest and Attractiveness

Participants discussed the need to interest more people in mental health careers early. They also named specific challenges to making counseling, therapy and psychology attractive career choices for people from diverse backgrounds.

Participants gave examples of the following barriers to diversity:

- Cultural stigma;
- Negative experiences with mental health professionals;
- Lack of awareness of mental health careers in particular demographic groups; and
- A career path that frequently leads toward private practice serving predominantly white and well-off clients.

In the Asian community, there's still a significant amount of stigma around mental health …. My own experience of becoming a professional involved having to explain to family and others what it is that I do.

Asian American/Pacific Islander, non-binary mental health professional

It took a lot for clients [from certain demographic groups] to even recognize that it was okay to say, 'I was depressed' or 'I have problems from my trauma.' If I'm living in a community that doesn't necessarily understand, value or even recognize the benefit of [counseling], then I'm not gonna want to go into this field.

White, female licensed professional counselor

Some [people of color] have been less exposed or negatively exposed to [mental health] professions …. maybe because they received culturally incompetent care from well-meaning white therapists.

Asian American/Pacific Islander, male licensed professional counselor

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More [information] needs to be dispersed to diverse communities about getting into the counseling field.

White, female licensed professional counselor

When I was in college, I had very few professors or teachers who could properly explain to me what the actual career paths were for becoming a therapist.

Asian American/Pacific Islander, non-binary mental health professional

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Why would — just as an example — a person of color become a therapist only to find that the only sustainable career involves a client base consisting of mostly upper-middle class white people?

White, female professional counselor associate

E. Factors Affecting Diversity — Participant perspectives

Degree Programs and Educational/Career Pipeline

Participants spoke frequently about degree programs and the population of graduating students as factors important to the diversity of the profession.

Degree programs/pipeline were the most frequently cited hinderance to diversity. Degree programs were also one of the most frequently cited factors that support diversity of the professions.

Education related factors cited as supporting diversity included:

- Availability of degree programs;
- Diverse faculty; and
- Degree program content and inclusion efforts.

The following pages will present additional analysis about education programs and the pipeline of graduates as potential hinderances to diversity organized by the following themes:

- Degree program and training availability;
- Pipeline of graduating students; and
- Program content and faculty.

[There are] more opportunities for schooling and education [in the mental health field than in the past].

White, female licensed professional counselor

Diverse mentors [and] diverse tenured professors … positively affect retention [of trainees].

African American, female licensed professional counselor

It is helpful when graduate programs provide culturally diverse theories and training.

White, female licensed psychologist

I graduated from a counseling program last year and it was an intentionally safe place for all kinds of diversity.

White, LGBTQ+ professional counselor associate

Having finished my last year of grad school last year, there was a heavy focus in each class on multicultural inclusion and diversity.

White, male professional counselor associate

E. Factors Affecting Diversity — Participant perspectives

Degree program and training availability. Participants spoke of the limited number and nature of graduate programs for counseling, therapy and psychology in Oregon as barriers.

Some also noted challenges related to internship availability.

There are far too few graduate programs within the state that train psychologists to be practitioners. The two main doctoral psychology programs that are heavily practice-focused are both private universities. One is notoriously expensive, most accessible to those with economic privilege [which is] correlated with many other forms of majority privilege. The other requires signing a statement of commitment to abide by Christian doctrine [which is] not exactly conducive to religious, sexual, or gender diversity.

White, female psychologist

Many of the programs for counseling are at Christian universities …. There were a few people that went into the university [I went to] and were kind of hesitant, and then ended up dropping out because they felt like the campus was too religious. They just didn't feel comfortable there.

LGBTQ+, male professional counselor associate of color

[The] locations of universities offering master's degree programs in the mental health field [hinders diversity].

Biracial, female licensed marriage and family therapist

As someone who works primarily in an educational setting, we lack sufficient placements/supervisors within the community to provide training and supervision in languages other than English.

White, female licensed psychologist

… coming into the field, one of the things I ran into … was finding people willing to take me on as a student. There are so many agreements between schools and sites …. I contacted maybe a hundred different places, and the common [response was], 'We're booked out for interns for two years' …. If you're not privileged enough to be in one of those universities, you're not going to get an internship.

White, female licensed professional counselor

There [aren't] a lot of options in terms of training …. I did my doctoral internship … in Eugene. I moved here from [out-of-state] and then ended up having to leave after a year because there weren't any post-doc options and I had to complete a post-doc to be licensed.

Mental health professional

E. Factors Affecting Diversity — Participant perspectives

Pipeline of graduating students. Many participants noted that limitations to diversity in the mental health professions begin "upstream to licensing and regulation" with the population of students in degree programs. Many participants pointed to the cost of education and the lack of scholarships (also addressed in the financial challenges section of this analysis). Some described inadequate efforts to retain and support students from underrepresented backgrounds through graduation.

There [aren't] enough scholarships on the undergraduate level for this field to even get people interested in psychology or family therapy. [Students] don't know what a wonderful career it is. They don't know how much we can help our community. There's no one going in to tell you, 'Hey, come be a counselor!'

Hispanic American, female licensed marriage and family therapist

This is a pipeline problem. Schools do not do enough to actively recruit and maintain students of color in mental health fields. This needs to start prior to college.

White, LGBTQ+, female psychologist

There were about two or three people of color in my grad school program cohort of 57. None of the people of color completed the program.

White, LGBTQ+, female licensed psychologist

Our graduate programs are not necessarily recruiting LGBT people or people of color. Since you can't get into licensure unless you have a graduate degree, I think that's a place to start looking.

White, LGBTQ+, non-binary licensed professional counselor

[There is a] lack of effective recruitment of people in diverse groups [and a] lack of support and resources for underprivileged people who are interested in joining the profession.

Asian American/Pacific Islander, female licensed professional counselor

Many of the factors presenting challenges to persons pursuing higher education are systemic and beyond the control of boards.

Female professional counselor licensure applicant of color

E. Factors Affecting Diversity — Participant perspectives

Degree program content and faculty. Some participants mentioned that the content of their degree programs did not prepare them well to work with clients facing issues related to their race, ethnicity, gender identity or sexual orientation. Comments cited degree programs and faculty as key to developing a culturally competent mental health workforce.

Participants also described the impact of largely homogenous faculty as counterproductive to attracting students from racially minoritized backgrounds or the LGBTQ+ community and fostering belonging and inclusion.

[Diversity] was talked about as a concept [but not], 'What do you do if somebody … comes to see you that struggles with gender identity?'

White, female professional counselor applicant

My training came from a really Eurocentric lens. I didn't feel prepared to work with anyone else who wasn't white.

Biracial, LGBTQ+, female licensed psychologist

Not having diverse faculty members in mental health programs is a grave misstep in the training of … a culturally competent clinician.

Asian American/Pacific Islander, female associate counselor

The lack of representation of faculty of color in our graduate institutions is extremely problematic, as are opportunities for recruitment and retention of BIPOC students.

American Indian, female licensed psychologist

In my experience, the available faculty at the time that I applied didn't necessarily look like a lot of queer people that I know.

White, LGBTQ+, female licensed professional counselor

Where I went to school, all of my professors were of a certain socioeconomic, ethnicity and racial background …. there's more … attention given to those students [with similar backgrounds] and less given to the students that are not of the same background.

Biracial, female professional counselor associate

In my counseling degree program, there was not [a lot] of openness to people who had different cultural experiences or backgrounds. It seemed geared towards people that grew up with privilege.

Hispanic American, female licensed professional counselor

E. Factors Affecting Diversity — Participant perspectives

Financial Challenges

Participants frequently described financial challenges that may limit the diversity of the counseling, therapy and psychology professions. As a result, participants frequently described counseling and therapy as difficult professions to enter for people without socioeconomic advantages. They noted that this has an impact on diversity both in terms of socioeconomic status but also on other aspects of diversity because socioeconomic differences tend to advantage white, heterosexual practitioners without disabilities.

Many research participants cited the time from graduate school until full licensure as a time of financial strain. They often pointed out the cost to attain advanced degrees as just the beginning. Many spoke of additional barriers such as unpaid internships, clinical supervision costs and licensing fees.

Participants explained that compensation in the registered associate stage can be low or may be contingent on a fee-for-service model. They reported that insurers (with the recent exception of Oregon Health Plan) will not cover services provided by registered associates, which means that clients must be willing to pay out-of-pocket to see less experienced clinicians.

Participants often highlighted that the costs accrued early in clinical careers drive most practitioners toward private practice or other more lucrative jobs outside of clinical practice.

The following pages will present additional analysis and descriptions of financial challenges grouped as follows:

- Financial viability of degree;
- Internships;
- Clinical supervision costs;
- Compensation;
- Insurance reimbursement; and
- Pressure toward private practice or away from clinical work.

Practitioners, particularly those currently working toward licensure or only recently licensed, often described the combination of student loans, unpaid internships, supervision costs and compensation as netting out to make even comparatively modest expenses such as licensing application fees substantial challenges. Licensing fees will be addressed as part of Appendix F.

E. Factors Affecting Diversity — Participant perspectives

Financial viability of degree and internship requirements. The professions licensed by OBOP and OBLPCT require master's and doctoral degrees. Participants frequently cited the cost of education as a barrier to diversity.

I come from a very low-income family. I had to pay for everything out of pocket.

White, female licensed professional counselor

I have over $100,000 in student loan debt ….

Biracial, LGBTQ+, mental health professional

The cost of graduate school is really problematic for most people. If you don't have the ability to secure loans or have … a cosigner on loans, that would be really challenging for students from marginalized backgrounds or who may not have financial support ….

Biracial, female licensed psychologist

The cost to become a mental health professional and to maintain your licensure has risen in the last 20-30 years. People who identify as minorities are often of lower socioeconomic status or experience financial hardship in this country. They may be barred from the profession given the [large] amount of money required to obtain a formal degree, licensure and continuing education.

White, LGBTQ+, female licensed marriage and family therapist

Graduate education for a social service field requires a lot of upfront financial assistance with limited return on investment. Historically marginalized groups may find that they do not have the social and financial support to undertake the endeavor or may wish to move directly to higher paying fields

White, LGBTQ+, female licensed marriage and family therapist

… lack of financial access, lack of generational wealth and the cost of entering the profession are massive hurdles. I saw incredibly talented, brilliant clinicians of color … drop out or prolong their program because they couldn't afford textbooks [or] childcare.

White, LGBTQ+, non-binary professional counselor associate

E. Factors Affecting Diversity — Participant perspectives

Internships. Many participants added that internships required as part of credentialing for mental health professionals compound the financial challenges. Unpaid internships combined with the hours required to graduate may mean the profession is not viable for those who need paid work to be able to afford living and education expenses.

The bad, exploitative habit of community mental health agencies not paying practicum and intern students for their services via a stipend or as … employees [hinders diversity]. NO other health care profession gets away with this and agencies are highly dependent on interns providing free services.

Mental health clinician, employer and educator

We just spent two years doing [a] graduate program …. Right at the tail end, we're asked to do six months of unpaid internship. We're working up to 32 hours a week for free while also going to school and having to pay bills.

White, female professional counselor associate

Perhaps most importantly training programs in mental health require an incredible amount of what is essentially donated time, until trainees and interns are compensated fairly (or at all) there is no way to narrow these gaps. People who come from families with wealth will always be more able to pursue this work.

White, LGBTQ+, female psychologist

E. Factors Affecting Diversity — Participant perspectives

Clinical supervision costs (LPCs and LMFTs). Participants frequently mentioned the number of hours of clinical supervision required for licensure as a financial challenge. This topic is addressed as part of Appendix F. Many participants also said that supervision is up to registered associates to procure and pay for. This expense occurs while they are not yet billable to payers other than Oregon Health Authority, which makes the net earnings on time worked difficult to sustain.

Oregon has a new requirement that requires employers to pay for supervision. [8] Participants reported that some employers may provide clinical supervision as a benefit, but many do not. Participants may have reported clinical supervision cost as a barrier because they were not aware of the new law or because employers are not covered by it or complying with it.[9] The law applies to employers who have supervisors on staff. Some participants reported that employers may offer supervision as a benefit only if they have a licensed supervisor available.

Some participants described reasons clinicians of color or those who are LGBTQ+ or disabled may wish to secure supervision outside their employer. For example, they may want to receive clinical supervision from someone who can help them navigate specific challenges related to race/ethnicity, sexual orientation or disability status. Obtaining supervision relevant to a clinician's personal identity or their client focus may not be possible within their employer. The law is silent about whether the obligation for employers to pay supervision cost applies if the supervisor is not on the employer's staff.

You have to pay to meet with a supervisor. All that [supervised] time [required by the board] comes out of your pocket unless you have an employer that pays for that.

Asian American/Pacific Islander, female licensed professional counselor

For those of us seeking licensure, non-white therapists have to pay out of pocket to receive supervision that is even somewhat racially relatable to our own professional experiences.

Female professional counselor associate of color

[8] Oregon ORS. § 675.661 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors675.html

[9] The extent of employer awareness and compliance is unknown. The law is silent on enforcement authority and consequences for employers who fail to comply. Some employers may also have concluded based on wording or ambiguity in the law, that it does not apply to them.

E. Factors Affecting Diversity — Participant perspectives

Compensation. Participants described low pay relative to their education levels as a factor that may make entering or staying in the mental health professions or in clinical service roles difficult.

To earn a reliable salary, registered associates may work in community mental health settings, where salaries are low. In private practices, compensation is typically fee-for-service. Private insurers will not reimburse for services provided by registered associates (a topic addressed separately in this appendix). As a result, registered associates often bill clients at low hourly or sliding scale rates to secure direct client service hours required for licensure.

In some cases, participants stated that it is not possible to earn enough from counseling or therapy alone during the registered associate stage. Some participants described inequitable compensation relative to other related professionals with the same levels of education.

I've been doing this 30 years and I make just under $40 an hour. That is ridiculous. I could go somewhere else and make more money [not being] a practicing clinician.

Multiracial, female licensed professional counselor

Starting jobs in mental health don't pay very well. It's really hard to want to go into a field that isn't necessarily very lucrative, especially when you need to get a master's degree [and] get licensed.

White, female licensed professional counselor

To pay off school loans, someone [in this industry] may need to work extra hours or have a second job.

White, female licensed professional counselor

… when you're a physician and become a resident, you get a minimum salary and can bill for your time. [You work] alongside a physician, and your services are reimbursable to employers. If you're a counselor, you have no defined path … to obtain the thousands of … hours of experience needed … for a license …. The easiest path [is working] in a day treatment or hospital treatment program, where they bill in bundles [so they can] afford to hire and pay you. [A private practice has] no set program to ensure consistent hours and [pay you] a reasonable wage. A pre-licensed therapist will mostly see patients who are self-paying … a reduced fee. It is difficult to keep a consistent caseload and those services are yielding very low income …. There's a high level of vulnerability and naivete for new counselors — most do not understand how hard it will be to obtain the required supervised clinical hours ….

National mental health professional association board member, out-of-state private practice owner

They [mental health providers] are living at the same poverty level as the clients they are seeing.

African American, female licensed professional counselor

We're not paid as well as physicians, even though we have the same level of education.

Asian American/Pacific Islander, female psychologist

From a non-dominant white culture [perspective] and as a BIPOC woman, [it] is much different [given the] resources that we have [and demands on our resources]. These are conversations that I have with other women of color when I hear [about] them having to support their extended family, having to keep two jobs in order to pay for student loans and in order to sustain their family.

Hispanic American, female mental health professional

E. Factors Affecting Diversity — Participant perspectives

Insurance reimbursement. Many participants who cited financial challenges discussed the impact of insurers on compensation. Participants often noted that insurers other than Oregon Health Plan (OHP) will not reimburse for services provided by registered associates.

Some licensed professional counselors described inequitable reimbursement rates and the exclusion of LPC services from Medicare reimbursement.[10] They also pointed out inferior pay compared to other mental health professions with similar education and experience requirements.

Some participants pointed to Oregon Health Plan, which recently extended coverage to registered associates, as a positive. In community mental health agency settings, clinicians may secure direct clinical experience hours working with Oregon Health Plan clients.

Lack of insurance reimbursement for associates [hinders diversity].

White, male licensed professional counselor

If I'm qualified to work with clients while I'm being supervised, why shouldn't I be able to take insurances and work with more people?

Middle Eastern, female professional counselor associate

Low pay for therapists doing community mental health work, in part due to the poor reimbursement rates for those with OHP, [hinders diversity in the field].

White, LGBTQ+, non-binary mental health professional

Medicare sets reimbursement standards at the federal level and private insurers base their reimbursement rates on CMS (Center for Medicare and Medicaid Services). [Their standard] is a huge issue for professional counselors. Medicare will not credential and reimburse a professional counselor. Medicare pays psychiatrists, physicians and psychologists — people with their doctorates — 100% of the set rate. Master's level providers in other disciplines are paid at 85% of the doctoral rate, but master's-level social workers are only paid at 75% of the doctoral rate and professional counselors aren't even credentialed by Medicare so they aren't eligible to provide reimbursable counseling services. That's federal policy. It is an enormous disadvantage. People going into the counseling field don't know that when they … choose to go to graduate school.

National mental health professional association board member, out-of-state private practice owner

Working as an intern is tough because many of the insurances will not panel with us while we're an associate. Recently, Oregon Health Plan has changed the policy there so we can now work with them. They will pay us. Other insurances are not doing that.

White, LGBTQ+, non-binary professional counselor associate

[The boards should be] advocating for state contracts and private insurers to pay more for LPC[s] like [the] LCSW [board] has done with their stronger lobby.

White, LGBTQ+, female licensed professional counselor

[10] Medicare reimbursement excludes services provided by licensed professional counselors. The advocacy arm of the American Counseling Association has advocated for bipartisan legislation to make LPC services reimbursable under Medicare.

E. Factors Affecting Diversity — Participant perspectives

Pressure toward private practice or away from clinical work. Many research participants spoke about the lasting impact of the financial model for mental health services. They pointed out that financial pressures drive most clinicians into private practice and that many other will leave for non-clinical jobs or exit the mental health profession entirely due to financial considerations.

Some participants explained that private practice may be the predominant career model to make mental health work financially sustainable, but starting a private practice is not accessible to everyone.

Who [will] go into private practice? [The] ones that have enough funding or money to say, 'I wanna put my life or salary [on] hold for six months, and I [am] going to invest in this private practice.'

Hispanic American, female mental health professional

Being massively underpaid by … agencies make[s] many [clinicians] leave the field due to burn out or not being able to make a living, especially while having to pay student loans.

White, LGBTQ+, non-binary licensed professional counselor

Not everyone's gonna be able or willing to go into entrepreneurial solo practice …. It's scary. It's risky. It requires having a lot of resources. So, a lot of people end up staying in agencies or working for the state.

Asian American/Pacific Islander, non-binary mental health professional

E. Factors Affecting Diversity — Participant perspectives

Role Models, Mentors and Supervisors

Participants often mentioned the lack of diversity in leadership roles and particularly among clinical supervisors as a hinderance to diversity in the mental health professions. Some described a sense of isolation and lack of support as a result.

In some cases, small pools of people with similar demographic backgrounds working in mental health in Oregon make it challenging for practitioners to find clinical supervision specific to their personal backgrounds or clientele that are not considered 'dual relationships,' pre-existing personal relationships that create a conflict of interest.

[There is a] lack of [diverse] role models/visibility due to … historic bias [in Oregon].

White, LGBTQ+, non-binary licensed professional counselor

I am a clinician of color and find that most of the classrooms, consult groups and professional [meetings] that I step into are either exclusively white or white dominant.

Male professional counselor associate of color

The lack of diversity among supervisors and overall staff has a negative impact. It feels like working in cultural isolation.

Female professional counselor associate of color

It is rare that a supervisor and/or clinical supervisor asks clinicians about their cultural background. Instead, it is assumed you come from a privileged background and subscribe to mainstream Caucasian Americans [beliefs and cultural values].

Hispanic American, female licensed professional counselor

Having more diversity in mentors and supervisors could help. As a Latina woman, I never had a teacher, supervisor or mentor who was Latinx.

Multiracial, female licensed professional counselor

The majority of our supervisors … are white. If you are a person of color, … you are most likely going to have a white supervisor in [an] all-white institution while you're seeing Black, brown and [other] disenfranchised clients.

African American, female licensed professional counselor

If you're a disabled clinician, good luck finding a supervisor who is also disabled and who you don't know from other places.

White, female licensed professional counselor with a disability

[There needs to be increased] availability of mentors of diverse backgrounds to support increased representation.

Biracial, female professional counselor associate

E. Factors Affecting Diversity — Participant perspectives

Employers and Colleagues

Participants somewhat frequently mentioned employers and colleagues as supporting diversity. Participants often mentioned employers and colleagues as factors that hinder diversity.

Efforts to support diversity. Participants who cited factors that support diversity in the profession somewhat frequently pointed out specific efforts made by employers and professional colleagues. Examples included professional development strategies and support for clinicians from marginalized groups.

Participants who are also employers described efforts to hire more diverse staff and the challenges they face in doing so.

Counseling organizations are making efforts to support mental health professionals with marginalized identities. These [efforts] include assisting BIPOC mental health professionals with professional development and offering equity rates for [facilitating] workshops or trainings.

Female marriage and family therapist associate of color

BIPOC therapists in Eugene formed a Therapist[s] of Color Guild in 2017 to support each other. Portland BIPOC therapists also started their own guild.

Asian American/Pacific Islander, female licensed psychologist

There's a 21 days of equity challenge that our site has recently completed. Each day there's a different activity where we check our privilege, we talk, we look at the population of our area, and we consider different aspects of marginalization ….

White, male professional counselor associate

Each time that I hear conversations [between other mental health professionals] around how to better accommodate or support someone from a target group, it makes me more comfortable and confident that my target memberships will also be accepted by the same teams.

Biracial, LGBTQ+, male mental health professional

It is difficult to attract diverse professionals, especially professionals of color.

African American, female licensed psychologist

We're just desperate for people [to enter the field]. We cannot hire anyone [because] there's no one to hire.

Biracial, male licensed professional counselor

E. Factors Affecting Diversity — Participant perspectives

Workplace microaggressions, bias and homogeneous staffing. Participants frequently described microaggressions and bias in the workplace as hinderances to diversity. They also discussed the impact of homogenous staffing as a barrier to diversity.

I've witnessed students, trainees, and interns experience microaggressions in their training programs that have an impact on the quality of their training, if they continue to pursue licensure, and their promotion to leadership positions.

White, LGBTQ+, non-binary licensed professional counselor

… I do not see many [opportunities where I live for Queer, Trans or BIPOC] individuals. I had such a difficult time while in school [trying] to obtain an internship and I had to postpone my internship for eight months just to get one …. Even then I did not feel I was able to be myself….

LGBTQ+, non-binary mental health professional of color

Too many people ignore the ACA code of ethics that state[s] that you not impose your own personal beliefs onto your clients. I feel this also applies to their coworkers or those being supervised.

Asian American/Pacific Islander licensed professional counselor

Oregon clinicians, particularly older clinicians who tend to hold power, are afraid unwilling or defensive about addressing issues of diversity microaggressions and privilege. When this happens, individuals of diverse backgrounds are put in a position to immediately feel invalidated or frustrated.

White, male psychologist

I have seen many [mental health practices] which have only white people working there. As a [person of color], that does not encourage me to want to work there as I see no steps taken to ensure more diversity in who is represented on staff.

African American licensed psychologist

[There are] few people with diverse backgrounds 'behind the scenes' in clinics where mental health professionals typically start out …. Therefore, [there is a] lack of understanding about differences [in] needs [and] approaches, and [an] unwillingness to make appropriate and acceptable accommodations and other system-wide changes.

White, LGBTQ+, female licensed marriage and family therapist

I've been with the same organization for [almost 20] years now. Never once have I had a supervisor that had any sort of identity that was shared with me. All [have been] from the dominant culture.

Biracial, female licensed professional counselor

E. Factors Affecting Diversity — Participant perspectives

Workplace conditions for professionals with disabilities. Participants described employers and work expectations that do not accommodate persons with disabilities as a barrier to diversity.

When I worked at an agency, our productivity requirements were such that I ended up working 60 hours a week and [was] still being told I wasn't doing enough. This is particularly difficult [to handle] when you're disabled.

White, female licensed professional counselor with a disability

I can't work in an agency setting because of my disabled status …. Private practice is my only option if I want to make income for myself, which means that I had to take business counseling classes … because I didn't know how to run a business. I've had to pay a ton of money out of pocket post-graduation just to learn how to best support myself.

Biracial mental health professional with a disability

E. Factors Affecting Diversity — Participant perspectives

Workplace DEI efforts. Participants cited DEI efforts that miss the mark as hinderances. Concerns included inadequate or inappropriately handled efforts. They also described programs that rely on clinicians from marginalized groups to "voluntarily" educate colleagues as a barrier to diversity and equity.

Marginalized clinicians are often expected to educate their teams for no additional pay.

White, LGBTQ+ professional counselor associate

It is inappropriately directed or implemented interventions aimed at improving diversity (ironically and sadly) that have hurt my career the most.

Biracial, female licensed psychologist

My agency has a diversity officer who just sends out emails that don't amount to any actual change or demonstrate any understanding of practical applications to promote equity.

Asian American/Pacific Islander, male licensed professional counselor

Having conversations about racism after BLM (Black Lives Matter) was very awkward being in an almost all-white agency. Since there was so much discomfort around talking about racism, it was easier to go back to the status quo of adhering to the majority culture.

Asian American/Pacific Islander, female licensed professional counselor

I would love to say the proliferation of DEI trainers and the mandates to have DEI training were somehow helpful, but I don't think they're doing what they originally wanted to be doing, sadly.

Middle Eastern, male licensed professional counselor

Diversity trainings are rarely taught by a diverse panel.

Biracial, female licensed professional counselor

E. Factors Affecting Diversity — Participant perspectives

Professional Stressors and Burnout

Interviewees, focus group participants and virtual workshop responses often cited how the stress of mental health work with inadequate support, high caseloads and long hours create conditions that are ripe for burnout. Many also spoke about the added demands of practicing during COVID-19 and the conditions that are specific to clinicians early in their careers.

Respondents frequently pointed out that professionals from marginalized groups face additional challenges that compound professional stressors. Participants of color and LGBTQ+ clinicians spoke of the toll of work stressors as amplified by issues that come with being part of a marginalized group.

Themes related to industry stressors that participants described as adversely affecting diversity are discussed on this page and the following pages.

Inadequate support. Participants described the emotional toll of working with mental illness and trauma. They cited inadequate support as a factor that may hinder diversity.

When you're working in the field, you're seeing so many clients. You're doing therapy [for clients], and [yet] you can't afford your own therapist …. How are you gonna sustain yourself in this field when you don't have support?

Biracial, LGBTQ+, male licensed professional counselor

It's [an] extreme [amount of work], especially if you're working with a certain demographic of people who have a particular diagnosis, whether it's severe mental health struggles [or] trauma. The number of hours [required] in a lot of these places [and] the lack of flexibility [are challenging]. A lot of places don't even have mental health days [for practitioners].

African American, female mental health professional

Working in trauma-inducing environments can be difficult. How people are [maintaining] health and balance in jobs or positions where they may not feel [valued] is another [difficult] thing.

Hispanic American, female mental health professional

E. Factors Affecting Diversity — Participant perspectives

Caseloads and hours. Participants described large caseloads and long hours of work as stressors that could hinder diversity in the field. They also highlighted the way these demands particularly impact early-career professionals before they are licensed.

They require therapists to see … up to 25 or 27 people a week. While that seems normal, when I graduated, I remember my program said 15 people a week is a full case load.

Hispanic American, female licensed marriage and family therapist

I have a case load of over a hundred [clients]. It's pretty much the norm here in [rural county].

White, female licensed professional counselor

A lot of [community mental health agencies] have very strong and important missions and are very well-intentioned but are either poorly organized or mismanaged or overwhelmed. [This] leads to [workers feeling they've been] poorly compensated.

Asian American/Pacific Islander, non-binary mental health professional

Most [mental health] clinics are understaffed and underpaid, so there is more burn out [than in other health professions].

White, female licensed professional counselor

Practices sort of treat unlicensed folks as if they're starting from scratch in terms of experience up until the day they meet the 2,400 [clinically supervised experience] hours. Suddenly, you get more money, you get to see different kinds of clients and you make it over this hurdle. So many of us are exhausted trying to get to that wall [that] we lose … people before they even become licensed because of burnout.

White, LGBTQ+, female licensed professional counselor

There is a HUGE power imbalance in the field between licensed professionals who own and operate agencies and their counselor associate employees who carry larger caseloads, earn less money and work with the most-acute clients.

White, LGBTQ+, female licensed professional counselor

E. Factors Affecting Diversity — Participant perspectives

COVID-19. Participants described the pandemic as a time that placed extreme demands on mental health professionals leading to burnout for many and a possible hinderance to diversity in the field.

After two years of [the] pandemic, we're fried. We're just toast. That's going to be another reason we're gonna bail out [of the industry].

Multiracial, female licensed professional counselor

With the pandemic, there is an [increased] need for mental health support and services …. There weren't many mental health professionals [to begin with] … [so] I feel like some people might have overdone themselves or not had enough of the resources needed to provide the care that was necessary [during the pandemic]. That leads to significant burnout.

Hispanic American, female licensed psychologist

The last two and a half years, being a psychotherapist, has been extremely challenging. We're humans and we're all going through the same trials and tribulations, [but] we need to show up five days a week for our clients. There are mornings I just don't have it in me.

Middle Eastern, male licensed professional counselor

E. Factors Affecting Diversity — Participant perspectives

Added labor for marginalized professionals. Participants described an extra layer of stress and work for professionals from marginalized backgrounds. This work may consist of navigating the stress and practical impacts of discrimination and bias. In some cases, this work may pertain to work demands such as when clinicians are asked to educate their colleagues or lead DEI efforts as noted in previous discussion of employers and colleagues.

Counseling and psychology programs have largely failed to create equitable and supportive environments for trainees. Many trainees, especially those who have marginalized identities and [are not being supported] bear an additional burden of labor [and] experience burn out even before licensure. Providers who have marginalized identities bear a similar burden and reach burn out faster than providers with more privileged identities.

Asian American/Pacific Islander, female licensed psychologist

As human beings experiencing discrimination, there's very little give in our profession to not be 'on' and have it together all the time.

White, LGBTQ+, non-binary professional counselor associate

APPENDIX F. Licensing

This appendix synthesizes feedback from mental health professionals about factors that impact diversity and equity as professional counselors, marriage and family therapists and psychologists enter their professions and attain their licenses in Oregon. This appendix also reports findings related to renewing and maintaining licenses.

Practitioners licensed and regulated by the Oregon Mental Health Regulatory Agency (MHRA), the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) provided input via interviews, focus groups and responses to a virtual workshop (similar to a survey, with more opportunity for open-ended comments).

Information in this appendix includes:

- Quantitative analysis of virtual workshop responses about the impact of licensing on diversity;[1]
- Qualitative analysis about the initial licensing process;
- Qualitative analysis about initial licensure requirements; and
- Qualitative analysis about maintaining and renewing licenses.

Sample comments from research participants throughout this appendix are drawn from the virtual workshop as well as from focus groups and interviews. In some cases, participants also emailed the study team with comments. Identifying information is excluded.

Many comments may appear not to be specific to impacts on diversity or equity. Such comments are included because of the context in which they were provided (in response to questions about diversity and equity) and because marginalized groups may experience amplified effects of challenges that are present for everyone.

Many comments from participants reflect misunderstandings of agency and board policies and procedures or do not match current facts. We include these comments as important data points about the challenges facing MHRA and the boards in their relationships and communications with professionals. Professionals are sharing information with each other, whether accurate or not, that contributes to a narrative about how boards treat professionals, including professionals from diverse backgrounds. That narrative can be a factor in whether professionals perceive that the boards are welcoming and equitable. To help to prevent perpetuating inaccurate information about polices or practices, we note discrepancies in accompanying narrative or footnotes.

[1] A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

F. Licensing — Quantitative analysis of virtual workshop responses

Entry to the Industry and Initial Licensure

Virtual workshop participants were asked to describe the specific programs, policies or actions MHRA and OBOP or OBLPCT take that support or hinder diversity when mental health professionals are first entering the industry and attaining their licenses.

The study team applied the following codes that describe commonly cited topic areas that agency and board policies do and can address:

- Clinical hours;
- Time (e.g., how long the process of licensure takes);
- Financial (e.g., cost of licensure);
- Exam;
- Supervision;
- Out of state or country applicants; and
- Board procedures or communication (e.g., how accessible the boards are and how information is communicated to applicants).

Codes could be either positive or negative to capture the emotional sentiment behind each comment. When responses included more than one factor, they received multiple codes. As a result, the total number of codes reported may exceed 1,793, the total number of participants who participated in the virtual workshop (note that not all respondents provided a response to be coded for every question).

Respondents cited factors that negatively impact diversity at nearly ten times the rate of factors that positively impact diversity.

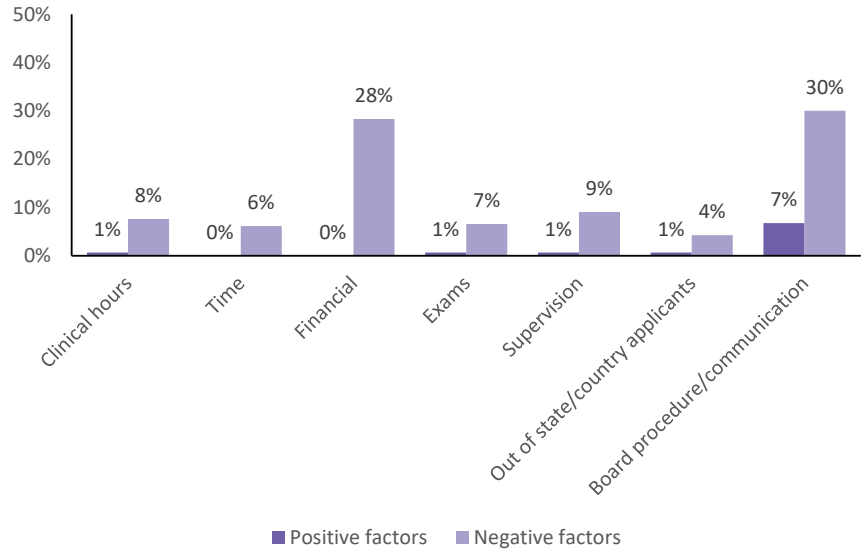
F. Licensing — Quantitative analysis of virtual workshop responses

Overall results. Figure F-1 shows frequently cited positive and negative factors under agency and board control that influence diversity as mental health professionals enter the industry and attain their licenses.

The most frequently cited positive factor was board procedures and communication at 7 percent. Only three other factors were cited at all as a positive influence (clinical hours, exams and supervision).

The most cited negative factors were board procedures and communication (30%) and financial issues (28%).

F-1. All respondents — factors mentioned that support or hinder diversity when mental health professionals are initially attaining licenses



Note: N = 473.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

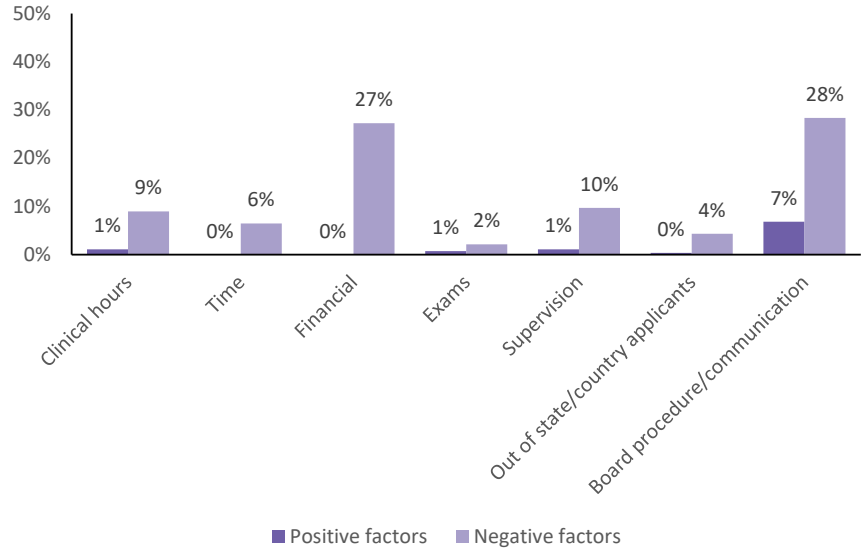
F. Licensing — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). Of the three practitioner license types, LPCs looked the most similar to the average response.

As with respondents overall, board procedures/communication was the most highly cited positive factor by which boards could influence the diversity of mental health professionals.

Financial issues and board procedures and communications were the most highly cited negative factors under board influence.

F-2. LPCs — factors mentioned that support or hinder diversity when mental health professionals are initially attaining licenses



Note: N = 279.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Licensed marriage and family therapists (LMFTs). For LMFTs, the most highly cited negative factor impacting diversity over which boards have control was board procedures/communication at 34 percent, the highest among professional license types.

LMFTs were the only licensed professionals to indicate that factors related to the licensure of out of state or out of country applicants were a positive impact the boards could have on diversity in the mental health profession.

F-3. LMFTs — factors mentioned that support or hinder diversity when mental health professionals are initially attaining licenses

Note: N = 56.

Participants' responses could contain more than one code, so percentages do not add up to 100.

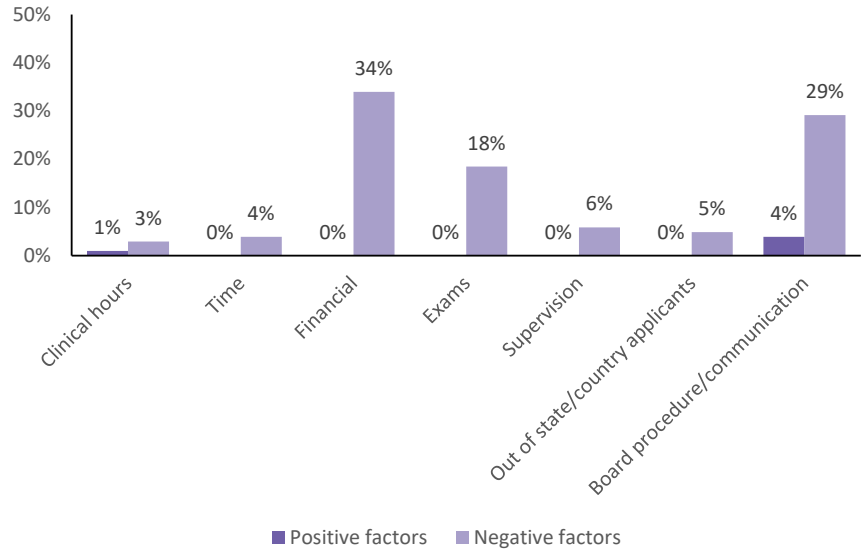
Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Psychologists. Unlike the other two license types, psychologists ranked financial concerns as the number one negative factor under board control that impacts diversity in the mental health profession.

Psychologists cited positive factors under board control less often than the other two license types.

F-4. Psychologists — factors mentioned that support or hinder diversity when mental health professionals are initially attaining licenses



Note: N = 103.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

People of color. Because of the relatively small numbers of participants from each racial and ethnic group who provided a comment for this question, we combined participants who identified as Black or African American, Asian American or Pacific Islander, Hispanic or Latino, American Indian or Native Hawaiian or multiracial into one group.

For respondents overall, financial concerns were the second most cited negative factor under board influence that affects diversity in the mental health profession. For people of color, financial concerns ranked first (31%).

People of color cited clinical hours as a negative factor the most highly out of any other subgroups we examined (11%).

F-5. People of color — factors mentioned that support or hinder diversity when mental health professionals are initially attaining licenses

Note: N = 122.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

LGBTQ+ participants. Due to the relatively small numbers of individuals within specific subgroups, the study team combined respondents who identified as gay or lesbian, bisexual, transgender or non-binary into one LGBTQ+ group.

Compared to other subgroups, LGBTQ+ participants cited board procedures and communication (43%) and financial issues (35%) the most as negative factors under board control that influence diversity in the mental health professions.

F-6. LGBTQ+ participants — factors mentioned that support or hinder diversity when mental health professionals are initially attaining licenses

Note: N = 130.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Participants with disabilities. Patterns of responses among participants with disabilities were similar to overall patterns.

F-7. Participants with disabilities — factors mentioned that support or hinder diversity when mental health professionals are initially attaining licenses

Note: N = 87.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Maintaining and Renewing Licensure

The virtual workshop asked participants to describe the specific programs, policies or actions MHRA and OBOP or OBLPCT take that support or hinder diversity when mental health professionals are renewing their licenses.

Keen Independent identified the following codes that describe commonly cited topic areas related to license renewal that agency and board policies do and can address and applied them to the open-ended responses:

- Cost;
- Cultural competency continuing education (CE) units;
- Other CE requirements;
- Frequency of renewal; and
- Board procedures or communication (e.g., how accessible the boards are and how information is communicated to applicants).

As with the codes for initial licensure, codes for license renewal were categorized as either positive or negative depending on the tone of the response. Responses that included more than one factor received as many codes as could apply. Thus, the total number of codes reported could exceed the total number of participants who participated in the virtual workshop. However, not all respondents provided a response to be coded for every question.

Overall, respondents cited factors that negatively impact diversity at over three times the rate of factors that positively impact diversity when professionals are renewing their licenses.

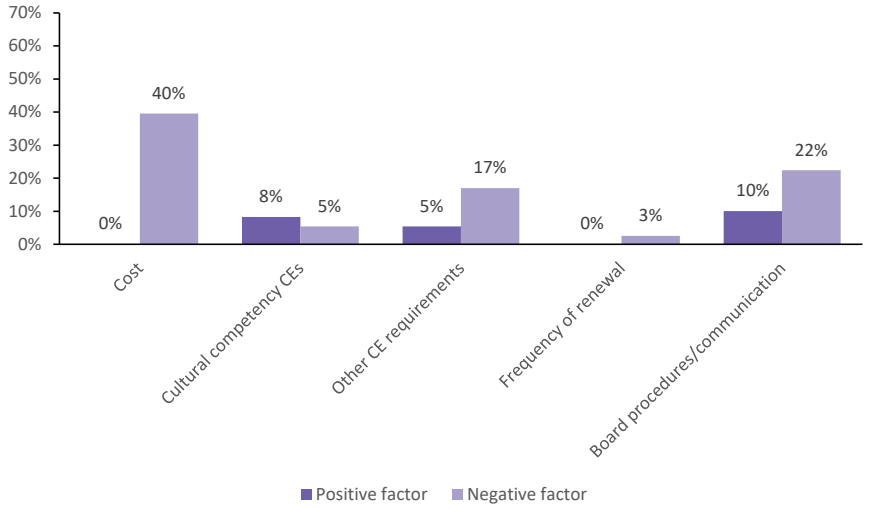
F. Licensing — Quantitative analysis of virtual workshop responses

Overall results. Figure F-8 displays the frequently cited positive and negative factors that the agency and boards control that influence diversity as mental health professionals seek to renew and maintain their licenses.

Similar to rankings of the previous question regarding initial licensure, the most frequently cited positive factor under agency/board control that influences diversity as mental health professionals renew their licenses was board procedures and communication at 10 percent. Cultural competency CEs was the only factor that was cited more positively than negatively in participant responses here.

By far, the most cited negative influence on diversity under board/agency control was the cost to renewing licenses (40%). Board procedures and communication was the second most cited negative factor (22%).

F-8. All respondents — factors mentioned that support or hinder diversity when mental health professionals are renewing licenses



Note: N = 389.

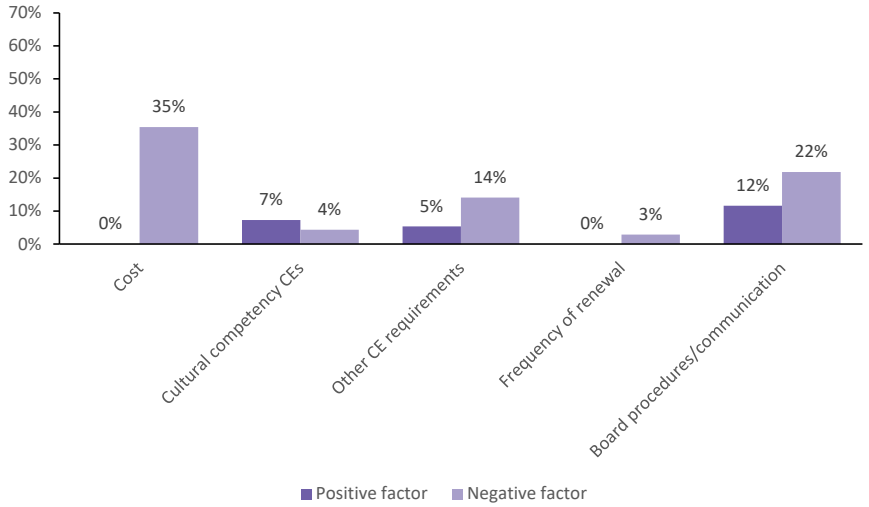
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). Although still a frequently cited factor, LPCs mentioned cost as a negative factor impacting diversity the least often out of the three license types (35%).

F-9. LPCs — factors mentioned that support or hinder diversity when mental health professionals are renewing licenses



Note: N = 206.

Participants' responses could contain more than one code, so percentages do not add up to 100.

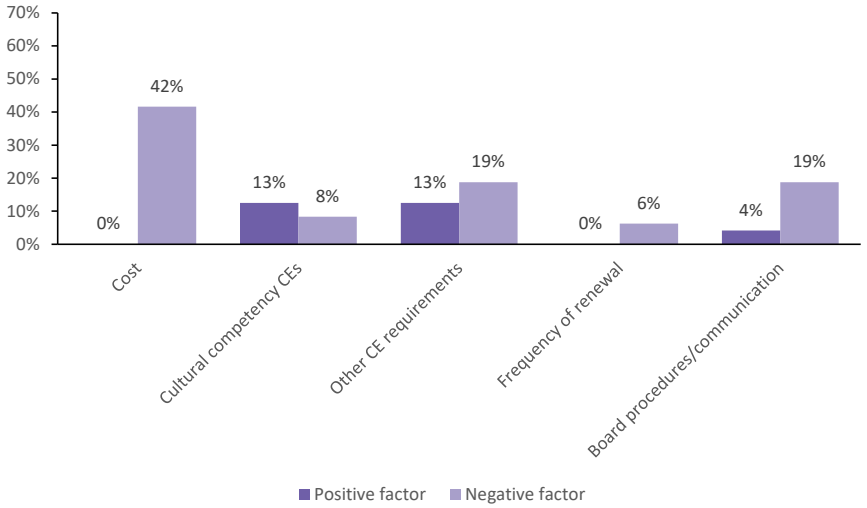
Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Licensed marriage and family therapists (LMFTs). LMFTs appeared to have the most favorable views of cultural competency CEs with 13 percent of responses citing them as a positive factor under board control that influences diversity as mental health professionals renew their licenses.

Responses concerning the top two negative factors impacting diversity are in line with those of overall participants.

F-10. LMFTs — factors mentioned that support or hinder diversity when mental health professionals are renewing licenses



Note: N = 48.

Participants' responses could contain more than one code, so percentages do not add up to 100.

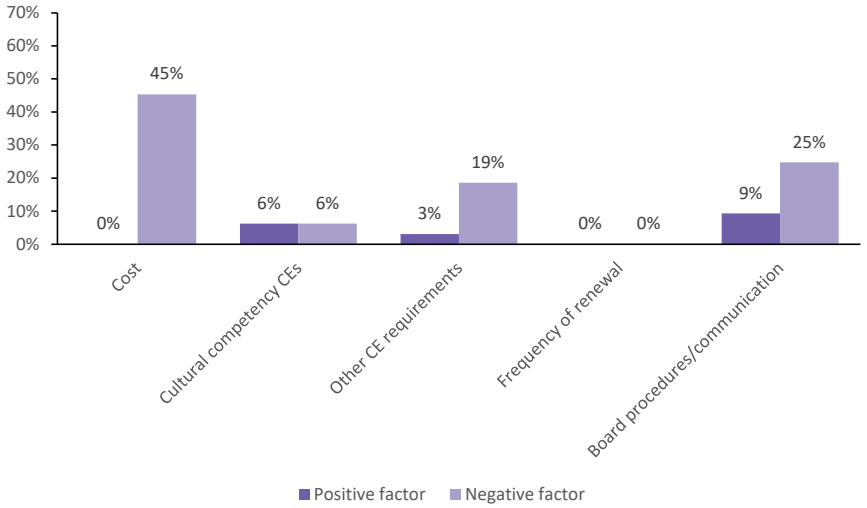
Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Psychologists. Of the three license types, psychologists were the most likely to mention the negative impact of cost on diversity when individuals are renewing their licenses (49%).

Cultural competency CEs were cited equally as positive factors and negative factors for psychologists and no psychology respondents cited frequency of renewal (either positive or negative) as a factor influencing diversity at the renewal stage.

F-11. Psychologists — factors mentioned that support or hinder diversity when mental health professionals are renewing licenses



Note: N = 97.

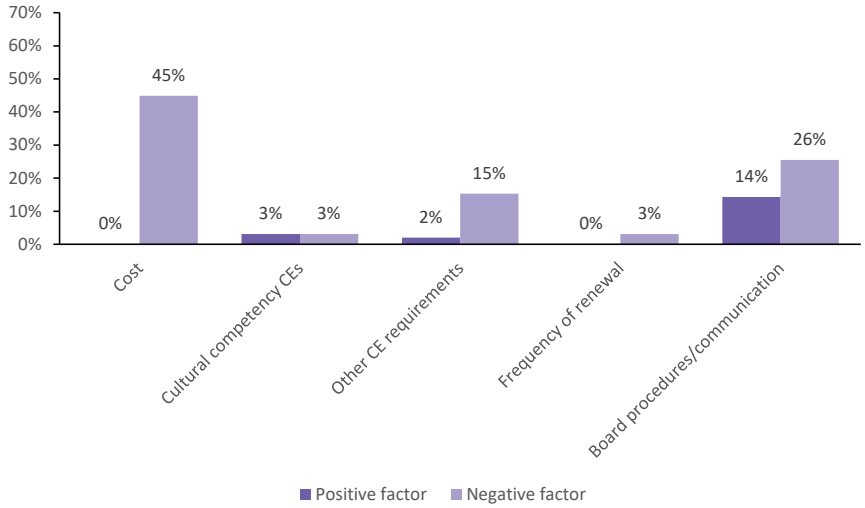
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

People of color. People of color cited board procedures or communication more than average as both a positive and negative factor under board control that impacts diversity among mental health professionals renewing their licenses.

F-12. People of color — factors mentioned that support or hinder diversity when mental health professionals are renewing licenses



Note: N = 98.

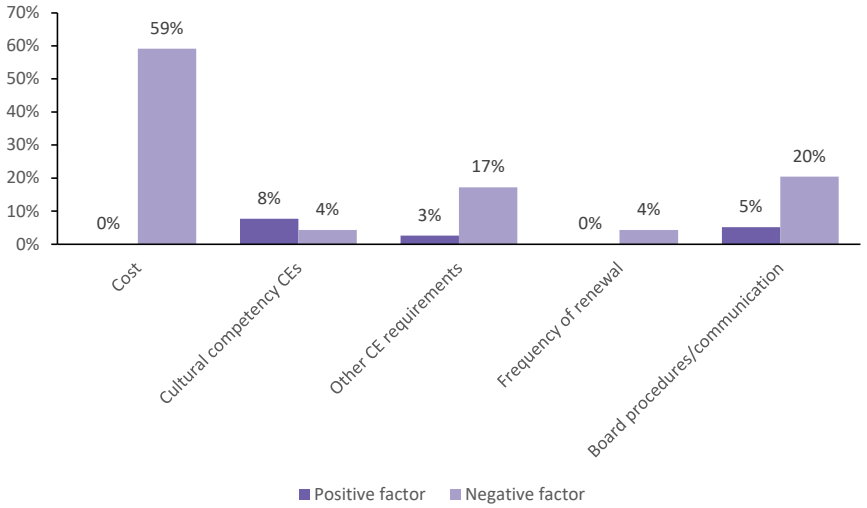
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

LGBTQ+ participants. Of all subgroups, LGBTQ+ participants were most likely to cite the cost of renewal (59%) as a negative factor under board control that influences diversity as mental health professionals are renewing their licenses.

F-13. LGBTQ+ participants — factors mentioned that support or hinder diversity when mental health professionals are renewing licenses



Note: N = 93.

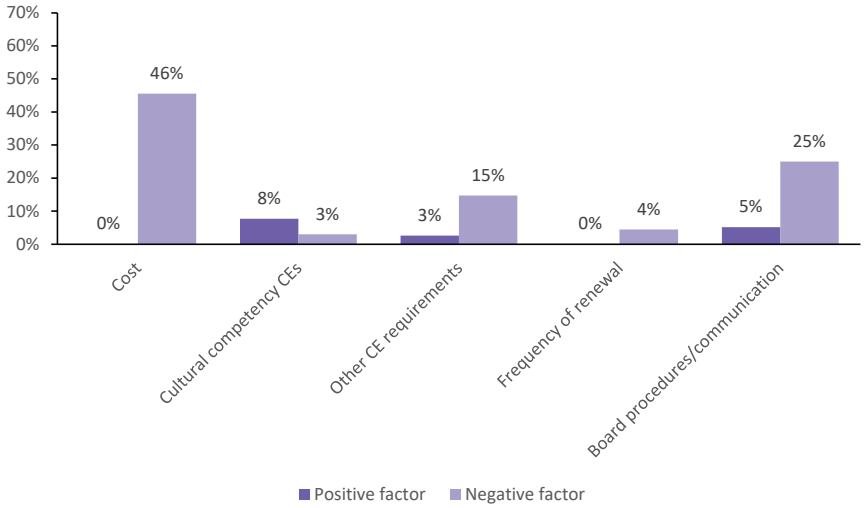
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Quantitative analysis of virtual workshop responses

Participants with disabilities. Cost was also cited by participants with disabilities at a higher rate than overall participants (46% versus 40% overall).

F-14. Participants with disabilities — factors mentioned that support or hinder diversity when mental health professionals are renewing licenses



Note: N = 68.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

F. Licensing — Participant perspectives about the initial licensing process

The next section of this appendix provides synthesis of topics related to processes, procedures and communications during initial licensure that may impact diversity.

In some cases, comments pertained both to initial licensing and renewal. Such comments are included in this section of the appendix pertaining to initial licensing. The final section of this appendix will address topics specific to renewal only.

Analysis of this topic is organized as follows:

- Perceptions of initial licensing regulations generally;
- Enforcement focus;
- Systems;
- Communications;
- Language barriers and inclusive processes for international applicants;
- Customer service and support; and
- Processing time.

F. Licensing — Participant perspectives about the initial licensing process

General Perceptions of Initial Licensing Regulations

As previously described, participants did not mention licensing related topics as frequently as they mentioned other barriers to diversity.

Some offered comments that were neutral or positive about initial licensing regulation, but these were comparatively rare.

Overall perceptions of regulations at the initial licensing stage described ways they hinder diversity. Chief concerns were the complexity and volume of regulations.

As long as you have what they are looking for [in an application], they're going to approve it. It's pretty black and white.

Hispanic American, female mental health professional

The laws [we must follow to get licensed] are not clear. One OAR [Oregon Administrative Rule] says one thing, then the OBLPCT says another.

White, female licensed professional counselor with a disability

Mental health graduates should not need a dual major in law to understand, interpret and obtain licensure.

Female licensed professional counselor

Many therapists with years of experience give up their practice due to so many unnecessary rules and regulations … applied to everyone, no matter how experienced the individual. Minorities are getting hit more for the same reasons.

Female professional counselor associate

The disparity between applying for Oregon compared to Washington was crazy. [When] I applied for Oregon, I felt like it took a while and it asked for so many different kinds of paperwork, whereas [the] Washington [application] I did in 20 minutes.

Asian American/Pacific Islander, male mental health professional

F. Licensing — Participant perspectives about the initial licensing process

Enforcement Focus

Participants frequently mentioned that they perceive MHRA, OBLPCT and OBOP to overemphasize gatekeeping for the profession resulting in a rigid or inflexible approach to licensing rule enforcement.[2]

MHRA staff note that the boards, as government entities, are required by law to apply standards consistently and cannot legally grant variances to laws, rules or ethics code provisions. When MHRA and the boards are able to allow variances, the authority is permitted by rule or law. For example, residents must complete their one-year residencies in two years, but Oregon Administrative Rules give the boards power to grant extensions upon request.[3] MHRA staff note that OBOP grants all timely requests for extensions when the requesting resident needs more time to complete the required hours for licensure.

OBLPCT, MHRA and OBOP serve as gatekeepers and have used that position to narrowly define their work. Gatekeeping also includes making sure the gates to the profession are approachable.

Asian American/Pacific Islander, female licensed professional counselor

There are rigid cutoffs in place for qualifications. These are regulatory agencies, so this is naturally a part of the process, but I think following these standards inflexibly potentially rules out some excellent candidates.

White, female psychologist

The culture of rigid expectations and extremely punitive reactions to minor infractions is a deterrent for those who disproportionately suffer excessive punitive policing in other contexts.

White, LGBTQ+, male licensed psychologist

OBOP is quick to punish or fine any applicants or licensees for late forms.

Hispanic American, male licensed psychologist

[2] Gatekeeping (granting or denying access) is a formal, sanctioned mandate for regulatory bodies such as MHRA and the boards. Gatekeeping can perpetuate inequities when practices err on the side of exclusion to prevent potential harm without weighing the harm of disparate impact to professionals and consumers.

[3] Oregon OAR § 858-010-0036 (3)(b). (2021). https://oregon.public.law/rules/oar_858-010-0036

F. Licensing — Participant perspectives about the initial licensing process

Impact for persons with disabilities or neurodiversity. Participants also described ways that a rigid approach to enforcement could adversely impact candidates from marginalized groups, particularly professionals with disabilities or neurodiversity.

The rigidity of options and time limits on postdoctoral residencies [and the] application approval period creates substantial hinderances for professionals with disabilities. The lack of disability support materials for acquiring accommodations on the EPPP [Examination for Professional Practice in Psychology] and the board's unwillingness to operate with reasonable flexibility are likewise huge hinderances.

White, LGBTQ+, male licensed psychologist

Board policies and practices could be more accessible, flexible, etc. … [the current policies] hurt some folks more [than others]: those with disabilities, those from poorer SES (socioeconomic status) backgrounds [and] those with neurodiversity.

Asian American/Pacific Islander, male licensed professional counselor

As somebody with ADHD (attention-deficit/hyperactivity disorder), the application process for OBLPCT can feel very scary.

Marriage and family therapist associate of color

F. Licensing — Participant perspectives about the initial licensing process

Systems

Some participants described the application portal as a positive.[4]

Participants much more frequently cited online-only applications and challenges with the portal as barriers to diversity.[5]

Some respondents specified challenges they linked to inclusion for practitioners from specific demographics.

Others expressed more general concerns about complexity or functionality as points of friction.

The [application] portal has been helpful [and] is supporting those who may [be] struggling with ways of learning [how to navigate the licensure process].

Biracial, female licensed professional counselor

There is some technological access assumption [regarding] forms and websites [which hurts those without access].

American Indian, female licensed professional counselor

Systems can be confusing or have inbuilt biases that are obvious to [people of color] or [people] from [other] marginalized groups …. [For example, there are] complex processes asking for paperwork immigrant applicants may not have access to, [though] in this case the board has worked with applicants which is definitely a positive.

Asian American/Pacific Islander, female licensed professional counselor

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As an older therapist returning to the field, I found the online application portal a very difficult system to navigate. Frankly, I could have used more handholding and encouragement from … staff.

White, female licensed professional counselor

The fact that my students are paying graduate-level tuition to take a course to explain how to use the frickin portal is ridiculous. That one credit could be used to teach them about how to work with couples or other things that are actually relevant to their counselor identity.

White, LGBTQ+, non-binary licensed professional counselor

Nothing says "we don't care about you" like a malfunctioning portal and no live staff.

Female licensed psychologist with a disability

[4] Customer service research in general suggests that the ability to conduct routine business online is now a basic expectation. While many individuals appreciate well-designed self-service options, most individuals will not comment positively when a basic expectation is met. Many more will share negative experiences.

[5] OBLPCT has taken steps to educate college students about licensing, including use of the application portals. MHRA staff visit Oregon degree programs and make presentations that include slideshow tutorials about the portals.

F. Licensing — Participant perspectives about the initial licensing process

Communications

Professionals frequently cited communication as an area that may be off putting and can hinder diversity. Comments focused on accessibility and tone of communications.

MHRA staff note that they regularly check the agency and board websites for broken links using a software solution for this purpose to ensure all links are working. Participant comments perceive otherwise, reflecting the long-lasting impact of negative customers experiences even after the originating issue has been resolved.

Accessibility of communications. Participants noted challenges surrounding the overall accessibility of communications and clarity of information about licensure.

Communication accessibility for practitioners who did not speak English as their first language is addressed later in this appendix.

The way information is presented to obtain licensure is not always accessible …. Requiring a computer, needing knowledge of English, [and] being able to navigate complex linguistics [all impact diversity].

Biracial, female professional counselor associate

[Board] websites are full of broken links, the same form is referred to by different titles, and responses from the board often come across curt and deprecating.

White, female professional counselor associate with a disability

The website can be clearer, more transparent, and forthcoming with information needed to be successful and timely in getting licensed.

Biracial, female licensed psychologist

F. Licensing — Participant perspectives about the initial licensing process

Tone of communications. Participants describe the tone and content of communications as transactional, impersonal and off putting and indicated this as a potential barrier to diversity.

They email information, and we provide information. It's very transactional …. It feels like you're going to the DMV.

Hispanic American female licensed marriage and family therapist

Cold, inflexible and impersonal email responses from the Psych Board may make it harder for people who have less experience navigating complex and impersonal systems and may wear down folks who have to navigate those systems regularly.

White, female licensed psychologist

When I receive emails from the board, I get really nervous. I feel worried that I've made a mistake in some way, and I'm pretty diligent about my documentation.

Biracial, LGBTQ+, female licensed psychologist

If you ask them a question, they quote the regulations back to you, but they don't tell you what to do.

Asian American/Pacific Islander, female licensed psychologist

I feel the way the board functions is adversarial, rather than collaborative …. Messaging that helps prospective and current licensees feel that the board is approachable (not stern white men just waiting to take licenses away) would also help possibly attract and hopefully retain licensees.

White, female licensed psychologist

F. Licensing — Participant perspectives about the initial licensing process

Language Barriers and Inclusive Processes for International Applicants

Participants noted that information about licensing is not available in languages other than English. The new website for MHRA, OBOP and OBLPCT does have integrated language translation (Google Translate). Links that open PDFs, however, are still presented in English.

Some participants also noted that materials and systems are not inclusive of international applicants (e.g., only accommodating U.S. addresses). However, the applicant portal includes country fields for addresses, applicants, references, universities, references and employers. As noted previously perceptions of service friction challenges do not always match current realities.

We have a person who's working with us …. She's bilingual and we've really supported her in trying to meet the [licensure] requirements. I think there are some language barriers …. She's got a really good supervisor who's helped her navigate that, but I think that in a different setting, that could've gone very differently for her.

Middle Eastern, female licensed psychologist

[It's] hard to navigate the portal if English isn't your first language.

Asian American/Pacific Islander, male licensed professional counselor

As a bilingual therapist and English not [being] my first language, I think most of the information should be also provided in Spanish ….

Hispanic American professional counselor applicant

Materials on [the] board website are all [only] in English.

Biracial, female licensed professional counselor

License application materials can be more inclusive. Some fields did not allow for entering a non-U.S. address.

Asian American/Pacific Islander, female psychologist resident

F. Licensing — Participant perspectives about the initial licensing process

Customer Service and Support

Participant feedback addressed topics related to receiving customer service or support from MHRA or the boards including:

- Positive experiences;
- Lack of response;
- The importance of live support;
- Variability of answers or service solutions; and
- Disproportionate impact of service challenges on people from marginalized groups.

Experiences and perceptions regarding responsiveness and accessibility of staff were notably inconsistent. Some spoke positively about their experiences and compared Oregon favorably to experiences in other states. More often, participants spoke of lack of response and challenges getting information about requirements or the status of pending applications. Additional discussion is provided on the following pages.

The ability to communicate with an actual person [when I applied internationally] made the licensing process a lot less stressful ….

Asian American/Pacific Islander, female licensed professional counselor

Compared to … other states, the [OBLPCT staff} are amazingly accessible and supportive … and on-line resources are user-friendly.

White, male licensed marriage and family therapist

I have been licensed in multiple states and this is the first time I feel like I could really ask questions and get follow-up if it was really important. I am [treated like] a person, not just the next LPC number.

White female professional counselor applicant

F. Licensing — Participant perspectives about the initial licensing process

Difficulty reaching a live representative. Participants described difficulty obtaining help from a live representative when they had questions about requirements or processes or needed to resolve an issue.[6] Some described this directly as a disadvantage for people from cultures that emphasize personal relationships and are less familiar with depersonalized procedurally oriented systems.

It would be wonderful if the board had someone that we could always call during business hours and that would pick up right away, that could answer questions about anything and have the right answers.

Asian American/Pacific Islander, non-binary mental health professional

Not being able to get answers quickly from the board has also been an issue. Phone messages were not answered and it was by chance emails were eventually given so answers could be provided

White female licensed marriage and family therapist

Back then, you could actually call them and speak to a human being. You cannot talk to anyone anymore at the Board, which is a shame because we are in the talking profession.

Biracial, male licensed professional counselor

When we call the board, a lot of us don't get calls back. We kind of feel like it's a wild goose chase as to who to call [to get answers].

White, female licensed professional counselor

[6] MHRA reports that they respond to hundreds of emails and calls daily.

F. Licensing — Participant perspectives about the initial licensing process

Variable answers or resolution to issues. Participants also noted service inconsistencies with resolution of issues varying by staff member and based on the level of self-advocacy on the part of the applicant or licensee. Participants expressed concern that professionals from marginalized backgrounds may be more negatively impacted by customer service and support factors than professionals from the dominant culture as a result.

It's often a matter of who answers your questions [that determines how your concern is addressed], it seems like. For example, I had to pay to switch from LMFT associate to LPC associate mid-internship when I personally know others who just had that done for them by someone at the MRHA.

White, LGBTQ+, male marriage and family therapist associate

When I got my counseling license, I also got [another professional license]. I talked with someone on both boards before I went through the education process to say, "Could I have [a practice that combines both professions] with proper consent forms if I get my degrees in both? Initially, I'd been told yes …. when I called people back and [started] emailing [the board after I graduated], the marriage [and family therapy] board said, "No way. We'll come after you."

Hispanic American, female licensed marriage and family therapist

F. Licensing — Participant perspectives about the initial licensing process

Inequity related to the necessity of self-advocacy. Participants expressed concern that licensing processes and practices require a substantial amount of self-advocacy, which may adversely affect practitioners from marginalized groups.[7]

Academic literature has documented differences in self-advocacy between dominant and marginalized group members in health care.[8,9] Marginalized group members may be less likely to self-advocate due to power imbalances, lack of familiarity with the need for self-advocacy or past experiences with authority figures. As a result, it is possible that people from marginalized groups do not fare as well as people from dominant groups when outcomes depend on self-advocacy.

Communities of color are about relationship. They want to be able to call someone … but [instead] we are forced to navigate the system outside of ways …. we know and are comfortable ….

Biracial, female licensed professional counselor

It's hard to navigate the system even with help. Without help, it can be even more difficult. Often … people who are unable to get help are those who are historically marginalized … there isn't the same support system … as there would be for someone with more privilege.

African American licensed psychologist

The administrative slowness and lack of responsiveness from the OBLPCT on licensing … requires a level of self-advocacy most commonly associated with whiteness and privilege.

White, male licensed professional counselor

… we all have to go to graduate school and we have to jump through hoops and follow directions and cross the T's and dot the I's, but … not everybody can do that without accommodations and assistance.

White, LGBTQ+, female licensed marriage and family therapist

Many individuals like myself who are the first in their family to attend college [are] intimidated by [licensure] processes. I had to advocate for myself a good deal and would have benefitted from [help, preferably from a Black, Indigenous or person of color] individual who understand[s] the need for extra support when you are already labeled or assumptions are made due to your name ….

Multiracial, female licensed professional counselor

It took me nearly a year to get licensed because the board does not respond in a timely manner, and sometimes not at all. I had given up hope of getting licensed until a colleague reached out on my behalf. I can imagine that for anyone who does not have a colleague to help them get through this process, it can be a bit off putting.

White, female licensed professional counselor

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[7] MHRA staff note that the applicant portal has improved self-service and that applicants who need assistance are encouraged to contact the board.

[8] Rooks, R. N., Wiltshire, J. C., Elder, K., BeLue, R., & Gary, L. C. (2012). Health information seeking and use outside of the medical encounter: Is it associated with race and ethnicity? *Social Science & Medicine, 74*(2), 176-184. http://doi.org/10.1016/j.socscimed.2011.09.040

[9] Wiltshire, J., Cronin, K., Sarto, G. E., & Brown, R. (2006). Self-advocacy during the medical encounter: Use of health information and racial/ethnic differences. *Medical Care*, *44*(2), 100-109. http://doi.org/10.1097/01.mlr.0000196975.52557.b7

F. Licensing — Participant perspectives about the initial licensing process

Processing Time

Turnaround time for processing applications and agency and/or board approvals was a frequently cited topic that is intertwined with both customer service and financial concerns.

Participants expressed that normal processing times and unexpected delays create considerable financial burdens at key junctures for early career professionals. These included:

- Initial application approval;
- Post-doctoral residency contract approval; and
- Licensure approval.

Approval of the initial application. Approval is required before professionals can begin supervised clinical practice. Many professionals mentioned that this means new graduates often have a period in which they cannot begin working in the mental health profession. In many cases, this not only impacts compensation immediately but also delays their ability to begin earning the supervised clinical hours that will allow them to become fully licensed and increase their earnings.

Application processing timing is an area where perceptions may persist that do not match the current reality. MHRA staff note that the boards are required to collect documents and complete review in accordance with Oregon rules and laws. The timing of some steps like fingerprinting or requesting that forms be sent to MHRA, are outside the agency and board control. The timing that is within the control of the agency and board, processing completed applications, is tracked and shared as a key performance indicator. In 2021 OBLPCT averaged two calendar days for processing completed license applications. OBOP averaged seven.

It is simply unacceptable to have a multi-week to multi-month turnaround on licensing requests.

White, male licensed professional counselor

I have been both frustrated as a licensee with just a turnaround time of requests to the licensing board … you get frustrated because you want answers. And I also know, having served on the board, how completely overwhelmed and understaffed the office is.

Former board member

Candidates for pre-license hand in all their paperwork and then it takes months, [during which they are] unable to work, before hearing back. Others are sometimes told they can't count months of hours because of some small technicality that wasn't communicated earlier or being a few days late on paperwork. These issues fall heavier on those who already are marginalized and have less time, resources, or emotional reserves.

LGBTQ+, female professional counselor associate

There should be a way for new graduates to quickly register and have [a] grace period to work between graduation and registration once [their licensure] application is received so they aren't missing work. The wider the gap between application and registration, the fewer folks can afford to be in the industry.

White, LGBTQ+, female licensed professional counselor

F. Licensing — Participant perspectives about the initial licensing process

Approval of a proposed postdoctoral residency supervision contract. Postdoctoral participants spoke of delays that impacted their ability to begin postdoctoral training.

Approval of full licensure after other requirements have been completed. Practitioners who have cleared the hurdles for full licensure are eager for their license. This is particularly true for registered associates who need the license to become reimbursable by insurance and unlock opportunities for increased compensation. The length of time for licensing at this stage, particularly if delays occur, was described as another financial burden.

Postdocs have a very tight turnaround time when it comes to graduating their program and trying to start a postdoc training for which they need a board approved supervision contract. Year after year, the board has been weeks if not months behind, which keeps those postdocs from being able to fully function in their role …. The response from the board typically is like, "Stop bothering us, we'll get to it when we get to it."

White, LGBTQ+, male licensed psychologist

It takes an abysmal amount of time for paperwork to be processed [by the board], so they [licensure applicants] and their employers are lost in this no man's land where they [employers] can't really say, 'Yes, you can be hired,' or, 'Yes, we can start to pay you' …. That can take months and it should be nearly automatic.

White, male licensed professional counselor

The board's delays in getting people licensed after submitting applications hurt the financial situations of potential licensees [who are] often in difficult financial places as they transition into their first licensed positions.

White, male licensed psychologist

F. Licensing — Participant perspectives about initial licensing requirements

The next section of this appendix provides analysis of participant perspectives on requirements for initial licensure.

In some cases, comments pertained both to initial licensing and renewal. Such comments are included in this section of the appendix pertaining to initial licensing. The subsequent section will address topics specific to renewal only.

Analysis of this topic is organized as follows:

- Eligible degree programs and residencies;
- Exams;
- Licensing fees;
- Disclosure of medical and mental health information;
- Background checks;
- Supervised clinical experience; and
- Licensing for professionals from outside Oregon.

F. Licensing — Participant perspectives about initial licensing requirements

Eligible Degree Programs and Residencies

Some participants cited limitations related to qualified educational programs and reliance on American Psychological Association (APA) or CACREP (Council for Accreditation of Counseling and Related Educational Programs) as factors that limit diversity in the professions.

Access to [board-approved] doctoral-level education/training which supports our license is reduced to either counselor education Ph.D. programs or Psy.D./Ph.D. in counseling, which requires on-campus attendance to qualify for APA licensure acceptance in Oregon. This then limits rural areas (some with high levels of ethnic diversity) … access to doctoral level practitioners.

American Indian, female licensed professional counselor

CACREP can be examined to see if it is inclusive [of] or hindering [the processes] of creating and cultivating diversity in counselors.

White, female licensed professional counselor

OBOP requirements for APA schools discriminate against programs that are more holistic and consistent with many diverse cultures. The APA programs [also] require the ability to move for internships which is harder for people with less resources.

LGBTQ+, non-binary licensed psychologist

Others noted that rules limit postdoctoral residency sites in ways that may be counterproductive to diversity.

Interns and residents from historically marginalized groups often have no contacts or support from other professionals …. [But] at times OBOP rules/requirements make it extremely difficult for them to find or get such [residency] settings [where they would receive that support] approved.

African American, female licensed psychologist

How the board defines postdoctoral residences and the time expectations and limitations for when you can satisfy your hour requirements … effectively limit how many sites can host a postdoctoral resident and how many sites a postdoctoral resident could potentially work at, especially sites that might serve higher need populations or sites … in more rural locations.

White, LGBTQ+, male licensed psychologist

F. Licensing — Participant perspectives about initial licensing requirements

Exams

Oregon requires standardized exams, one state and one national, for licensure. Some participants noted policy and procedure changes related to exams as positive steps. Most who mentioned exams cited them as hindering diversity, which will be discussed on subsequent pages.

Changes to exam requirements that support diversity. Some responses reflected a belief that the jurisprudence exam still requires travel to Portland or Salem and spoke strongly about this as a barrier to diversity and inclusion. Professionals who knew the jurisprudence exam could be taken online spoke of this change as helpful in eliminating a barrier.

Some cited the flexibility to take the exam before they have completed their supervised hours as a positive change.

Moving the jurisprudence exam to an online format supports the inclusion of those [for] who it would be a financial barrier to have to travel to Salem to take the exam.

White, female licensed psychologist

In the past, a therapist had to wait to take their licensing exam until they accrued their supervised hours. That is now changed, which I think is very helpful.

White, male licensed professional counselor

F. Licensing — Participant perspectives about initial licensing requirements

Exams as a hinderance to diversity. Participants frequently described problematic aspects of standardized exams required for licensure. These included:

- Incomplete and inadequate assessments of competence and value as a practitioner;
- Accessibility for practitioners for whom English is a second language and for persons with disabilities; and
- Bias in exams (addressed separately on the next page).

The qualifying exam to attain licensure is a joke and doesn't actually demonstrate one's ability to be a good mental health professional. It is not oriented very much at all to diverse professionals and is extremely Eurocentric.

Non-binary licensed professional counselor

The [licensure] testing does not create a way to demonstrate lived experience as a valuable resource and knowing.

Hispanic American, female mental health professional

I understand the importance of trying to make sure that there's a particular knowledge standard of people that are coming in, but I would love to envision a different kind of exam. I'm still confused about what I was tested on or what that was supposed to be measuring. I did not find that to be an adequate way of measuring my knowledge.

White, LGBTQ+, non-binary professional counselor associate

Licensing exams are English based and generally hard to understand even if English is a first language.

White, female licensed psychologist

Is there any extra support [for the licensure exam] in a specific language? …. Even to apply for a reasonable accommodation for a test, you have to know that you need to go through that process.

Hispanic American, female mental health professional

I supervise a disabled resident who has had a hell of a time just getting testing accommodations.

Asian American/Pacific Islander, female licensed psychologist

F. Licensing — Participant perspectives about initial licensing requirements

Exam bias. As discussed in Appendix A, evidence from related fields and for other standardized exams suggests cause for caution about validity and bias in credentialing exams. Participant comments reflected awareness of concerns about bias in standardized state and national exams generally as a cause for concern about the credentialing exams used in Oregon. In some cases, they specifically referenced evidence of race and gender bias in the national exam required for psychologists, the Examination for Professional Practice in Psychology (EPPP).[10]

Despite evidence suggesting the EPPP disproportionately impacts students of color, Oregon continues to implement difficult guidelines [e.g., the number of attempts allowed and waiting periods].

White, LGBTQ+, female licensed psychologist

I thought taking the EPPP test was a nightmare. I am a first generation, bilingual professional with a Ph.D. I felt that test had no bearing on my ability to be a good and ethical psychologist.

Asian American/Pacific Islander, female licensed psychologist

We've proven time and time again that standardized tests are discriminatory. [As] a person of color that automatically makes me like your state less ….

Asian American/Pacific Islander, female licensed professional counselor

[10]Sharpless, B. A. (2019). Are demographic variables associated with performance on the Examination for Professional Practice in Psychology (EPPP)? *The Journal of Psychology*, *153*(2), 161–172. https://doi.org/10.1080/00223980.2018.1504739

F. Licensing — Participant perspectives about initial licensing requirements

Licensing Fees

Professionals frequently mentioned licensing fees.

In some cases, participants cited instances of graduates who opted not to pursue licensure because they could not afford it. Participants frequently described even modest fees as a hardship and contextualized their impact as coming at a financially vulnerable time.

I have worked with staff members in my role where they're like, 'I'm not gonna go for a license because it costs too much money.'

Biracial, female licensed professional counselor

The astronomical cost of licensure leads to people seeking to practice for fees in ways that are counseling-adjacent and less regulated (e.g., life coaching, holistic wellness guidance, parent coaching), which is ethically questionable and leaves consumers vulnerable [because there is] no board to protect their rights.

White, LGBTQ+, female licensed professional counselor

As [a] first generation child of immigrants, I could not rely on much financial support from my parents [when I was] in graduate school and, once graduated, [when I was] getting ready to attain my license. It therefore was a great financial burden to pay for licensing and application fees.

Hispanic American, female licensed psychologist

… spending two years in school, then six months in an internship without monetary compensation make it challenging to afford even a small [application] fee. This is a major issue and huge barrier to entry into the field.

White, female professional counselor applicant

Financially, it is very discouraging to pay for fees. For [interns or] clinicians with financial constraints, this can mean choosing between paying for something basic such as a month's electric bill [and] transportations costs or paying licensing fees.

LGBTQ+, female licensed professional counselor with a disability

While my program did a good job [outlining] the steps needed to get licensed, when coming from a low-income background, it is quite difficult to afford some of the fees associated with attaining licensure.

Hispanic American, female mental health associate

F. Licensing — Participant perspectives about initial licensing requirements

Disclosure of Medical and Mental Health Conditions

Some participants expressed concern about considerations of medical and mental health conditions in the application process.[11] In some cases, they noted that there is no information about how the information they declare will be considered or whether it may be used against them if they disclose it.

Professionals expressed particular concern about how this question may affect practitioners with disabilities or those seeking mental health care services for personal issues. Some comments specifically noted that the current question without additional information can give the impression that ableism may negatively impact practitioners in the application process or other interactions with MHRA, OBOP and OBLPCT.

For therapists who identify as neurodivergent or having overcome a mental health condition, there is a space on the code of ethics we have to check stating we don't have any mental or emotional impairment that might impact our ability to provide mental therapy services.

White, female licensed professional counselor with a disability

They asked for a disclosure of whether or not you have any medical conditions that would impair your ability to do your job without appropriate treatment, which I found incredibly awful.

White, female licensed professional counselor with a disability

Questions about medical or mental health conditions impacting ability to perform the duties of a counselor are part of the licensure process. There's no disclosure of how this information is used, how it may be used against you, and why this is a relevant question. This will inherently lead to greater stigma against disabled counselors and those of us struggling with mental health concerns. This also leads to concern about ableism in potential disciplinary experiences [and] public disclosure of private information from counselors.

White, female licensed professional counselor with a disability

The clause about mental/physical impairment being a reportable cause to investigate a registered associate does not account for disability, physical experiences of intergenerational trauma, culturally different values around work/health balance, etc. Punishing and possibly barring a marginalized clinician due to health impairments does not fully capture historical experiences of trauma and oppression.

White, LGBTQ+ licensed professional counselor

[11] The license application and renewal processes ask about "any condition that in any way impairs or may impair your capacity to perform the duties" of the role "with reasonable skill and safety."

F. Licensing — Participant perspectives about initial licensing requirements

Background Checks

Interviews with MHRA contacts and former board members conveyed a sense of due diligence combined with an orientation toward finding ways to admit applicants to the profession. MHRA, OBOP and OBLPCT recently modified questions associated with criminal records in the application process to arrests only within the past six months.[12]

MHRA staff indicated that no crime automatically disqualifies an applicant. Staff note that person-on person crimes involving physical harm would be scrutinized more closely. Former board members who participated in interviews mentioned that believing in rehabilitation is part of what it means to be a counselor, therapist or psychologist and described that philosophy as one that guides decisions about issues arising from background checks.

While MHRA, OBOP and OBLPCT may take a rehabilitative perspective on background check issues, many practitioners are not aware of this or fear otherwise. Some expressed concerns about being required to disclose information that was dismissed or expunged by the criminal justice system.[13]

[The] criminal background check process [hinders diversity]. Sanctions or discipline against people with arrest records or cases [that were] thrown out [also negatively impacts diversity].

African American, female licensed professional counselor

A charge that was dropped from 20 years ago was brought up in the background check …. The process following [that] cost a lot of money and scrutiny of my character from over 20 years ago! Someone who has made changes, especially in the mental health field, should [not have] been kept in a box in that way.

Biracial, female professional counselor associate

If someone went through the set aside process and the legal bodies within the criminal justice system deemed the individual appropriately rehabilitated and eligible to have their record expunged, then requiring them to dredge up their past (which is likely retraumatizing for them as well) is a direct contradiction to public policy. If the court deems them as posing no risk to others or themselves and has sealed their records, OBLPCT should not use that information to inform their application decision. It's not ethical.

White, female professional counselor applicant

I disclosed [my expunged criminal record] …. They chose to hold up my application because of concerns over my competency and eligibility for this profession …. That was incredibly traumatizing for me to have to go over [something in my past that was] due to assumptions about me as a person, with [the board members] not knowing me … [I was] doing everything I was asked to do by the letter of the law to become rehabilitated.

White, female professional counselor associate

[12] The renewal process requires disclosure of any arrests since the last application or renewal.

[13] MHRA staff note that requiring disclosure of all offenses, including dismissed and expunged, sidesteps pitfalls of accurate memory or confusion about offenses believed to be expunged that were not. Review of expunged offenses is completed by the Executive Director rather than the board to prevent delays.

F. Licensing — Participant perspectives about initial licensing requirements

Clinicians with criminal records or substance abuse histories. Participants also explained that the way MHRA and the boards require and evaluate past information about criminal records may deter potential practitioners whose past experiences with the criminal justice system or substance use addictions may be beneficial to clients.

Perceptions about agency and board treatment of criminal history may not match current reality. MHRA staff note that the boards review criminal history information but rarely act on it.

Working class and BIPOC individuals who have previously engaged in criminal acts but are now in recovery are largely barred from obtaining state licenses or working in state-funded programs. Ironically, these individuals are often the most effective therapists in working with criminal justice and addictions clients.

White, male licensed professional counselor

I'm coming from the drug and alcohol world, where we want people with lived experience [providing counseling]. That lived experience might include a criminal background. On the one hand, I understand protecting vulnerable populations. But on the other hand, we do better when we have people with lived experience, whatever that lived experience looks like.

Multiracial, female licensed professional counselor

F. Licensing — Participant perspectives about initial licensing requirements

Supervised Clinical Experience

Participants frequently described Oregon's requirement for supervised clinical experience as a barrier to diversity. Comments on this page illustrate concerns about the number of hours. Subsequent pages address the cost of supervision and synthesize other factors many of which are also intertwined with financial concerns. [14] [15]

The high number of supervised hours required for associates, [as well as] the lack of specific criteria for supervisors who can oversee the quality of supervision for associates, [both hinder diversity].

Asian American/Pacific Islander, female licensed professional counselor

[The boards should] change licensure requirements to 1,200 [hours of supervision] so more therapists will enter into this field and stay.

White, female professional counselor associate

[14] Some participants may not have been aware of recent legislation that requires employers to pay supervision costs, ORS 675.661, or some employers may not be covering costs. Oregon statute that requires employers to cover the costs of supervision is silent on whether they must do so if they do not have supervisors on staff or if registered associates opt to receive supervision outside of their employer. The statute is also silent on enforcement authority, so no regulatory body is monitoring and taking action on non-compliance.

[15] MHRA requested additional analysis of the supervised clinical experience requirement in October 2022, which is included for convenience, following the appendices to this report.

F. Licensing — Participant perspectives about initial licensing requirements

Supervised clinical experience hours as a barrier to practice in Oregon. We note that the clinical experience requirement topic is intertwined with comments about financial barriers. Participants may value supervision as a source of support and learning as they enter a challenging field. However, the requirement delays their ability to be reimbursable by private insurers, impacts their compensation negatively and creates a sizable out-of-pocket cost for many professionals.

In some interviews and focus groups when participants suggested lowering the requirement, study team members asked them to clarify the reason. In cases where this topic was probed more deeply, participants said the issue was financial, not the value of or need for the supervision as a source of training or support. The view that clinical supervision can be an important source of support for clinicians, including those from marginalized backgrounds or working with clients from marginalized backgrounds was also clear in comments included in Appendix E.

I think that the price of supervision is (a hinderance) … the supervision (itself) is very helpful, depending on … the cost. Personally, I like supervision, but it is expensive.

White, LGBTQ+, non-binary professional counselor associate

I think training [and supervised clinical experience] is great. Where it falls short is the compensation piece. Train me like crazy, and please pay me for my time …. We should be supervised until we retire.

White, male, out-of-state professional counselor intern

… those two years of training post postgraduation are vital. They really are their formative and developmental years [so] the students or the new graduates still need that that very close eye of the supervisor to guide them and their confidence level, is not there …. I don't even think the students and new graduates are really worried about the hours, because there's an understanding that you need that training … there's only so much we can teach in three years.

African American mental health professional and educator

The supervision structure is too rigid and relies on [the assumption that] people have steady streams of discretionary income ….

LGBTQ+, female licensed marriage and family therapist

[There is] no path for submittable hours other than 'qualified supervision' which, if not adequately provided in an agency setting, costs $100-400 OOP (out of pocket) per month.

White, LGBTQ+, non-binary licensed professional counselor

F. Licensing — Participant perspectives about initial licensing requirements

Duration to accrue supervised clinical experience hours. As discussed in Appendix E, prior to licensure, registered associates are not reimbursable by private insurance. Those working in private practices are typically on a fee-for-service model and may have difficulty attaining direct client service hours. This occurs while many may be paying out-of-pocket for clinical supervision.[16] Some may find it difficult to meet the required number hours and work toward it over a prolonged period.

Lower supervision requirements 'next door.' Some participants pointed out that Washington state may draw clinicians away from Oregon because it requires half the clinical experience hours Oregon does.

The time between education and licensure is extremely long. For those without [financial resources], this time of paying a clinical supervisor without being able to collect on insurance creates a disadvantage economically.

LGBTQ+, male licensed professional counselor

It took me nearly seven years to complete my [supervised] hours ….

Biracial, female professional counselor associate

Oregon's requirement of 2,400 direct client contact hours makes it much more difficult for individuals to become licensed here than in other states. It makes a lot more sense for a new grad making low wages to go to Washington, where only 1,200 [supervised] hours are required for full licensure.

Non-binary professional counselor associate

It's a long process to attain your license in Oregon and that's why a lot of interns choose to go to Washington to get their hours because they will get licensed faster. I have several friends who graduated with me who already have their license (and have had [it] for seven months) in Washington and I am still five months out from mine.

Biracial, LGBTQ+, female professional counselor associate

[16] As noted previously, some participants may not have been aware of recent legislation that requires employers to pay supervision costs, ORS 675.661, or some employers may not be covering costs. Oregon statute that requires employers to cover the costs of supervision is silent on whether they must do so if they do not have supervisors on staff or if registered associates opt to receive supervision outside of their employer. The statute is also silent on enforcement authority, so no regulatory body is monitoring and taking action on non-compliance.

F. Licensing — Participant perspectives about initial licensing requirements

Ineligibility of hours supervised by clinicians in closely related professions. Some participants cited the inadmissibility of clinically supervised experience hours in social work as a barrier. Some also noted that hours supervised by clinical supervisors who are licensed in social work are ineligible. [17]

Lack of reciprocity [is a barrier] for those of us who are dually trained as counselors and social worker[s]. [Give] some credit for our years of experience ….

Multiracial, LGBTQ+ licensed professional counselor

Not allowing … counselors to count their agency supervisor's hours if they are LCSWs [harms diversity]. This puts a huge hardship on new professionals who are often working in agencies and serving the most needy clients.

White, female licensed professional counselor

[17] This reflects a misperception of current practice. MHRA reports 210 of 1,810 supervision plans had an LCSW as the board approved primary supervisor as of September 2022.

F. Licensing — Participant perspectives about initial licensing requirements

Other challenges related supervised clinical experience. Participants described other ways the clinical supervision requirement may hinder diversity including:

- Ineligibility of experience and supervision by professionals in closely related fields;
- Inequitable requirements for professionals who serve couples and families; and
- Vulnerability of hours based on factors beyond the clinician's control.

The OARs [Oregon Administrative Rules] are set up for people who are going into community mental health … But ignore those of us who work as BHCs [behavioral health consultants] …. We see patients for 15 to 30 minutes normally. [We] can only count that as half an hour [of direct contact hours] because that's our direct patient time, but we spend so much time consulting with the other providers. [There's] so much work in the background that we can't get credit for.

Multiracial, female licensed professional counselor

The MFT licensure requirements are completely inequitable compared to LPC licensure requirements. … MFTs [must] obtain 1,000 relational hours. LPCs do not have to obtain a specific number of relational hours and are still considered competent to treat couples, which begs the question of why the relational hour requirement is so high for MFTs at all.

Biracial marriage and family therapist associate

I have a colleague who's a clinician of color. [He] found out after his six-month report that his supervisor's license had actually lapsed, so he lost almost 500 hours.[18] That's not okay. That should have been caught and that should not have been on my colleague to be watching what his supervisor was doing.

Biracial, LGBTQ+, non-binary mental health professional

[18] MHRA confirms that clinical supervisors letting licensure lapse while actively supervising associates will disqualify hours for associates under their supervision. This has happened and resulted in sanctions on the supervisors at fault.

F. Licensing — Participant perspectives about initial licensing requirements

Licensing for Professionals from Outside Oregon

Practitioners discussed the challenges facing professionals who move to the state but were originally licensed outside of Oregon. Themes on this subject included:

- Ineligibility of previously completed requirements or requirements fulfilled with only minor differences;
- Substantial prior experience in other jurisdictions being inadequate in Oregon;
- Interest in smoother cross-jurisdiction work including Oregon's participation in interstate compacts; and
- Out of state supervisors

These topics are described on subsequent pages.

F. Licensing — Participant perspectives about initial licensing requirements

Ineligibility of previous qualifications. Participants described the inadmissibility of previously completed requirements in other jurisdictions such as exams. They also noted inflexibility of minor differences. The desire for flexibility about minor differences in requirements is intertwined with the wish for years of experience in other jurisdictions to receive greater weight in the licensing process as discussed on the next page. [19]

As a [bilingual professional] with 12 years of clinical experience outside [the] US and seven years in the US, the barriers [have] been enormous …. All the clinical direct contact hours [I've accrued] weren't counted toward my license [and] countless ones I provided in my country of origin as a psychologist are LOST.[20]

Hispanic American, female professional counselor associate

Upon moving to Oregon, [I was] already licensed in another more racially and culturally diverse state with a notoriously rigorous licensure process …. Jumping [through] the board's hoops [in Oregon] was a costly and poor use of my time. I am very vocal with my licensed out-of-state queer and BIPOC colleagues not to move here [because of this].

Multiracial, LGBTQ+, male licensed professional counselor

Anyone coming from another state must take a national exam again.[21]

White, female licensed marriage and family therapist

We're bringing on someone who's been licensed for 12 years in [a different state] … [in] the first four months [of her residency there], her supervisor had only been licensed for one year, eight months instead of the two years [Oregon requires] … [The board is] not going to accept her training. She has to do a postdoc again in Oregon.[22]

Middle Eastern, female licensed psychologist

It's odd to me that I can serve clients in California, which is [a state with an] incredibly rigorous process to be a marriage and family therapist, and then move here and be told … I [cannot] be a marriage and family therapist right away.

Biracial, LGBTQ+, male licensed professional counselor

[19] MHRA staff note that participant comments in this section misstate board agency and board policies and practices in a number of ways. We note discrepancies to help illustrate the challenge professionals have in understanding board practices and the challenge MHRA and the boards have in being understood by professionals.

[20] MHRA staff note that the boards accept hours accrued in other countries that otherwise meet requirements.

[21] Exam retake is required after ten years or can be waived with a continuing education alternative requirement. MHRA staff report that most professionals relocating from another jurisdiction meet the CE alternative because CE would have been required to maintain their license in another jurisdiction.

[22] MHRA notes that most applicants in this situation provide post licensure supervised experience to remedy a gap rather than repeating a postdoc.

F. Licensing — Participant perspectives about initial licensing requirements

Credit for prior experience. Participants described the lack of credit for years of experience in other jurisdictions as a hinderance to pursuing licensure in Oregon.

The lack of any means to transfer licensure from another state, even for a practitioner with decades of experience and a Ph.D. in the field [hinders diversity].

White, female licensed professional counselor

There is the issue of how many professionals come trained from other states or countries, have years of experience, but because of certain regulations they cannot become licensed [and] cannot become part of the workforce [in Oregon] …. They may have done 20-30 years of [work already] … but they're not doing it [in Oregon] because they're not gonna be able to [get a] license.

Hispanic American, female mental health professional

[A] long time ago, even getting licensed as a teacher in this state, it was exclusionary [to those coming from out of state]. It was like, 'No, no. You can be licensed, in 35 other states, but not Oregon.' That tone has [also been] the case with OBLPTC.

White, male licensed professional counselor

F. Licensing — Participant perspectives about initial licensing requirements

Interstate compacts. Participants often described MHRA, OBOP and OBLPCT's lack of support for interstate compacts that honor licenses obtained in each other's jurisdictions as a barrier to diversity.[23]

If you want more people to be able to access [diverse mental health care in] your state, why are you not joining the counseling compact?

Asian American/Pacific Islander, female licensed professional counselor

[Oregon is harming diversity through its] lack of participation in PsyPACT (Psychology Interjurisdictional Compact).

White, LGBTQ+, female licensed psychologist

It would be extremely beneficial for the [boards] to work towards reciprocity between states. It was great to see the action taken in the COVID pandemic state of emergency but there is no reason why it couldn't be worked towards and achieved now.

White, LGBTQ+, female professional counselor associate

[23] MHRA staff report that the boards have looked into compacts but participation would be prohibited under the Oregon constitution.

F. Licensing — Participant perspectives about initial licensing requirements

Out-of-state supervisors. Participants described the handling of professionals licensed outside of Oregon as a barrier not only to diversity of mental health providers in Oregon but also as a barrier to diversity in clinical supervision.

MHRA staff note that starting in 2020 virtual supervision is allowed, so supervisors do not have to be physically in Oregon. However, by statute, supervisors must be licensed in Oregon.

Things like an interstate compact would be really helpful for more diversity, especially in supervision … practitioners are formed by supervisors …. as a as a therapist and a counselor educator of color, one of the reasons I became a counselor educator was to … bring in and mentor and encourage therapists and counselors of color right? If there's that opportunity to be able to do that [across] borders, I know many therapists of color would choose to … because we know our struggle so to speak ….

African American, female mental health professional

You can do supervision online. For instance, I have all of my same supervisees [from when I lived in Oregon] even though I live in [a different state now]. [I] maintain my Oregon practice and my Oregon license so those supervisees can get 100 percent of their supervision online.

White, female licensed marriage and family therapist

Allowing for supervisors from out of state to supervise candidates would be huge. There are less than a handful of black supervisors and I already have pre-existing relationships with most of them, which automatically eliminates my access to culturally specific supervision.

Biracial, LGBTQ+ mental health professional

F. Licensing — Participant perspectives about renewing licensure

The final section of this appendix presents synthesis of comments pertaining to maintaining and renewing licenses.

As noted in the prior sections about initial licensing and initial licensing requirements, comments that pertained to both attaining and renewing licenses were addressed with initial licensing. Therefore, this section will focus on topics specific to renewal only.

Analysis of this topic is organized as follows:

- Renewal costs;
- Renewal frequency;
- Renewal process and service;
- Renewal requirement enforcement;
- License status options; and
- Continuing education.

F. Licensing — Participant perspectives about renewing licensure

Renewal Costs

Participants cited cost most frequently among renewal related topics that may hinder diversity in the mental health professions.

First-time renewals. Some practitioners noted a lack of awareness that their renewal date and fee would fall in their birth month following initial licensure. When birthdays were close to initial licensure dates, the renewal fee coming on the heels of initial licensing was cited as a burden.

Both boards offer a free grace period after the initial licensure date, which may range from one to 13 months depending on the proximity of the licensure date to the birth month. [24] Information about this policy is not readily evident on either board website. Participants may object to the policy as is because it does not equally benefit all professionals, or they may be objecting to not having been able to make an informed decision about timing their licensure to achieve a more generous grace period.

My license expires in October, within the same year of me obtaining it. I am self-employed and it takes [financial] resources to keep licenses active. I am a single black woman and those resources don't come easily to me. I will have to make sacrifices to keep my license current so that I can operate my business … I wish I had known prior to obtaining licensure just so I could have time to be more prepared.

African American, female licensed professional counselor

Let's say I'm a postdoc [with a November birthday] …. I just spent $1,500 on my prep material. I take the test and I get licensed in September …. The renewal is based on birthday, so I could get licensed in September, pay 500 bucks and [still] have to renew two months later for [another] 500 bucks.

White, LGBTQ+, male licensed psychologist

[24] Renewal fees are paid to cover licensure for the 12 months following the licensees birth month. Both boards offer a grace period of free licensure after initial licensure that lasts until the first renewal in the birth month of the licensee. Practitioners who are initially licensed in their birth month receive the most generous grace period, about 13 months if their birthdate is late in the month. Their renewal will be due at the end of their birth month the following year. Practitioners who are initially licensed late in the month prior to their birth month receive the least generous grace period, about one month of licensure free before their first renewal is due. According to MHRA staff, most other boards prorate the charge for the time period that OBOP and OBLPCT currently offer without charge.

F. Licensing — Participant perspectives about renewing licensure

Psychologists. As noted in appendix A, renewal fees in Oregon for psychologists are substantially higher than initial licensing fees and are about twice the average of the 50 jurisdictions reported by the Association of State and Provincial Psychology Boards in 2021.[25]

MHRA staff note that psychology renewal fees are affected by policies that differ from those pertaining to counselors and therapists. MHRA and board budgets receive no taxpayer, lottery or grant funds; they are completely funded by licensing-related fees.[26] By statute, OBLPCT can assess disciplinary costs when issuing action for violations. OBOP cannot. Those costs are funded by psychology fees. In addition, OBLPCT cannot take disciplinary action for unlicensed practice on someone who does not meet the education requirements to be a counselor or therapist ("the education loophole"), but OBOP can. Unlicensed practice violations are referred from OBLPCT to OBOP for investigation and action, further impacting psychology fees.[27]

Extras and increasing costs. Some professionals cited a variety of smaller fees they believe add up, particularly on top of a renewal fee they view as high. Some clinicians also noted that costs keep increasing.

I and other BIPOC therapists make a lot of financial sacrifices to serve BIPOC clients, yet our state licensing fees are nearly twice that of Washington and California.

Asian American/Pacific Islander, female licensed psychologist

Eight hundred bucks is a lot, especially to come up with in one year.

White, female psychologist

It used to be [that] you always got a wall certificate with your renewal. Now, they just send a little wallet card …. That [was] rejected somewhere. [They were] like, 'That's not a real license. You have to pay for that wall license.' I mean, the fees are exorbitant.[28]

Asian American/Pacific Islander, female licensed psychologist

The amount of money people have to spend … to remain licensed, renew their licenses and keep their license in good name continues to rise and is going to impact therapists and counselors who are undervalued and underpaid already — but this will especially have an adverse effect on people from marginalized backgrounds.

Multiracial licensed professional counselor

[25] The Centre for Data and Analysis on Psychology Licensure. (2021). *ASPPB InFocus 2021* (Rep.). The Association of State & Provincial Psychology Boards. https://asppbcentre.org/

[26] A small portion of the budget comes from civil penalties assessed by the boards in disciplinary actions.

[27] MHRA has supported legislation to close OBLPCT's education loophole and allow OBOP to assess disciplinary costs.

[28] BOP sends a free wall certificate upon initial licensure. Replacement certificates are currently $12. Perceptions of various fees on top of renewal may be more about the cumulative impact or the feeling of being "nickeled and dimed."

F. Licensing — Participant perspectives about renewing licensure

Renewal Frequency

The annual renewal requirement was described as hinderance for counselors and therapists. This topic was closely linked to the financial burden of renewal fees. MHRA and OBLPCT have identified annual renewal, required by statute, as problematic and have introduced a legislative concept for 2023 that if passed will allow two-year renewals for counselors and therapists.

Psychologists, who renew every two years, rarely mentioned frequency of renewal as an issue.

… annual renewal should be looked at. It should be [valid for] at least two years given [that] people [are struggling with] the ability to pay.

LGBTQ+, non-binary licensed professional counselor of color

My other state of licensure requires renewal every 3 years, which is much more reasonable [than annual renewal].

White, LGBTQ+, female licensed professional counselor

The requirements to renew every year, not every two or three years, is a financial burden on marginalized community professionals who don't earn as much as mainstream professionals.

White, LGBTQ+ licensed professional counselor

F. Licensing — Participant perspectives about renewing licensure

Renewal Process and Service

Participants discussed their experiences with renewals including the process, service and support mentioning some positive aspects as well as potential hinderances to diversity.

Online renewal process and system. Participants sometimes spoke of online renewals as a positive. Some pointed out that requiring access to the internet in order to renew may be counterproductive to diversity.

They've switched to more of the renewal stuff being electronic, where you're not even having to see each other face-to-face and think about demographic backgrounds. [That] really eliminates a lot of problems.

Biracial, male professional counselor associate

Now that the portal exists, [license renewal] is more manageable.

African American, female licensed professional counselor

You have to have access to the internet to renew licenses. Some of our rural areas still do not have either cell or internet. That make[s] it really difficult to renew licensing.

Multiracial, female licensed professional counselor

F. Licensing — Participant perspectives about renewing licensure

Service. The initial licensing sections of this appendix included analysis of general customer service issues which cut across initial licensing and renewals. A positive comment that references renewal specifically is included here. Negative comments pertained to renewal reminders. Participants sometimes perceive that the boards are not sending renewals. [29] Some mentioned processing time, a topic also addressed with initial licensing.

The renewal process is fairly straightforward, and the board is responsive to emails and phone calls.

Female licensed professional counselor with a disability

I know people who submitted renewals … in advance and due to the OBOP's processing times their licenses lapsed even though the check cleared many weeks prior

White, female psychologist resident

The OBLPCT used to send reminders for renewal of licenses, then without any notice stopped sending them. [I was] lucky to have caught the renewal before it was too late. A notice in change of protocol would have been good.

Female licensed professional counselor with a disability

[29] Both boards send four renewal emails to professionals with valid email addresses on record.

F. Licensing — Participant perspectives about renewing licensure

Renewal Requirement Enforcement

Participants described strict enforcement of renewal requirements as a possible hinderance to diversity.

Minor mistakes in licensure renewal can result in costly and time-consuming efforts. Mistakes may happen with new professionals from marginalized communities [so strictness can harm them].

African American, female licensed psychologist

[A minority practitioner] recently had a renewal come up. [He] contacted the board two days late …. [He] was told that they would not be meeting to review license renewals again for two months, he would have to wait and would be ineligible to practice psychology for those two months ….. He literally had to take two months off work because there was no room [for flexibility].[30]

White, male licensed psychologist

I submitted my hours less than a month late …. None of those count now. That entire six months [of work]? Flushed.

Biracial, male licensed professional counselor

[30] MHRA and the boards permit late renewal within the thirty-day grace period following expiration. No board review is required. This comment may refer to board review that is required when licenses lapse but practitioners continue practicing, unlicensed practice by statute, which does require board review.

F. Licensing — Participant perspectives about renewing licensure

License Status Options

Some respondents noted the absence of license status options in psychology that would better support parental leaves and part-time status while some professionals juggle family or personal obligations.

While there is a semi-active license structure and fee reduction for elderly colleagues, no such thing exists for women working part-time to support their families. This feels like a form of subtle discrimination.

Licensed psychologist

There is no adequate license option for single or working [parents]. I am in private practice and planning to take a six-month maternity leave. There is no option for me to [pause] my license during that time and not pay the license fee during a time I will not actively be seeing clients.

Female licensed psychologist with a disability

F. Licensing — Participant perspectives about renewing licensure

Continuing Education Requirements

Participants also cited continuing education (CE) requirements as both supporting and hindering diversity.

Continuing education requirements as supportive to diversity. Some participants cited the cultural competency continuing education requirement somewhat positively as it relates to diversity.

There's a lot of emphasis on continuing education [that focuses] on cultural reflectiveness.

Asian American/Pacific Islander, female mental health professional

They're not equitable in any way [at the board], with the one tiny exception: they require a certain number of CEUs in the area of diversity, equity and inclusion. If that makes them equitable, which it doesn't in my mind, then they're equitable. But it feels like crumbs.

Licensed professional counselor

F. Licensing — Participant perspectives about renewing licensure

Continuing education requirements as a barrier for some professionals. Participants described continuing education requirements as a potential barrier, especially for rural practitioners or professionals with disabilities or neurodiversity.

The in-person CE requirement puts a terrible burden on rural professionals. I can't drive six hours, stay in a hotel for a night just to get six hours of in person CEs. It's criminal.[31]

Hispanic American, female licensed psychologist

OBOP rigidly prescribes how a person must obtain continuing education credits …. For example, professionals that are neurodivergent may learn best by reading, but OBOP only allows four hours of reading for CE.[32]

White, female licensed psychologist with a disability

[31] This comment may reflect a misunderstanding or outdated expectation. CE credits do not require in person attendance.

[32] OBOP allows 20 credits for home study, which includes up to four hours of self-directed reading of books or journal articles.

F. Licensing — Participant perspectives about renewing licensure

Number and variety of CE requirements. Some participants described the hours and variety of CEs required by topic as onerous and a potential hinderance to diversity. Certain required CE topics are not useful to some practitioners. Prior to legislated changes, ethics was the only topic required by the boards. Legislation now mandates pain management, suicide risk assessment and cultural competency credits.[33]

Monitoring and CE compliance enforcement. Practitioners described CE requirement enforcement as potentially counterproductive to diversity, equity and inclusion.

Comments reflect that some participants perceive the boards as taking action on CE non-compliance that are not aligned with current reality. Civil penalty disciplinary action for CE violations are not reported to the National Practitioner Databank and not published in the board newsletters or licensee lookup. OBOP put the CE sanction schedule into rule for consistency and transparency in 2015.[34]

MHRA staff note that the boards shared information about the new CE requirement in multiple emails, newsletters and on the website. Comments about lack of communication about CE requirements reflect the challenge MHRA and the board face in communicating the volume and complexity of information they have in ways that professionals can access and absorb.

There are so many CE requirements (pain management, suicide, ethics, cultural competency) that it feels rather onerous.

White, female licensed psychologist

Stop making the pain management CEs the only specific topic that you require psychologists to get specialty focus on. That CE has literally helped me in zero ways in my career.

Hispanic American, female licensed psychologist

The board recently enacted a penalty if you don't renew your CEs in a particular way [and] in a particular [amount of] time. There has always been a penalty for that, but the new ruling per my understanding is that in addition to getting a fine and having your name on the shame email, there's also an unprofessional conduct charge levied against you. It seems like kind of a double whammy.

Biracial, female licensed psychologist

Due to the lack of communication around adding the new CE requirements, the process felt top-down heavy and not in-line with a [diversity, equity, inclusion and belonging] approach. The micromanaging of CEs also may reflect the lack of trust the board has in its members, which does not go unnoticed ….

Female licensed psychologist of color

[33] House Bill 2078, Oregon Legislature § 2 (2021). https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2078
Senate Bill 885, Oregon Legislature (2001). https://www.oregonlegislature.gov/bills_laws/archivebills/2001_BESB885.pdf
House Bill 2315, Oregon Legislature (2021). https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB231

[34] Oregon OAR § 858-040-0070 (6)-(7) (2021). https://oregon.public.law/rules/oar_858-040-0070

F. Licensing — Participant perspectives about renewing licensure

Restrictions around eligible continuing education. Some practitioners reported that valuable education opportunities related to cultural competency, diversity, equity or inclusion may not be eligible for CE credit.

Many anti-racism trainings may not meet criteria for [the required cultural competency] CEs.

White, LGBTQ+, female licensed professional counselor

I've been on many trainings from formal CE providers and non-formal CE providers, and often those who do not belong to formal CE network[s] provide much deeper learning experiences.

White, female licensed professional counselor

F. Licensing — Participant perspectives about renewing licensure

Negative aspects of the cultural competency requirement. Professionals also spoke about ways the cultural competency CE requirement may be inadequate or counterproductive.

Some participants described the requirement as too broad or too narrow to be effective. Others suggested ideas that might have a greater impact on the ability of clinicians to provide culturally competent care.

Requirements for renewal CEUs [continuing education units] are often too broad and nonspecific when it comes to diversity. [The specific] culture [being focused on] should be spelled out more and [be] specific to [supporting the] workforce.

American Indian licensed professional counselor

There should be greater requirements for cultural CEUs, including culturally connected ethics units.

White, female licensed marriage and family therapist

Requirements for cultural diversity training and suicide prevention help keep counselors in the industry informed, but they do not help promote new research and information, relying on the same trainings year after year which results in stagnation.

Female licensed professional counselor

If you're not a native speaker [of a language you conduct therapy in], maybe you should have [to take] a class [on how to professionally translate], but that should be [counted as] part of your CEUs.

Hispanic American, female licensed marriage and family therapist

We need … CEs on bias, privilege, systemic racism and homophobia.

White, female licensed marriage and family therapist

Even though in renewing [a] license, you must have many hours of cultural competency, everything else in between is basically chosen [by] that person based on their interest[s] …. People will take clients on with these issues [related to diverse identities] and not know how to deal with them because they don't take any further education [on those topics].

Multiracial, non-binary licensed professional counselor

F. Licensing — Participant perspectives about renewing licensure

Impact or utility of the cultural competency for professionals from marginalized backgrounds. Some professionals of color and LGBTQ+ practitioners described their experiences with the requirement as unhelpful or insensitive.[35]

… we're all supposed to say we did three hours of cultural competency, but my cultural competency is different than somebody else's cultural competency.

African American, female licensed professional counselor

I would hope that the board understood that professionals of color may not feel comfortable paying for trainings lead by white professionals, [which is] still the majority of trainings.

Multiracial, female licensed marriage and family therapist

The need for cultural competence is helpful but often times some of the CEs offered can also feel off-putting, or even offensive, and to keep a current and active license, you have to go anyway.

LGBTQ+, female licensed professional counselor

We need to take a look at [the] cultural competency [requirement] …. [The primary goal] has always been to educate white people on the issues of diversity, equity and inclusion, which puts the burden as educators on our BIPOC community members to do this.

Biracial, female licensed professional counselor

Some of the continuing education interests of marginalized professionals are hard to find and don't fit neatly into the requirements of the board.

African American, female licensed psychologist

[Licensees must] have four hours of diversity related training, but in my experience all the trainings are geared toward white people learning how to work with people of color. There are no trainings … that are [for example], 'Here's a space for people of color to learn how to navigate majority spaces.'

Hispanic American, male mental health professional

[35] Oregon Health Authority reviews and approves cultural competency continuing education trainings.

APPENDIX G. Complaints and Investigations

This appendix synthesizes feedback from mental health professionals about how the handling of complaints and investigations might impact diversity and equity in Oregon's professional counselor, marriage and family therapy and psychologist professions.

Practitioners licensed and regulated by the Oregon Mental Health Regulatory Agency (MHRA), the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) provided input via interviews, focus groups and responses to a virtual workshop (similar to a survey, with more opportunity for open-ended comments).

Information in this appendix includes:

- Quantitative analysis of virtual workshop responses about complaints and investigations;[1] and
- Qualitative analysis about how complaints and investigations may impact diversity in the professions.

Sample comments from research participants throughout this appendix are drawn from the virtual workshop as well as from focus groups and interviews. In some cases, participants also emailed the study team with comments. As in other appendices, identifying information is excluded.

Throughout our qualitative analysis of participant perspectives, we include comments even if they do not explicitly name an impact on diversity or equity. Such comments are included because of the context in which they were provided (in response to questions about diversity and equity) and because marginalized groups may experience amplified effects of challenges that are present for everyone.

Many comments from participants reflect misunderstandings of agency and board policies and procedures or do not match current facts. We include these comments as important data points about the challenges facing MHRA and the boards in their relationships and communications with professionals. Professionals are sharing information with each other, whether accurate or not, that contributes to a narrative about how boards treat professionals, including professionals from diverse backgrounds. That narrative can be a factor in whether professionals perceive that the boards are welcoming and equitable. To help to prevent perpetuating inaccurate information about polices or practices, we note discrepancies in accompanying narrative or footnotes.

[1] A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

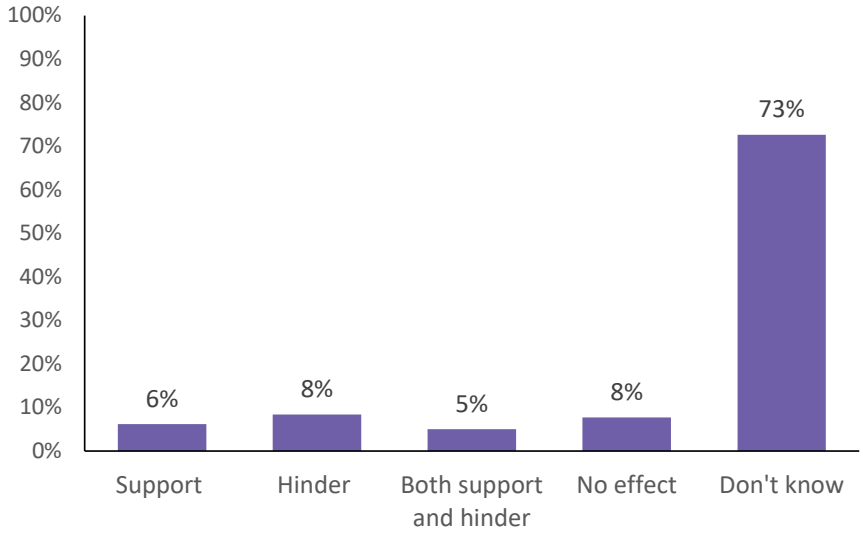
Impact of Complaints and Investigations on Diversity

Nearly three-fourths of respondents indicated that they did not know whether the boards supported or hindered diversity during the complaints and investigations process. Another 8 percent indicated that the boards have no influence over diversity during complaints and investigations. Six percent said the boards support diversity, equity and inclusion at this stage, 8 percent said they hinder DEI and 5 percent said they both support and hinder DEI.

Keen Independent applied codes to the follow-up question asking for examples of how the board supports or hinders the diversity of mental health professionals during the complaints and investigations process. Codes covered the following topic areas:

- Respondent expectations/experiences (e.g., consideration of complaint respondents' perspectives);
- Appropriateness of sanction (e.g., extent to which the determined sanctions fit the accusation);
- Board composition (e.g., how experiences of the board due to their identities may influence outcomes);
- Financial (e.g., monetary cost of hiring a lawyer, missing work to address a complaint, fines, etc.);
- Time (e.g., how long the complaints process takes);
- Oversight and accountability (e.g., checks and balances on the complaints and investigations process); and
- Board procedures/communication (e.g., how accessible the boards are and how information is communicated to complaint respondents).

G-1. All respondents — how boards impact diversity of the mental health profession during complaints and investigations process



Note: N = 1,656.
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

The most frequent hindrances identified among those who responded were the lack of consideration for the complaint respondent and their experience of the process, and the board's procedures and/or communication during the investigation.

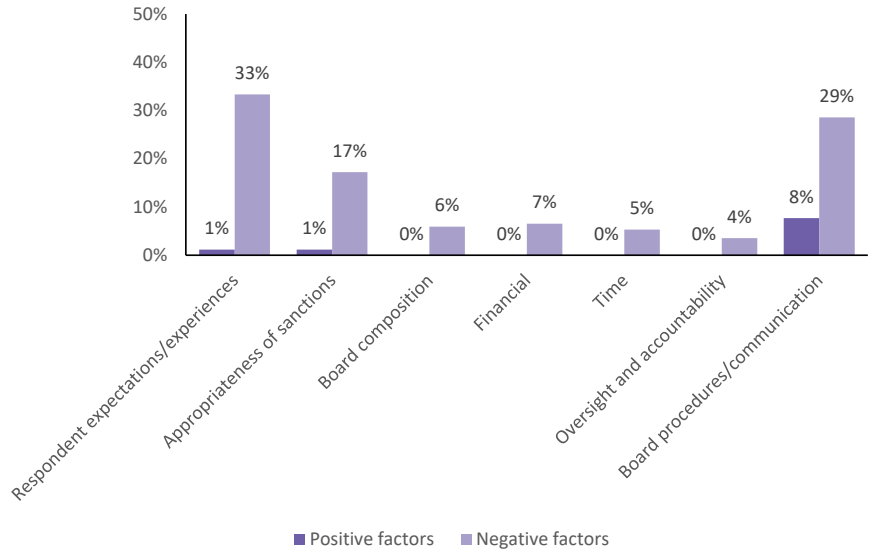
G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

Overall results. Figure G-2 shows frequently cited positive and negative factors under agency and board control that influence diversity as mental health professionals experience the complaints and investigations process.

Board procedures and communication was the most frequently cited positive factor at 8 percent.

The most frequently cited negative factors were respondent expectations/experiences (33%), board procedures and communication (29%) and appropriateness of sanctions (17%).

G-2. All respondents — factors mentioned that support or hinder diversity during complaints and investigations process



Note: N = 168.

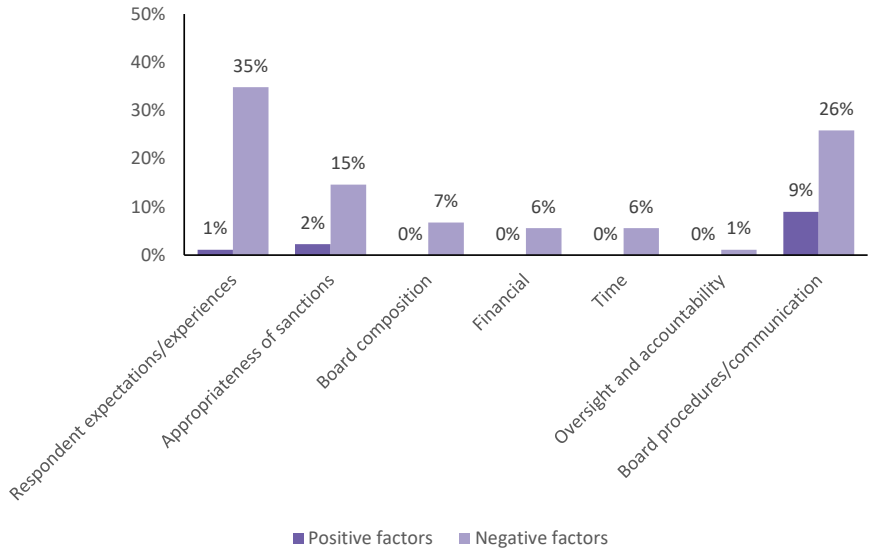
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). LPCs made up the majority of the respondents to this question. Thus, their responses are similar to of the responses to this question among all professionals. Figure G-3 provides results from LPCs.

G-3. LPCs — factors mentioned that support or hinder diversity during complaints and investigations process



Note: N = 89.

Participants' responses could contain more than one code, so percentages do not add up to 100.

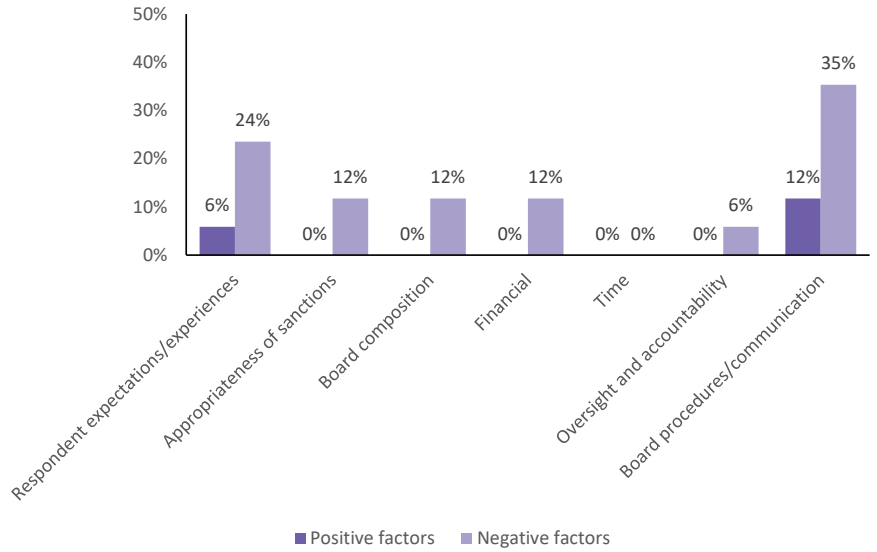
Source: Keen Independent Research.

G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

Licensed marriage and family therapists (LMFTs). The number of LMFTs who provided a comment for this question was relatively small (17).

Board communications/procedures was the top cited negative factor influencing diversity (35%) among this group of practitioners whereas it was second most cited for practitioners overall.

G-4. LMFTs — factors mentioned that support or hinder diversity during complaints and investigations process



Note: N = 17.

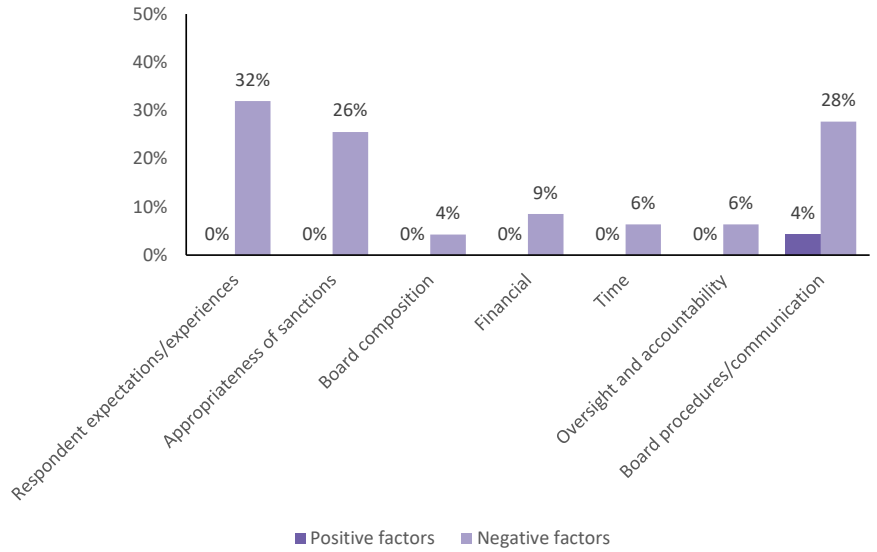
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

Psychologists. Psychologists were more likely than others to mention appropriateness of sanctions as a negative factor influencing diversity (26%). The negative factor cited most frequently among psychologists was respondent expectations and experiences at 32 percent.

G-5. Psychologists — factors mentioned that support or hinder diversity during complaints and investigations process



Note: N = 47.

Participants' responses could contain more than one code, so percentages do not add up to 100.

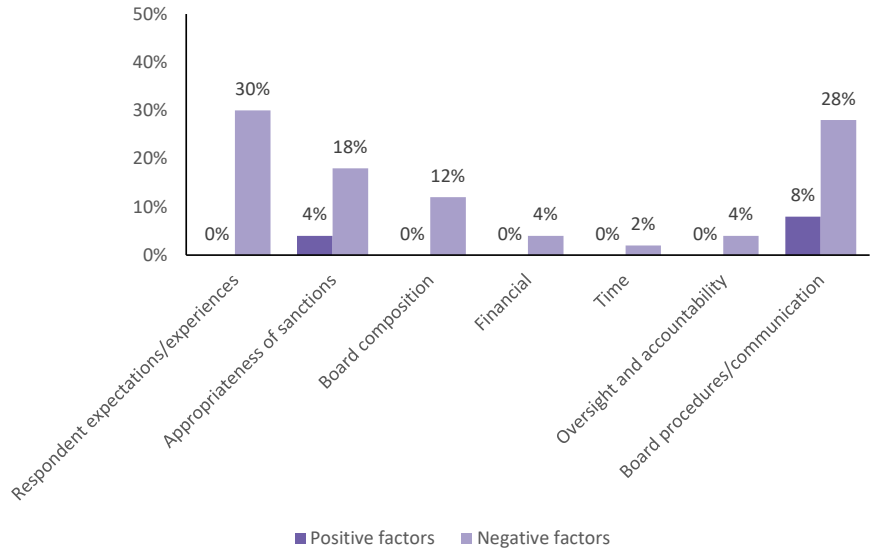
Source: Keen Independent Research.

G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

People of color. Because of the relatively small numbers of participants from each racial and ethnic group who provided a comment for this question, we combined participants who identified as Black or African American, Asian American or Pacific Islander, Hispanic or Latino, American Indian or Native Hawaiian or multiracial into one group of people of color.

People of color had similar responses as white participants, except in being more likely to cite board composition as a negative factor influencing diversity during the complaints and investigations process (12% compared to 6% overall).

G-6. People of color — factors mentioned that support or hinder diversity during complaints and investigations process



Note: N = 50.

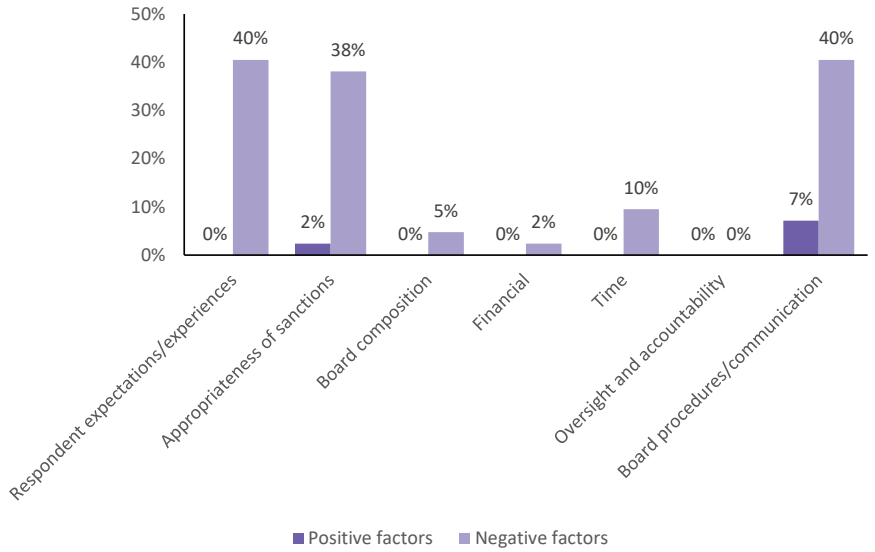
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

LGBTQ+ participants. Of all subgroups, LGBTQ+ participants were most likely to cite board procedures/communication (40%), respondent experiences and expectations (40%) and appropriateness of sanctions (38%) as negative factors under board control.

G-7. LGBTQ+ participants — factors mentioned that support or hinder diversity during complaints and investigations process



Note: N = 42.

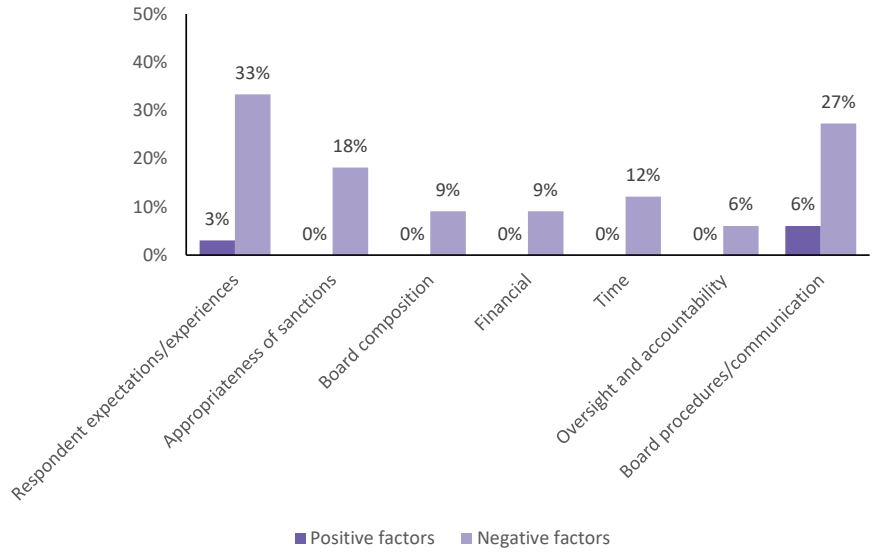
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

G. Complaints and Investigations — Quantitative analysis of virtual workshop responses

Participants with disabilities. Responses from participants with disabilities were similar to those of participants overall. We note that there were a relatively small number of participants with disabilities who responded to this question (33).

G-8. Participants with disabilities — factors mentioned that support or hinder diversity during complaints and investigations process



Note: N = 33.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

G. Complaints and Investigations — Participant perspectives

The following pages of this appendix provide a synthesis of practitioner perspectives on how complaints and investigations may impact diversity.

Analysis is organized as follows:

- Positive impressions;
- Fear of MHRA, OBOP and OBLPCT;
- Experiences of complainants
- Protections for complainants
- Complaints about professional leaders or board members;
- Timeliness and duration of investigations;
- Advocacy and representation;
- Investigations;
- Investigators;
- Impact of investigations on respondents;
- Subjectivity and bias;
- Disciplinary action;
- Understanding cultural differences
- Communications; and
- Oversight and accountability.

Procedural note. Many aspects of complaints and investigations were troubling to practitioners. Study team members found it helpful to seek additional information on some topics that could illuminate whether certain concerns were due to MHRA, OBOP and OBLPCT policies and practices or attributable to misunderstandings or poor communication about MHRA, OBOP and OBLPCT policies and practices.

Action may be warranted by MHRA, OBOP and OBLPCT in either case, but the necessary action (policy/practice changes versus communication improvements, for example) depends on that distinction.

Throughout this appendix, where clarification of MHRA policies or practices is possible and helpful, we provide it under a "procedural note" heading as shown here.

G. Complaints and Investigations — Participant perspectives

Positive Impressions

Keen Independent is aware that complaints and investigations are lightning rod topics. We understand that practitioners who have been through complaints and investigations who received sanctions would be unlikely to feel positively about the experience. Confidentiality hinders the ability of those who have not had firsthand experiences to offer informed opinions. This section presents comments received, with the caveat that Keen Independent did not have complete information about these events or their context.

As noted in the quantitative analysis of virtual workshop results, there were only a few positive comments regarding complaints and investigations. Those we received focused on board procedures and communications. Sample comments are provided to the right. There was only one comment that praised the complaints process from someone who was the respondent to a complaint.

Having been through an investigation I felt the board did a good … job of exploring the concern, respecting myself as the clinician without prejudgment and encouraging supports for the patient.

White, male licensed professional counselor

Investigations of which I have knowledge [of] were handled professionally with regard to protecting civil rights.

White, male licensed psychologist with a disability

The board appears to have fair and adequate procedures to protect professionals and consumers.

African American, female mental health professional

Should there be complaints or investigations due to consumer bias [or] prejudice, the board will discover the concern through a thorough investigation and take appropriate action.

Biracial, LGBTQ+, female licensed professional counselor

G. Complaints and Investigations — Participant perspectives

Fear of MHRA, OBOP and OBLPCT

Some participants commented on the reputation of the board related to complaints and investigations as a basis for fear among practitioners, which may hinder diversity.

[The board] hinders [diversity] in their behaviors and reputation for siding with consumers against the professionals they should also be providing advocacy for, [thus] creating an atmosphere of fear and intimidation which causes marginalized communities to avoid the field entirely to avoid being licensed with the board.

Female licensed professional counselor

… frankly one of the reasons that I decided to apply to be on the board … was I was terrified. Like I was afraid! I mean, these are the people that can take my license and I felt it was important to better understand that process.

Former board member

There's a sense [that] the board is policing us first and foremost and that one misstep is an invitation for as much punishment as can be warranted.

White, LGBTQ+, male licensed psychologist

G. Complaints and Investigations — Participant perspectives

Experiences of Complainants

Some practitioners, who are mandated to report any professional violations they learn about that involve other practitioners, described concerns stemming from their experiences as complainants. Respondent concerns included:

- Lack of communication; and
- A sense that complaints involving cultural bias or racial discrimination are not treated seriously.

Some of the comments about mishandling of complaints that adversely affected clients of color or from the LGBTQ community are addressed in Appendix H.

Procedural note. According to MHRA staff, complainants receive two written communications.

- The first is confirmation that their complaint was received and has been assigned for investigation. The agency has also been moving toward calling the complainant after a complaint is received (though this is not required).
- The second is notice of any action taken. If the outcome is dismissal, the communication to the complainant is generic and does not cite a reason.

Communications with the complainant in between confirmation and notice of action taken are at the discretion of the assigned investigator.

If [you] work for an agency that has done something horrific and you report it, [you] don't know that it's been addressed.[2] [You] can only see that the behavior hasn't changed. So, you file another report and [there's] nothing [given to you as an update]. There's still no [indication] your complaint was listened to.

African American, female licensed professional counselor

We filed some concerns about compliance. It took them six months …. Then they dismissed that case …. They haven't responded as to [why].

White, LGBTQ+, non-binary professional counselor associate

There were three clinicians on the floor [I worked on]. One got up in my face and was threatening me …. I was shaken by that experience, and I wrote to the board. I never heard a thing back from them.

Biracial, male licensed professional counselor

Several years ago, I filed a complaint regarding unprofessional behavior and racial discrimination against colleagues with ample evidence. That [complaint] was promptly dropped. It was unclear if the person doing the investigation was even qualified. This was deeply unsettling.

Middle Eastern, female mental health professional

[2] MHRA and the boards do not have authority to investigate or discipline agencies or businesses, only individual practitioners. MHRA and the boards send a generic written notice when complaints are dismissed that does not explain the reason for the dismissal.

G. Complaints and Investigations — Participant perspectives

Protections for Complainants

Some participants expressed reservations about the risk of consequences for professionals bringing forward complaints about other professionals, especially in situations where power is imbalanced between the parties.

Examples of concerns regarding retaliation included:

- Associates bringing complaints about clinical supervisors, which might put their clinical hours at risk;
- Employees bringing complaints against employers, which might put their employment at risk;[3] and
- Professionals counter-complaining about each other.

Procedural note. MHRA confirms that a supervisor refusing to sign off on hours after a complaint against the supervisor by the supervisee has happened. MHRA does not offer guidance to associates about bringing complaints on supervisors other than the general point made to all potential complainants that they do not inform the respondent of the complainant's identity. MHRA also notes that retaliation is an ethical violation and can be grounds for a complaint and potential disciplinary action. MHRA staff note there is no statute of limitations on the ability to file a complaint, so a supervisee could potentially file a complaint after their hours have been secured.[4]

I have wanted to file an ethical complaint against a supervisor, but didn't … because they're responsible for signing off on my hours, and I was afraid they weren't gonna do that, and they were also my employer.

White, LGBTQ+, female, licensed professional counselor

OBOP ignored ethical complaints regarding racial discrimination, emotional abuse and retaliation by a prominent mental health agency and former employer.

Hispanic American, male licensed psychologist

[3] In some cases, participant comments reflected expectations that MHRA and the boards receive and act on complaints about agencies and businesses as employers. MHRA and the boards have no authority to investigate or take enforcement action over agencies or businesses. Nor can they enforce employment law.

[4] Delayed reporting may entail perceived risks for supervisees. MHRA staff report that they have never seen the boards express concern over the timing or duty of a supervisee to report a supervisor, but this may not be evident to practitioners who are mandated to report within ten working days of learning of a violation. Delays in reporting can also adversely impact the availability of records and memories.

G. Complaints and Investigations — Participant perspectives

Complaints About Professional Leaders or Board Members

Some participants expressed concern that board members may be biased in favor of clinicians who are well known in the mental health professions or have existing relationships with MHRA staff and/or board members.

Procedural note. Oregon statutes define when board or staff must recuse themselves due to conflict of interest. In the event a complaint concerns a current board member that board member does not receive materials pertaining to their own case as part of the meeting packet and leaves the meeting while the case is heard. Board minutes of public session votes reflect recusals when board members have a conflict of interest.

MHRA staff report that board members decide complaints involving current or former board peers because there is no other option.

It doesn't sound like an equitable fact-finding process. [How seriously a complaint was investigated] depended potentially on the status of the licensed individual in relation to the board … The result of that complaint [against a person known to the board] was seemingly a slap on the wrist.

White, LGBTQ+, female licensed professional counselor

The board [is] using its power to protect people in power. [When a complaint involves a member of the board, someone known to the investigator, professional leaders] …. the board's not protecting the public, not protecting clients, not protecting clinicians who are being harmed ….

Mental health professional

G. Complaints and Investigations — Participant perspectives

Timeliness and Duration of Investigations

Some practitioners commented on the time it takes to resolve an investigation.[5] They expressed concern about the:

- Impact of this for clients;
- Quality of the investigation; and
- Toll the long duration takes on clinicians who are being investigated.

Procedural note. MHRA may not investigate complaints in the order received. Staff describe a triage-like process in which some complaints involve allegations so serious they "jump the line." By statute, all regulatory bodies have 120 days from receiving a complaint to complete an investigation and present findings to the board. MHRA staff explain that some investigations are complex and delays with requests for evidence (e.g. cell phone records) or scheduling witnesses may result in requests for extensions. Every board agenda includes a standing item to vote to grant extensions on investigations.

I saw … a recent report they filed that said [the board has] an ambitious goal of 180 days to investigate. That's six months. To me, that's extremely slow and not ambitious at all. Clients have moved on, you know.

Asian American/Pacific Islander, female licensed psychologist

I had to beg them [board members] to look at my stuff [during the investigation] …. I lost my livelihood and any ability to support myself or my family [because it took so long].

White, female former licensed professional counselor

[5] Participant comments described investigations as taking too long. MHRA staff report that they also hear from respondents, respondents' attorneys and professional associations that respondents need more time to respond to allegations and produce records.

G. Complaints and Investigations — Participant perspectives

Advocacy and Representation

Participants addressed investigations as an area where professionals from marginalized backgrounds may face disadvantages. Our discussion of licensing in Appendix F noted that professionals from marginalized groups may be less likely to self-advocate to resolve a licensing customer service issue than a professional from the dominant culture. Participants described a similar concern about complaints and investigations, with even higher stakes.

Some professionals reported that were surprised by the shift in their relationship to the board, which they had viewed as their professional resource for entering the industry.

The [complaints and investigation] policies and actions simply do not consider the realities of marginalized professionals who may be unfamiliar with the extremely rigid and legalistic way complaints and investigations are handled.

African American, female licensed psychologist

When I went through the complaint process … I felt so tricked. I was not prepared for the way the board functions …. I know of several counselors who were shell shocked and gave up their licenses ….

White, female licensed marriage and family therapist

G. Complaints and Investigations — Participant perspectives

Legal representation. Using a lawyer may not occur to some professionals or may not be financially feasible. Even those professionals who have professional liability insurance that covers representation noted that they had to cover the costs until investigations concluded.

Procedural note. MHRA staff estimated that about half of respondents engage attorneys at some point. Websites for both boards advise respondents that the boards, staff and counsel are unable to provide advice or opinions and invite them to contact a private attorney or professional association. Once the board issues a notice of proposed disciplinary action to a respondent, the respondent may request a contested case hearing. The notice of a contested case hearing advises respondents that they may wish to be represented by an attorney and that this is customary.

MHRA staff observed that legally represented clinicians may have better outcomes than those who self-represent due to coaching by experienced lawyers. Experienced attorneys may negotiate settlements; whereas unrepresented professionals may not know of this option or be unfamiliar with how to pursue informal resolution options.[6]

Having access to a professional lawyer who can advocate and educate us on what to do next [during an investigation] is vital.

White, female licensed professional counselor

I observed a better outcome for licensees against whom there had been a complaint when they did have [legal] representation. There's a socioeconomic thing there, you know …. I suspect there's no such thing like a public defender … for a licensing board. Some of the folks who came before the board were so inadequately prepared …. Had they had the benefit of an attorney [who was] helping them prepare, I think their outcome would have been better. … I would never go before a licensing board without … having representation.

Former member of an out-of-state licensing board

Even with liability insurance, if a professional is in private practice, the fees for legal assistance have to be paid until the board investigation is concluded prior to compensation.

White, female licensed professional counselor

[6] Frequently asked questions on both OBOP and OBLPCT complaint websites explain, "Informal resolution can be negotiated through a stipulated order, settlement agreement, or consent order." For example, see FAQ #12 at https://www.oregon.gov/psychology/Pages/Complaint.aspx

G. Complaints and Investigations — Participant perspectives

Investigations

Participants who spoke about investigations raised concerns about whether clinicians receive adequate information and opportunity to defend themselves.

Procedural note. Confidentiality requirements are defined by Oregon statute and are applicable to all professional regulatory boards.[7] When complaints are filed, MHRA informs respondents what has been alleged and which client(s) are alleged to have been harmed. MHRA does not inform respondents who made the complaint and cautions respondents against making assumptions about the identity of the complainant.

MHRA staff view information about the allegation and clients involved as essential for the respondents to be able to defend themselves. However, some complaints filed about clinicians are vague. According to MHRA staff, when information about allegations and clients is not communicated to the respondents, MHRA does not have it. MHRA must inform respondents of complaints regardless and is required to investigate all complaints. MHRA staff note that many such complaints will eventually be dismissed because the board cannot take action on investigations that do not yield details.

[After finding out a complaint has been filed], it's been my experience that I don't get to ask any questions, or I can ask all the questions I want but get shut down right away, [I'm] basically assumed guilty until proven innocent by a random set of people that I may or may not get to address in person. …. My reservations are that neither party [the complainant or respondent] really knows what the other one is saying and exactly who's saying it. You can surmise, but it's not like you know who your accuser is.

White, LGBTQ+, female licensed marriage and family therapist

I've been involved in a lot of [complaints and investigations] because of my work [on another state's board]. Where I was [before Oregon] we did know [who brought a complaint against you] and that was really helpful because you knew exactly what the accusation was and how to address it. Transparency is really critical to the profession that we are in while keeping things confidential.

White, LGBTQ+ female licensed professional counselor

[7] Oregon ORS. § 676.175 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors676.html

Oregon ORS. § 676.175 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors676.html

G. Complaints and Investigations — Participant perspectives

Due process. Some participants reported awareness of or involvement in complaints that were "not investigated" before being decided by OBOP or OBLPCT.

Some participants perceive that MHRA treats respondents as guilty and the boards tend to side with complainants. Professionals lack awareness that the most common outcome of complaints is dismissal.

Procedural note. In some cases, investigators may learn new information about a complaint that lacked specificity at the time the respondent was informed of it. MHRA does not have any required or standard procedure to share that new allegations or details with respondents. However, MHRA staff noted they would usually do so in the normal course of an investigation because new information may open up the possibility of new evidence to request and new potential charges. One reason MHRA staff might not inform a clinician of new allegations on an initially vague complaints is if they have insufficient time before investigation findings are presented to the board.

When I had my hearing per the complaint that was filed against me, the state investigators said they "did not investigate." They didn't talk to any of the players involved; they just took the client's word and decided to discipline me without hearing my side.

White, female licensed marriage and family therapist

OBOP has … issued sanctions against [clinicians] who were never given the opportunity to respond to the allegations made against them by another therapist.

Mental health professional of color

The fact that you can determine a case and impose discipline without even interviewing the licensee or witnesses is completely unjust. There's no opportunity for the licensee to communicate with the investigator beyond a one-page written statement.

Mental health professional

Complaints are treated as fact. Licensees [who have a complaint lodged against them] are not considered innocent until proven guilty — which they should be.

White, female licensed psychologist

G. Complaints and Investigations — Participant perspectives

Investigators

Participants frequently mentioned the backgrounds of investigators as a potential barrier to equity.

Former law enforcement officers as investigators. The use of former law enforcement professionals as investigators at MHRA was a principal concern.[8] Incidents and patterns of negative interactions for African Americans with police have been widely reported and have resulted in distrust of law enforcement by African Americans and other communities of color.[9]

Research participants expressed that distrust of law enforcement officers among people of color results in distrust in the use of former law enforcement officers as investigators for MHRA.

Related concerns included the potential for investigations to be traumatic for people of color, the potential chilling effect on willingness to file complaints about practitioners of color, and whether the techniques and expertise of former law enforcement officers are appropriate for MHRA.

A former police officer is the one who is investigating [my case] …. How would that feel to a non-white person?

White, female licensed professional counselor

[Counselors report] investigators act as if they are police officers, and … interrogations feel like you're a criminal being interrogated in a police station. [Using former law enforcement officers creates] inequitable footing … [with] bias … on the [investigator's] side and bias on counselors of color's [side], specifically African American counselors. … you start asking yourself, 'Is it truly an equitable process when … law enforcement and the judicial system [haven't] been equitable to people of color in general, especially to African Americans [and Native Americans]?'

African American, licensed female marriage and family therapist

I feel like I would literally be calling the police on a fellow clinician [if I filed a complaint against them], and that does not sit right with me.

Asian American/Pacific Islander, female licensed professional counselor

Investigations are performed … by ex-law enforcement officers, often from the military, who treat licensees as criminals, using interrogation techniques [from] law enforcement …. These investigators have no mental health training and don't understand what LPCs do.

White, male licensed professional counselor

The State Investigators are not trained in mental health.

White, female licensed marriage and family therapist

[8] MHRA employs six investigators including three with past experience in law enforcement and one with past experience in military/national security. MHRA staff note that MHRA and other state agencies are required by law to give preference points in the hiring process to military veterans and additional points to veterans who are disabled due to military service. They have found that former law enforcement officers are often also veterans.

[9] Santhanam, L. (2020, June 5). *Two-thirds of black Americans don't trust the police to treat them equally. Most white Americans do.* PBS News Hour. https://www.pbs.org/newshour/politics/two-thirds-of-black-americans-dont-trust-the-police-to-treat-them-equally-most-white-americans-do

G. Complaints and Investigations — Participant perspectives

Other reservations about investigators. Some participants described concerns about dual relationships at MHRA and the potential for investigations involving people of color by white investigators to be hampered by distrust.

They hired the investigator's son to be the co-investigator. That's not cool, [that's] like nepotism. The optics are bad.

Asian American/Pacific Islander, female licensed psychologist

Investigations about unfair treatment of a BIPOC individual conducted by a white person will have limited success due to perspective and sense of safety.

Hispanic American, female mental health professional

G. Complaints and Investigations — Participant perspectives

Impact of Investigations on Respondents

Participants expressed concern that investigatory techniques are heavy-handed and abusive. This point was closely connected to concerns expressed about use of former law enforcement officers. Professionals who discussed this aspect of investigations expressed concern about the impact of the process on professionals with past trauma and experiences as members of marginalized groups. Some expressed specific concerns about bias in the views expressed by investigators or other personnel involved in board cases.

Investigators treat licensees as criminals. It is a terrifying and traumatizing process. For someone with previous trauma, this could end a career.

White, female licensed professional counselor

The investigation process is abusive, intimidating, and punitive in ways that create fear for all providers. I am especially concerned about women of color or LGBQT persons who are often trauma survivors, who in an investigation are treated in ways that can retraumatize them often over simple mistakes that harmed no one.

White, male licensed professional counselor

I started connecting with other female therapists who had been in the investigation process [and] experienced misogyny during the interview process. I did not get that same impression from some of the men who had gone through the investigation process.

White, female former licensed professional counselor

Many women … have ended up caving in under the pressure and said, 'Yes, I guess there was no release sign,' or, 'I guess the diagnosis was not on the form,' when in fact, it was ….

White, male licensed professional counselor

G. Complaints and Investigations — Participant perspectives

Subjectivity and Bias

Participants who spoke about complaints and investigations frequently raised concerns about how bias can find its way into processes that are subjective. Areas discussed included:

- Defining appropriate conduct;
- The discretion and biases of individual investigators; and
- Decisions about disciplinary action.

Feedback about disciplinary actions is discussed in more detail later in this appendix.

LGBTQ+. Some participants expressed concern that bias against LGBTQ+ clinicians may influence investigations and disciplinary actions.

Oregon's vaguely worded law requiring reporting of licensed professionals for 'conduct unbecoming of the profession' can be used to target providers in politically charged areas with bad faith complaints that significantly impact future renewals and cost time and money even when unfounded.

White, LGBTQ+, female licensed psychologist

Who defines what appropriate characteristics are? …. It's easy when you're in an ivory tower to say, 'Oh, this is what's fair and equitable.'

White, female professional counselor associate

Investigations and handling of complaints are too subjective to the individual investigator handling the particular case, leaving a lot of room for inequity. Clearly delineated policies and fines for specific violations would reduce this.

White, female licensed professional counselor

I have been made aware of numerous instances in which OBOP has taken actions that appear to be biased against LGBTQA+ professionals.

White, LGBTQ+, male licensed psychologist

I don't [see] how sexual minorities can feel safe when the people at the top of leadership at the board have such clear homophobic bias.

Hispanic American, LGBTQ+, male mental health professional

A colleague (was investigated who) happens to be a person of color and is gay. The way the board published their allegations of inappropriate conduct against my peer had biased, homophobic language and assumptions … that met stereotypes about gay men. I really didn't think that was appropriate.

Mental health professional of color

G. Complaints and Investigations — Participant perspectives

Disciplinary Actions

Participants discussed views about disciplinary action by the boards as a hinderance to diversity. Themes included:

- The goal of action;
- Unpredictability of board decisions;
- Financial sanctions; and
- Mitigating factors.

Goal of disciplinary action. MHRA staff and board members report that the boards strongly emphasize rehabilitation and actions often employ supervision, continuing education and self-reflective essays. Sample comments from participants highlight perceptions that the boards are focused on punishment rather than support and rehabilitation. Some spoke about procedurally oriented processes missing the opportunity to achieve real resolution of concerns.

Unpredictability. The topic of disciplinary actions closely relates to concerns about lack of transparency and the potential for biases to impact outcomes (see Subjectivity and Bias section on previous page).

I am not aware of any policies that is premised on support and rehabilitation instead of punitive action for therapists, especially for BIPOC therapists, when there are complaints and investigations.

Asian American Pacific Islander, female mental health professional

The [Oregon] Psychology Board, when compared to other medical profession boards I have worked with, [can be viewed] as … more focused on being punitive of professionals in efforts to protect consumers. I have witnessed other boards take a much more restorative approach when dealing with licensees.

White, male licensed psychologist

The board is a colonialist entity …. There's not a lot of insight about how cultural differences between counselors and clients lead to misunderstandings that need to be addressed collaboratively rather than punitively, as is the way of colonialist regulatory entities.

White, LGBTQ+ licensed professional counselor

I have participated in one complaint …. The treatment of that complaint was very transactional and not relational at all. One could argue that this is the professional way of handling things, but it did not provide any sort of resolution for the parties involved.

Multiracial, LGBTQ+, female mental health professional

The lawyers that I have been fortunate enough to retain have basically said to me, 'I've been doing this a long time, and I'm pretty sure these cases against you are gonna be dropped … but also [with] the board you never know. They're fickle. You never know what they're going to do.'

White, LGBTQ+, female mental health professional

G. Complaints and Investigations — Participant perspectives

Financial sanctions. Some participants reported concern about the impact of financial sanctions including both the proportionality of the sanctions and the difficulty to pay on short notice (particularly for low paid, associate level or other early career mental health professionals. Some questioned the propriety of the size of sanctions and the use of financial penalties for conduct that did not involve financial impact.

Procedural note. MHRA systems and staffing do not support paying financial sanctions over time. Financial penalties are typically due within 30 days and the timeline for payment is indicated in the order and case deposition letter. By law, any unpaid sanctions are referred to the Department of Revenue for collection at which time payment plans may be negotiated.

When respondents negotiate settlements with the boards, they may include alternative time periods for payment of financial penalties.

Going after professionals [and] requesting fines of up to $20,000 for not changing their work address within 30 days of moving, creates an appearance of corruption, and an atmosphere of mistrust, especially from BIPOC communities who have experienced too much of that historically.[10]

Female licensed professional counselor

[The board] imposes fees and other penalties [on licensees who have complaints lodged against them] without proving that any financial loss or other harm occurred as a result [of] the alleged conduct.

White, male licensed psychologist

I ended up having to pay a fee [after the investigation concluded]. It had to be paid within 30 days of them signing this thing [about my case] …. [But] I didn't [even] know when the 30 days [would] start.

Mental health professional

[10] MHRA staff note that the maximum civil penalty from OBLPCT is $2,500 per violation by statute and that the boards do not issue such large penalties for recordkeeping issues. However, the perception on the part of practitioners of disciplinary action that is disproportionate to the violation in question was a recurring theme in participant feedback reflecting confusion and distrust about disciplinary actions taken by the boards.

G. Complaints and Investigations — Participant perspectives

Mitigating factors. The boards appeared to many participants to disregard the ways that experiences of marginalized groups may be mitigating factors.

I sat in board meetings where there was no consideration of the person's race, culture, identity [or] demographic gender expression when making decisions [about complaints and investigations]. I sat in meetings and there [was consideration of past] convictions …. There should be a consideration that there [are more] arrests for Black individuals than white individuals.

Mental health practitioner of color

It appears that the board attempts to take a more colorblind approach [to investigating], instead of being aware of factors that may increase [the] likelihood of complaints against BIPOC.

Middle Eastern, female licensed psychologist

If a therapist is working hard at a few jobs and raising a family, or managing systemic injustice and ageism, or if a therapist has a disability that hinders some aspects of the paperwork, it is not considered [by the board].

White, female mental health professional with a disability

I have seen how where the board lands [sometimes] erring on the side of assuming the worst version of the misconduct, even when there is plenty of evidence to the contrary.

White, LGBTQ+, male licensed psychologist

G. Complaints and Investigations — Participant perspectives

Understanding of Cultural Differences

Participants expressed that professional codes of ethics enforced by the boards through complaints and investigations are defined by the dominant culture and leave little room for cultural differences in mental health treatment approaches.

Comments also expressed reservations about whether MHRA, OBOP and OBLPCT have the expertise needed internally and whether they bring in outside experts when necessary. Comments occasionally revealed confusion about the purview of the boards, for example reflecting belief that the boards have authority to act on employment discrimination complaints.

Saying that you adhere to the code of ethics [when investigating complaints] is understandable, but the ethics are based on western and white-centric views, leaving little room for cultural nuances that affect how therapists of color interact with clients.

Asian American/Pacific Islander, female mental health professional

The way the Board is presented to both clients and professionals is extremely non-relational, which is counter to the ethos of the profession and many non-dominant cultures' values.

White, LGBTQ+, non-binary licensed professional counselor

I think they [the boards] look into complaints and consider the person's cultural background and what type of clientele they work with [when making a decision about the case].

Hispanic American, female licensed professional counselor

Cultural context is not considered in investigations.

Asian American/Pacific Islander, female mental health professional

I've seen sanctions recently for less standard ways of interacting with clients that were nonetheless in that client's best interest …. Since minorities may need more flexible approaches to find counseling helpful and meaningful, they [therapists serving minority communities] are more likely to be sanctioned for doing so.

White, LGBTQ+, female licensed professional counselor

Cultural differences in mental health treatment options are not respected. I have known culturally diverse clinicians choose not to get licensed because they felt they could not practice in a way consistent with their cultural healing values.

White, female licensed psychologist

If the people doing investigation of a complaint did not have firsthand knowledge [or] familiarization with the humor of a minority group, things like a verbatim reading of a transcript might be damning for a professional [even if what was said was] completely acceptable within the culture.

White, male professional counselor associate

There is a disturbing lack of awareness by OBOP [Oregon Board of Psychology] members regarding APA Ethical Standards related to multiculturalism issues. OBOP members also do not seem to be aware of State and Federal employment discrimination laws.

Hispanic American, male licensed psychologist

It doesn't seem to me that they have any procedures to bring in outside perspectives or a consultant if they're out of their league when comes to a certain marginalized community.

Hispanic American, LGBTQ+, male mental health professional

G. Complaints and Investigations — Participant perspectives

Communications

Many professionals who participated in this study expressed that they were troubled about the publication of complaints, board findings and disciplinary actions in the newsletter and on the website. Some expressed concern about this practice contributing to the biases facing professionals from marginalized groups.

Practitioners frequently referred to "shaming" or the "the wall of shame" as unnecessary, invasive, damaging to the profession and damaging to individuals.

Procedural note. The Administrative Procedures Act requires agencies to include sufficient information in the notice document, a Notice of Proposed Disciplinary Action or a Notice of Proposed Civil Penalty, before taking action on violations by a licensee or applicant.[11] The boards must balance the privacy interests of parties involved with the requirement to provide sufficient information.

It feels especially troubling the way OBOP makes public all the details of a [violation] …. I worry this level of shaming can serve to further marginalize underrepresented psychologists who might fear impacts of implicit bias in complaints.

Hispanic American, female licensed psychologist

Shaming professionals in the newsletter harms our entire community.

White, LGBTQ+, female licensed psychologist

Their newsletter is mostly about shaming people [who have had complaints lodged against them] in public. I try not to read it.

Female licensed psychologist of color

The Board posts [information about the violation] and the Board's findings on the internet prior to deciding on [whether or not they will discipline the licensee being investigated]. It's not fair and it's humiliating.

White, female licensed marriage and family therapist

It's absolutely inappropriate that the Board publishes the findings of all of the complaints in full detail on the website. I understand that some information needs to be shared, but we've heard people's criminal backgrounds in those complaints. I think that's really inappropriate and an invasion of privacy.

White, LGBTQ+, female licensed professional counselor

Monthly or four-times-a-year, the Oregon Board of Psychologists … sends out a document that lists licensees' violations …. Sometimes it looks like some of the things [included] are more accusations rather than findings, and it's scary.

Biracial, LGBTQ+, female licensed psychologist

[11] Oregon ORS. Ch. 183 (2021). https://www.oregonlegislature.gov/bills_laws/ors/ors183.html

G. Complaints and Investigations — Participant perspectives

Lasting impact of published information. Practitioners also raised concern about the 'long tail' of a public report that may impact their reputations forever.

If there is a finding [during an investigation], it stays on our record forever, just like a felony. This has lasting impact on our experience — including having to explain it over and over to [insurers], during contracting and to peers.

White, LGBTQ+, non-binary licensed professional counselor

We had someone here who had a preliminary action … that was in the newsletter. I got all these emails from people saying, 'I want to make sure that if we refer to you, they don't go to her' …. This was a person of color, Native identified woman …. In the final action, that [complaint] wasn't in there anymore, but it's too late, that's out there. Putting preliminary findings in [the newsletter] is a good way of getting lots of people to think negative things about [a person] that may or may not be the final outcome.

Middle Eastern, female licensed psychologist

G. Complaints and Investigations — Participant perspectives

Oversight and Accountability

Participants spoke about lack of checks and balances in complaints and investigations as a barrier to diversity.

Some noted the likelihood of disparities in complaints against professionals from marginalized backgrounds.

Others perceive the boards to operate with "absolute power," working without transparency, operating without accountability to anyone and having unfettered final decision-making authority.

Procedural note. When the boards decide on disciplinary action, respondents receive a notice of proposed disciplinary action that informs them of the option to appeal the decision by requesting a hearing with an Administrative Law Judge (ALJ). After hearing the evidence, the ALJ issues a proposed order, which is a recommendation to the boards. The boards may accept or reject the ALJ's proposed order. According to MHRA staff, the boards rarely reject proposed orders because of the possibility of being overturned on appeal. All final orders inform respondents that they may appeal the decision to the Court of Appeals.

MHRA staff report that the boards must feel strongly about the principle at stake to risk an appeal. One high profile instance involved a case in which a clinician was alleged to have put his arm around a teenage girl's waist. While the ALJ was persuaded of the value of comforting human touch in the therapeutic relationship, the board felt strongly about the importance of informed consent, overriding the ALJ's proposed order and reprimanding the clinician. The board's reprimand was subsequently upheld on appeal.

When there is a complaint … from a client …, the implicit bias of the client and those on the board do not have checks and balances.

Biracial, female licensed professional counselor

What is the mechanism for filing a … complaint against the board? Or for holding them to accountability for their lack of actions … ?

White, female psychologist resident

There is a fear of standing up to them [board members]. There is no body that holds them accountable, so if they're engaging in discriminatory or unethical behavior, there's very little recourse because they have a pretty sturdy legal shield around them.

Hispanic American, LGBTQ+, male mental health professional

… you don't really know what their process was … or how [they came] to the decision they came to. [It just] seems very arbitrary and like it's not in any of our hands.

White, LGBTQ+, female licensed marriage and family therapist

The board can do what they want to. They can overrule the [ALJ] and sometimes will [actually] do that.

Hispanic American, male licensed psychologist

The board still gets the final say. They can even overrule a Judge.

White, female licensed marriage and family therapist

… there's no way to … challenge decisions made by the board …. [which] further marginalizes professionals … under investigation.

White, female licensed professional counselor

APPENDIX H. Equitable Protection

This appendix synthesizes feedback from mental health professionals about equity in the protection of mental health consumers in Oregon. It also examines equity in the protection of licensed professional counselors, marriage and family therapists and psychologists.

Practitioners licensed and regulated by the Oregon Mental Health Regulatory Agency (MHRA), the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) provided input via interviews, focus groups and responses to a virtual workshop.

Information in this appendix includes:

- Quantitative analysis of virtual workshop responses about equitable protection of mental health consumers and professionals;[1] and
- Qualitative analysis about the equitable protection of mental health consumers and professionals.

Sample comments from research participants throughout this appendix are drawn from the virtual workshop as well as from focus groups and interviews. In some cases, participants also emailed the study team with comments. As in other appendices, identifying information is excluded.

Throughout our qualitative analysis of participant perspectives, we include comments even if they do not explicitly name an impact on diversity or equity. As noted in prior appendices, such comments are included because of the context in which they were provided (in response to questions about diversity and equity) and because marginalized groups may experience amplified effects of challenges that are present for everyone.

Many comments from participants reflect misunderstandings of agency and board policies and procedures or do not match current facts. We include these comments as important data points about the challenges facing MHRA and the boards in their relationships and communications with professionals. Professionals are sharing information with each other, whether accurate or not, that contributes to a narrative about how boards treat professionals, including professionals from diverse backgrounds. That narrative can be a factor in whether professionals perceive that the boards are welcoming and equitable. To help to prevent perpetuating inaccurate information about polices or practices, we note discrepancies in accompanying narrative or footnotes.

[1] A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

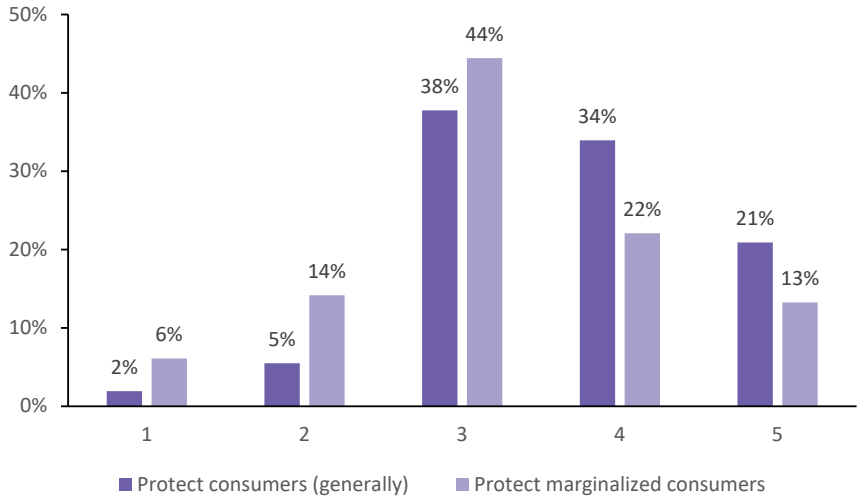
H. Equitable Protection — Quantitative analysis of virtual workshop responses

Ratings of Equitable Protection of Consumers

Virtual workshop participants were asked to rate on a scale of 1 to 5 (1 being poor and 5 being excellent) how well their respective licensing boards protect consumers, generally, as well as consumers from historically marginalized backgrounds.

Overall ratings. The average ratings given the boards were 3.66 in protecting consumers and a 3.22 in protecting consumers from historically marginalized backgrounds. Twenty percent of respondents gave a rate of 1 or 2 when gauging how well the boards protected consumers from historically marginalized backgrounds (compared to just 7% when asked about all consumers).

H-1. All respondents — ratings on a 1 to 5 scale of how well boards protect consumers generally and consumers from marginalized backgrounds

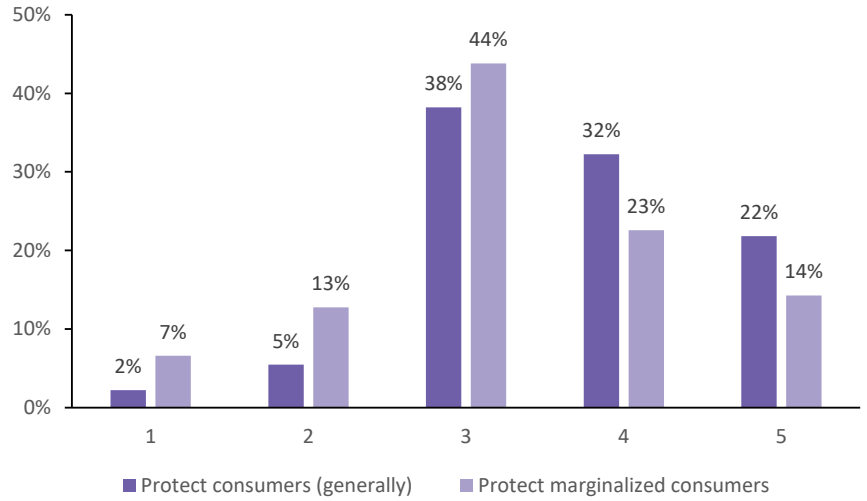


Note: N (protect consumers generally) = 1,721.
N (protect consumers from marginalized backgrounds) = 1,562.
Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). LPCs on average rated board protection of consumers in general as a 3.66 and customers from historically marginalized backgrounds as a 3.25 on a 1 to 5 scale (1 being poor and 5 being excellent). Again, 20 percent of LPCs gave a rating of 1 or 2 when asked about how well the board protect consumers from marginalized backgrounds.

H-2. LPCs — ratings on a 1 to 5 scale of how well boards protect consumers generally and consumers from marginalized backgrounds



Note: N (protect consumers generally) = 1,026.
N (protect consumers from marginalized backgrounds) = 925.

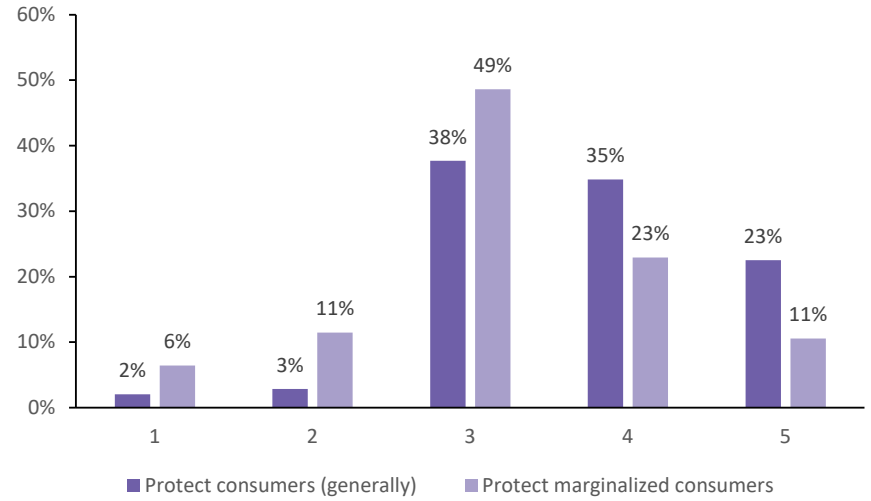
Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Licensed marriage and family therapists (LMFTs). For LMFTs, the average rating for how well boards protect consumers in general was 3.73 (the highest among all subgroups we examined).

For protection of consumers from historically marginalized backgrounds, LMFTs gave an average rating of 3.20 on a scale of 1 to 5 (1 being poor and 5 being excellent).

H-3. LMFTs — ratings on a 1 to 5 scale of how well boards protect consumers generally and consumers from marginalized backgrounds



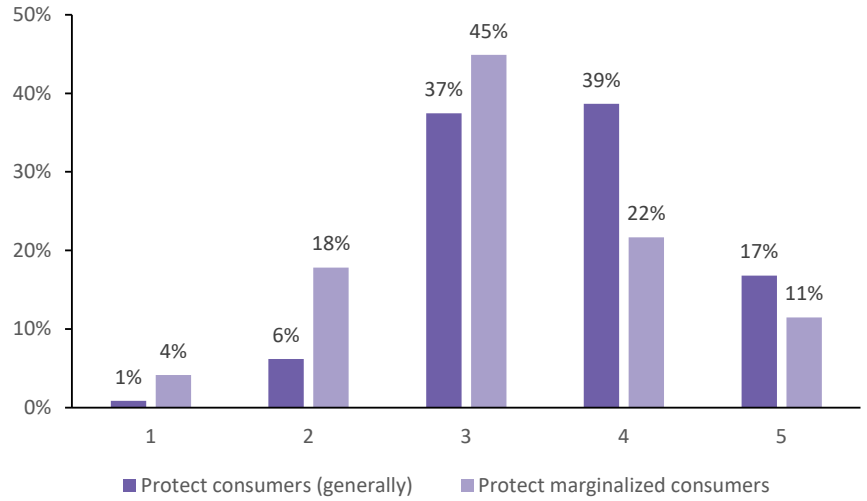
Note: N (protect consumers generally) = 244.
N (protect consumers from marginalized backgrounds) = 218.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Psychologists. On a 1 to 5 scale (1 being poor and 5 being excellent), the average rating among psychologists of how well boards protect consumers in general was 3.64. The average rating of how well boards protect consumers from historically marginalized backgrounds was 3.18.

H-4. Psychologists — ratings on a 1 to 5 scale of how well boards protect consumers generally and consumers from marginalized backgrounds



Note: N (protect consumers generally) = 339.
N (protect consumers from marginalized backgrounds) = 314.

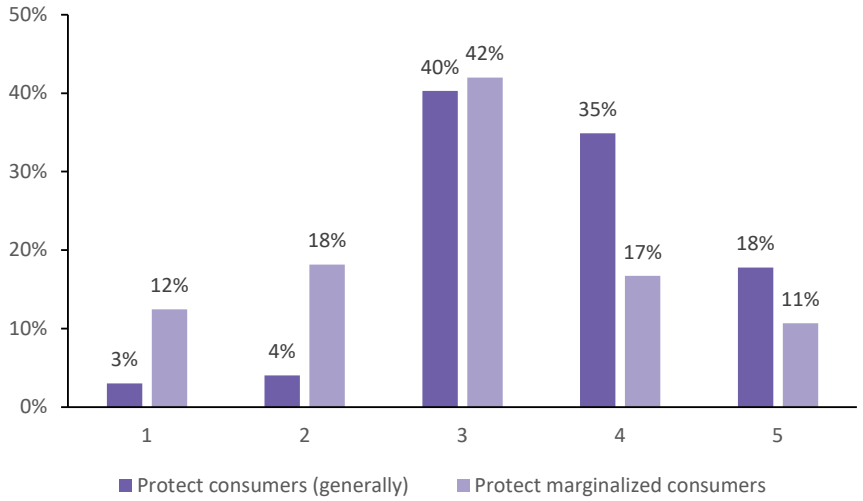
Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

People of color. Because of the relatively small numbers of participants from each racial and ethnic group who provided a comment for this question, we combined participants who identified as Black or African American, Asian American or Pacific Islander, Hispanic or Latino, American Indian or Native Hawaiian or multiracial into one group of people of color.

People of color had the largest difference between their rating of how well boards protect consumers generally (3.60) and consumers from historically marginalized backgrounds specifically (2.95). On a 1 to 5 scale (1 being poor and 5 being excellent), about 30 percent gave a rating of 1 or 2 to how well the boards protect consumers from historically marginalized backgrounds.

H-5. People of color — ratings on a 1 to 5 scale of how well boards protect consumers generally and consumers from marginalized backgrounds



Note: N (protect consumers generally) = 298.
N (protect consumers from marginalized backgrounds) = 281.

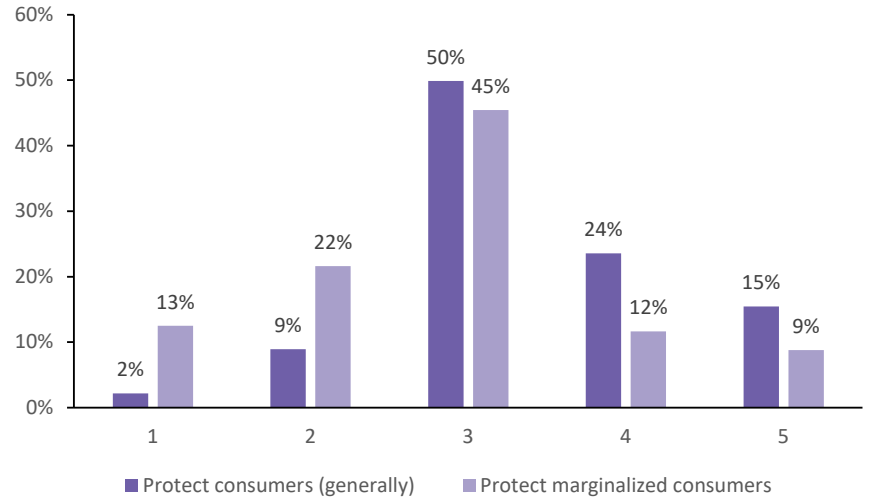
Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

LGBTQ+ participants. Due to the relatively small numbers of individuals within specific subgroups, the study team combined respondents who identified as gay or lesbian, bisexual, transgender or non-binary into one LGBTQ+ group.

On a 1 to 5 scale (1 being poor and 5 being excellent), LGBTQ+ participants' average rating of how well boards protect consumers generally was 3.41. Their average rating of how well boards protect consumers from marginalized backgrounds was 2.83, the lowest average ranking among subgroups we examined (35% of LGBTQ+ participants responded with a 1 or 2 for this question).

H-6. LGBTQ+ respondents — ratings on a 1 to 5 scale of how well boards protect consumers generally and consumers from marginalized backgrounds



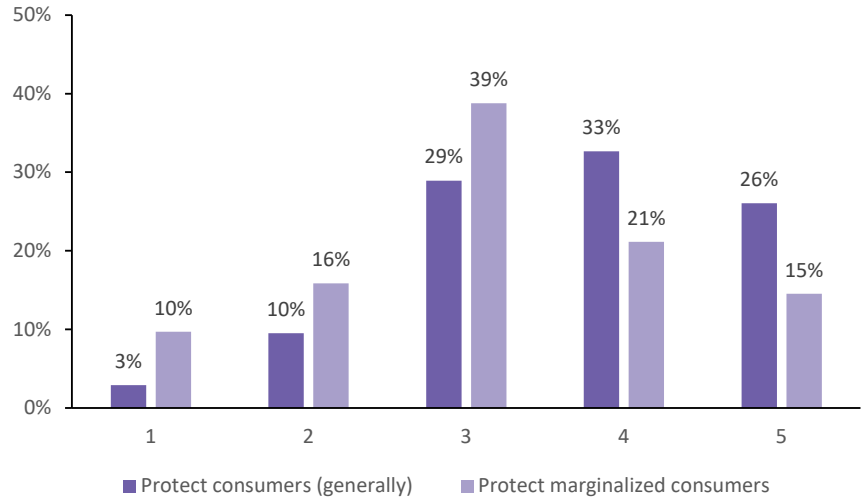
Note: N (protect consumers generally) = 369.
N (protect consumers from marginalized backgrounds) = 352.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Participants with disabilities. On a 1 to 5 scale (1 being poor and 5 being excellent), the average rating among participants with disabilities for how well boards protect consumers in general was 3.69 and the average rating for how well boards protect consumers from historically marginalized backgrounds was 3.15.

H-7. Respondents with disabilities — ratings on a 1 to 5 scale of how well boards protect consumers generally and consumers from marginalized backgrounds



Note: N (protect consumers generally) = 242.
N (protect consumers from marginalized backgrounds) = 227.

Source: Keen Independent Research.

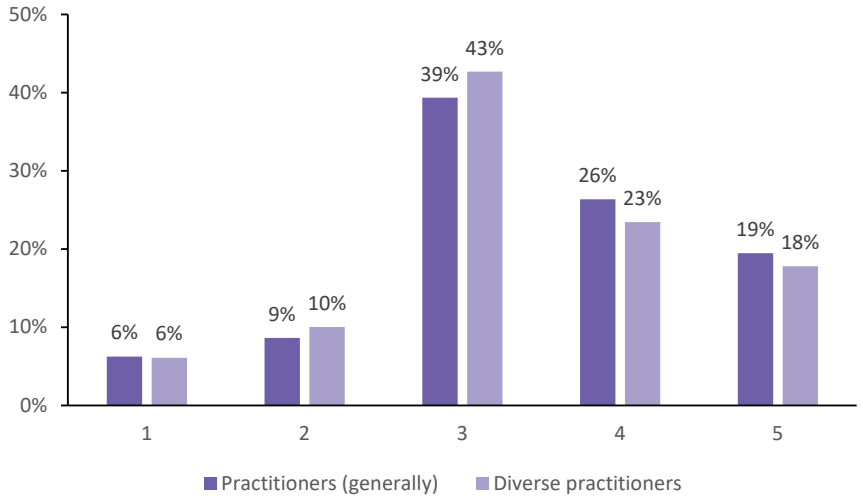
H. Equitable Protection — Quantitative analysis of virtual workshop responses

Ratings of Equitable Protection of Practitioners

In subsequent virtual workshop questions, participants were prompted to rate on a scale of 1 to 5 (1 being poor and 5 being excellent) how equitably their respective licensing boards treat mental health practitioners in general and diverse mental health practitioners specifically.

Overall ratings. Participants overall rated the boards as a 3.44 in terms of how equitably they treat mental health practitioners. When asked about diverse mental health practitioners specifically, the overall rating was a 3.37 (very little difference in the ratings).

H-8. All respondents — ratings on a 1 to 5 scale of how equitably boards treat general and diverse mental health practitioners



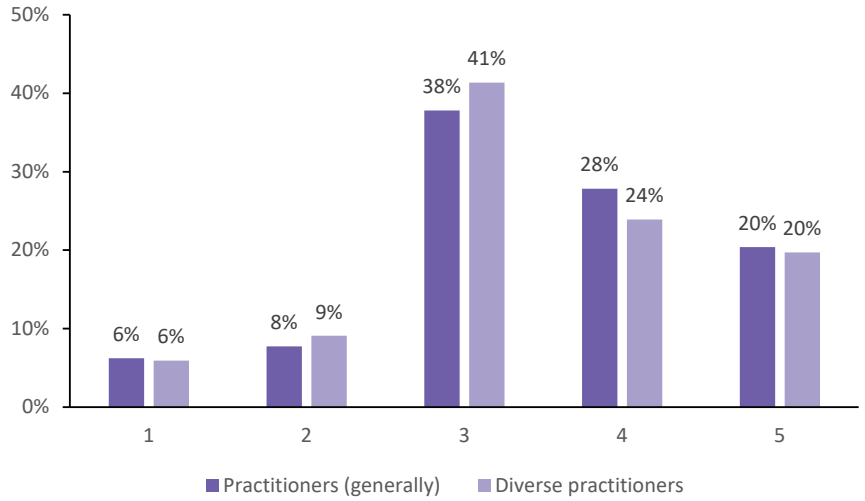
Note: N (equitable treatment of mental health practitioners) = 1,670.
N (equitable treatment of diverse mental health practitioners = 1,558.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). On a 1 to 5 scale (1 being poor and 5 being excellent), LPCs had similar ratings on average of how equitably their board treats mental health practitioners (3.48) in general and diverse mental health practitioners specifically (3.42).

H-9. LPCs — ratings on a 1 to 5 scale of how equitably boards treat general and diverse mental health practitioners



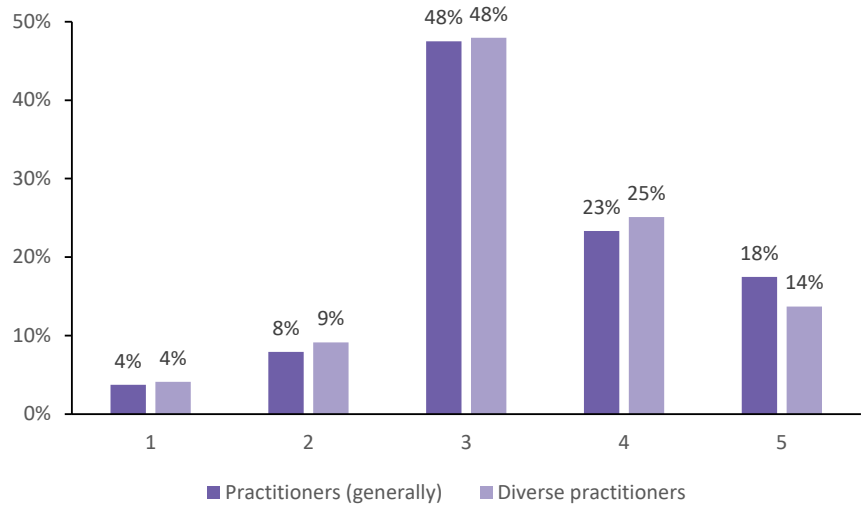
Note: N (equitable treatment of mental health practitioners) = 995.
N (equitable treatment of diverse mental health practitioners) = 924.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Licensed marriage and family therapists (LMFTs). On a 1 to 5 scale (1 being poor and 5 being excellent), LMFTs' ratings were fairly similar for how equitably boards treat mental health practitioners and diverse mental health practitioners (averages were 3.43 and 3.35, respectively).

H-10. LMFTs — ratings on a 1 to 5 scale of how equitably boards treat general and diverse mental health practitioners



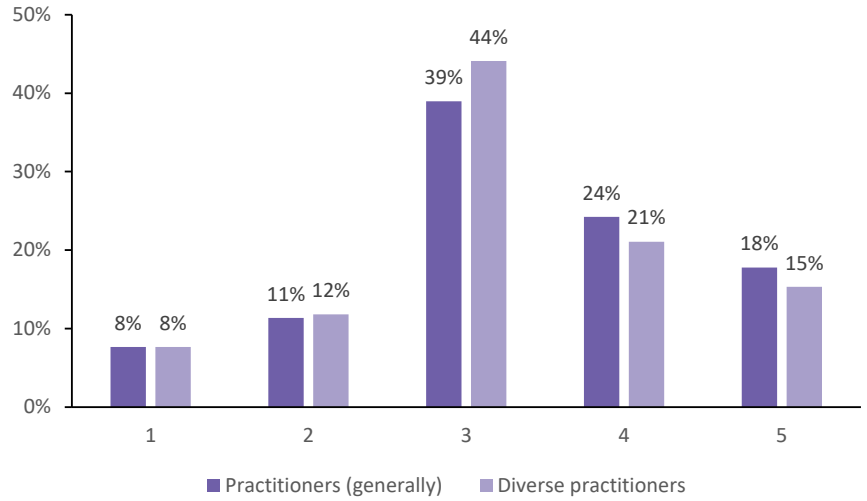
Note: N (equitable treatment of mental health practitioners) = 240.
N (equitable treatment of diverse mental health practitioners) = 219.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Psychologists. The average rating among psychologists of how equitably their board treats mental health practitioners in general on a 1 to 5 scale (1 being poor and 5 being excellent), was 3.33 and the rating for board treatment of diverse mental health practitioners in particular was 3.25.

H-11. Psychologists — ratings on a 1 to 5 scale of how equitably boards treat general and diverse mental health practitioners



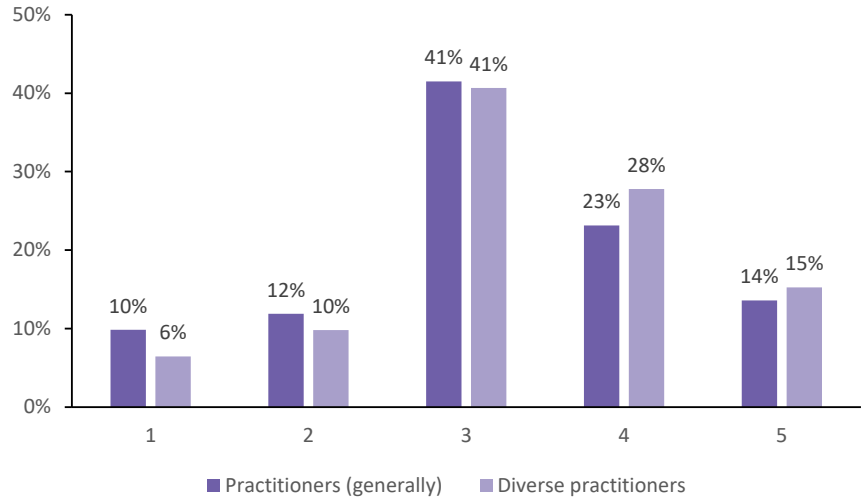
Note: N (equitable treatment of mental health practitioners) = 326.
N (equitable treatment of diverse mental health practitioners) = 313.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

People of color. Of the subgroups we examined, people of color were the only demographic to give an average rating on a 1 to 5 scale (1 being poor and 5 being excellent) for equitable board treatment of diverse mental health practitioners (3.36) that was higher than that of mental health practitioners in general (3.19).

H-12. People of color — ratings on a 1 to 5 scale of how equitably boards treat general and diverse mental health practitioners



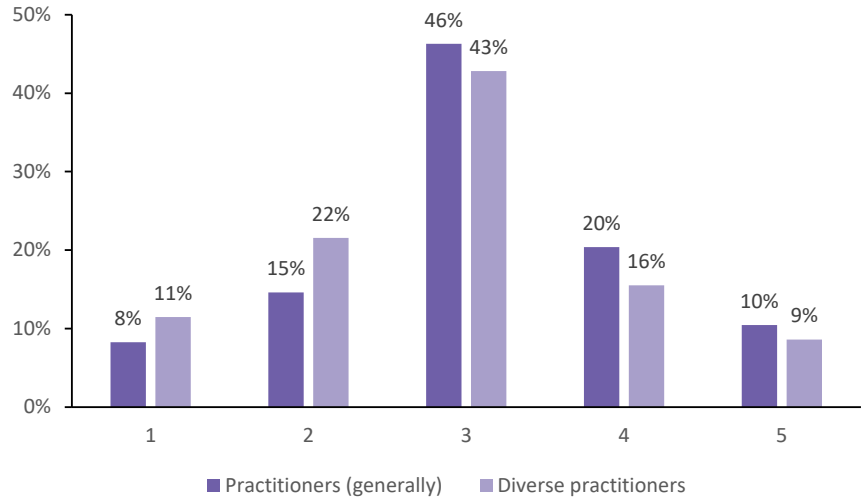
Note: N (equitable treatment of mental health practitioners) = 294.
N (equitable treatment of diverse mental health practitioners) = 295.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

LGBTQ+ participants. LGBTQ+ participants had the largest difference between their average rating on a 1 to 5 scale (1 being poor and 5 being excellent) of how equitably boards treat mental health practitioners in general (3.10) and diverse mental health professionals specifically (2.88).

H-13. LGBTQ+ respondents — ratings on a 1 to 5 scale of how equitably boards treat general and diverse mental health practitioners



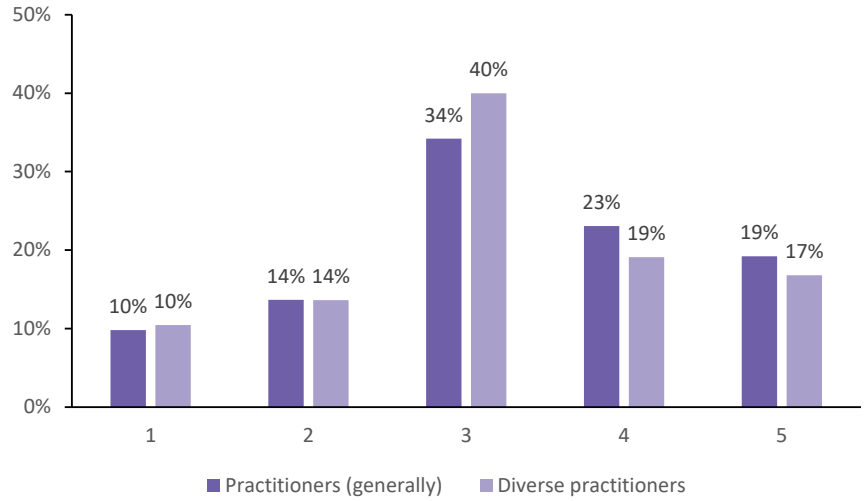
Note: N (equitable treatment of mental health practitioners) = 363.
N (equitable treatment of diverse mental health practitioners) = 348.

Source: Keen Independent Research.

H. Equitable Protection — Quantitative analysis of virtual workshop responses

Participants with disabilities. The average rating on a 1 to 5 scale (1 being poor and 5 being excellent) among participants with disabilities for how equitably boards treat mental health practitioners in general was 3.28. The average rating for how equitably boards treat diverse mental health practitioners was 3.18.

H-14. Respondents with disabilities — ratings on a 1 to 5 scale of how equitably boards treat general and diverse mental health practitioners



Note: N (equitable treatment of mental health practitioners) = 234.
N (equitable treatment of diverse mental health practitioners) = 220.

Source: Keen Independent Research.

H. Equitable Protection — Participant perspectives

The following pages of this appendix provide qualitative analysis of frequently cited factors related to the equitable protection of mental health consumers and professionals by MHRA, OBOP and OBLPCT.

This analysis draws on comments submitted through the virtual workshop as well as interviews and focus groups with mental health professionals.

Findings are organized by theme as follows:

- Positive aspects;
- Finding "like" counselors;
- Uninsured and underinsured consumers;
- Complaints without adequate action;
- LGBTQ+ mental health consumers;
- Disciplinary action impact on consumer protection; and
- Protecting the public by protecting professionals.

H. Equitable Protection — Participant perspectives

Positive Aspects

Participants infrequently mentioned ways that the boards support equitable protection. Positive comments noted that the boards take complaints seriously and have made efforts to support diversity.

The board takes complaints very seriously and actively investigates consumer concerns to protect consumers across the entire state.

Biracial, LGBTQ+, female licensed professional counselor

[The board's] intent to address [and] impact diversity has been more apparent in the last five year[s].

Hispanic American, female licensed professional counselor

By advertising and showcasing the diversity of mental health professionals, [the boards] are able to create community with all Oregonians.

White, female licensed professional counselor

[The board's] requirements for us to take workshops on diversity alert us to implicit bias and help us to examine our own attitudes more deeply.

White, female licensed professional counselor

H. Equitable Protection — Participant perspectives

Finding "Like" Counselors

Clinicians' comments recognized the importance of understanding their client populations as a foundation for successful therapeutic relationships. Comments also recognized that clients may seek services from someone "like themselves" in terms of specific demographic characteristics as way to trust the ability of the clinician to understand their background and experiences and provide support.

… research has shown that in both the therapeutic relationship and in the supervisory relationship, clients do not return to counseling because of culturally related … therapeutic ruptures or supervisees give up on becoming counselors because of ruptures that happen in the supervisory relationship.

African American mental health clinician and educator

It's really important as a white practitioner that I know the populations I'm working with and I understand the demographic makeup of my area, as well as the impact that I make as a counselor in a position attempting to [help clients] heal or work in a human service capacity while still representing my part of the dominant society that's very oppressive.

White, male professional counselor associate

H. Equitable Protection — Participant perspectives

Lack of diverse clinicians. Many professionals described lack of diversity of clinicians from specific backgrounds. They expressed concern that this lack of diversity may adversely affect mental health services for Oregonians of different racial and ethnic groups, who speak languages other than English, persons with disabilities and men, (notably mental health professions are female-dominated fields).

In some cases, participants perceive practitioners to be less diverse than they are. For example, some participants described Spanish speaking practitioners as nearly non-existent. Demographic data analysis, as reported in Appendix B, found more Spanish speaking clinicians than some participants appeared to realize. However, Spanish speaking clinicians are underrepresented compared to Oregon's population (with 9% of Oregon's population speaking Spanish compared to 6% of Oregon's professionals).

There are certainly not a lot of Black clinicians, let alone Black psychologists, in this state.

African American licensed psychologist

We have several reservations [in the state, yet] in the entire time I have been in Oregon, I have never met a Native American clinician.

White, female mental health professional

It's sad to see and it's disheartening when clients are asking for more representation [of] their background, as in a counselor, and then there's just not that [available].

Female professional counselor associate of color

When it comes to serving the Latinx community [so] people can receive services in their [native] language, there are very few of us [qualified to do that]. Many of those … licensed are [at the] master's degree level. When it comes to psychologists? You can count them almost with your two hands and that's it.

Hispanic American, female mental health professional

While 26 percent of U.S. adults are disabled, less than six percent of counselors are … — [often] the data on disability isn't even collected.

White, female licensed professional counselor with a disability

There are few providers who are deaf/hard of hearing or who [have] other disabilities [because they are often] viewed as less able.

White, female licensed professional counselor with a disability

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[When] I go to trainings, there will be 80 people in the room and there will be five men. This profession is overwhelmingly feminine.

Biracial, male licensed professional counselor

H. Equitable Protection — Participant perspectives

Uninsured or Underinsured Consumers

Some professionals discussed services and protection for uninsured or underinsured clients as a limitation to equitable protection. This topic is closely related to protection of consumers of color or from other non-dominant groups.

Uninsured and underinsured consumers are often served in community mental health agencies. They may also have complex intersecting and complex challenges involving socioeconomic status and mental health diagnoses. Many are people of color or other marginalized groups.

As discussed in prior appendices, less experienced clinicians accruing hours toward licensure often have caseloads of clients with the most acute challenges due to insurance reimbursement policies (Oregon Health Plan is the only insurer that covers services by registered associates).

I work exclusively in community mental health. [For] so many of our clients who are clients of color — specifically black clients — it's nearly impossible to find a clinician who can take their insurance … who is BIPOC (Black, Indigenous, People of Color).

Licensed professional counselor of color

Working with the Latinx community predominantly … A lot of those folks are uninsured. It's hard to be able to provide services when they might not be able to pay for it out of pocket and they might not necessarily qualify for health insurance.

Hispanic American, female licensed psychologist

H. Equitable Protection — Participant perspectives

Complaints Without Adequate Action

Appendix G includes in-depth information about complaints and investigations. Participant perspectives included comments about the experiences of professionals as complainants, whether the boards are equitable in their response to complaints involving clients from marginalized groups and specific concerns about complaints involving allegations of racial discrimination and LGBTQ+ professionals.

When asked directly about the boards' equitable protection of consumers, some practitioners raised the topic of complaints again, expressing concern about adverse impacts of complaint dismissals on clients from marginalized groups.

Some also criticized MHRA, OBOP and OBLPCT for selective enforcement of complaints (e.g. Covid related), which they believe put clients at risk.

Some participants reported that they no longer encourage their clients to file complaints about professional misconduct by prior clinicians because the toll on their clients of unexpected outcomes and delays in investigations was too great.

As described in Appendix G, some participants believe MHRA, OBOP and OBLPCT do not take complaints about cultural bias or racial discrimination against practitioners as seriously as other types of complaints. Participants expressed similar concerns about the protection of clients of color.

During the pandemic, the board did little to respond to reports of licensed practitioners violating the governor's order and placing clients at risk of exposure to COVID.

Licensed professional counselor with a disability

If [an] associate or license [holder] experiences racism in the workplace, there are no EXPLICIT policies that support the experience [of the person] who has experienced racism. If we do report it, we have white dominate culture investigators, board members and staff that gather subjective data to determine the outcome.

African American, female licensed professional counselor

I've experienced bizarre rulings in the few times I made complaints to the board. I no longer encourage my clients, who are mostly BIPOC, to file complaints because it can be counter-therapeutic.

Asian American Pacific Islander, female licensed psychologist

At this point, I no longer encourage my clients to file complaints [against other mental health practitioners who hurt them] …. I've had two clients do that, and they ended up being more hurt because the board didn't investigate until so long [had passed since the incident].

Mental health practitioner of color

… if you file a complaint that is thematically about cultural bias, it's not taken as seriously as sexual harassment [or] a boundary violation, like taking gifts or something like that.

African American, female licensed professional counselor

H. Equitable Protection — Participant perspectives

LGBTQ+ Mental Health Consumers

Some participants expressed concern that MHRA, OBOP and OBLPCT dismiss complaints and ignore concerns involving the safety and mental health of LGBTQ+ clients.

As discussed in Appendix E, diagnostic classifications in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association defined sexual orientations other than heterosexuality as treatable mental health conditions until the publication of DSM-5, just nine years ago.[2]

Discredited treatment approaches. In recent years, every major mental health organization has warned against treating sexual orientation as curable and has opposed the use of discredited practices that focus on changing sexual orientation ("conversion therapy").[3] The American Psychological Association (APA) and the American Association for Marriage and Family Therapy (AAMFT) issued statements in 2009 that reiterated the dangers of "conversion therapy" and underscored the ethical expectations that clinicians practice based on clinical evidence. The American Counseling Association (ACA) condemned "conversion therapy" in 2013. "Conversion therapy" is banned in 19 states, including Oregon, if the recipient of conversion therapy is under the age of 18.[4] [5]

… it is scary to think people could be fooled into [conversion therapy]. Where is the protection for consumers? …. [It] is wrong when some therapists put down LGBTQ as a population they counsel, and it … is for conversion therapy. I don't think anyone enforces [honesty] ….

Mental health professional

Of particular recent concern is the board's decision to dismiss a complaint against a counselor conducting conversion therapy against trans youth and children on the technicality of it being done by proxy of the parents.

White, LGBTQ+, licensed professional counselor

[The board condones] homophobic practices and attitudes including conversion therapy condoned as acceptable for therapists if aligned with their religious beliefs.

White, female, LGBTQ+ professional counselor associate

OBOP's previous attorney general openly supported a judge who refused to officiate same sex marriages. Also, the Vice Chair has self-published a book with homophobic elements …. How are sexual and gender minorities [supposed] to feel safe [dealing with the board] when such overtly biased members are serving in its highest ranks?

Mental health professional

[2] Cabaj, R. (n.d.). *Working with LGBTQ patients.* American Psychiatric Association. https://psychiatry.org/psychiatrists/diversity/education/best-practice-highlights/working-with-lgbtq-patients

[3] Human Rights Campaign. (n.d.). *Policy and position statements on conversion therapy.* https://www.hrc.org/resources/policy-and-position-statements-on-conversion-therapy

[4] American Counseling Association. (n.d.). *Conversion therapy bans*. https://www.counseling.org/government-affairs/state-issues/conversion-therapy-bans

[5] Oregon ORS. § 675.850 (2021). https://oregon.public.law/statutes/ors_675.850

H. Equitable Protection — Participant perspectives

Gender-affirming care. Similarly, major medical associations and the APA and ACA support gender-affirming care for individuals who are transgender or gender non-conforming.[6] [7] [8] Some practitioners express concern that MHRA, OBOP and OBLPCT do not do enough to prevent harm to transgender and gender non-conforming clients.

Procedural note. Oregon's ban exempts "conversion therapy" provided to adults and/or provided by clergy. MHRA, OBOP and OBLPCT have adopted the APA and ACA codes of ethics as their professional standards and both APA and ACA condemn "conversion therapy" as unethical. According to MHRA staff, complaints that allege misconduct but do not yield evidence of harm to specific clients or that "conversion therapy" was performed on a minor are challenging to investigate.

[Clinicians] will say their … personal opinions [about gender therapy such as] 'Well, you do know that's wrong?' I had a transgender client] tell me their [prior] therapist told them that they were 'gonna go to you-know-where.' That's very discouraging … ethically [and] this is something that gets overlooked and is very damaging

Multiracial, non-binary licensed professional counselor

[6] Human Rights Campaign (n.d.). *Get the facts on gender affirming care*. https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care

[7] American Psychological Association. (2015). *Guidelines for psychological practice with transgender and gender nonconforming people.* https://www.apa.org/practice/guidelines

[8] Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H., Loos, B., Harper, B., Graham, S., Singh, A., Kocet, M., Travis, L., & Lambert, S. (2009). *ALGBTIC competencies for counseling LGBQIQA.* American Counseling Association. https://www.counseling.org/docs/default-source/competencies/algbtic-competencies-for-counseling-lgbqiqa.pdf?sfvrsn=1c9c89e_14

H. Equitable Protection — Participant perspectives

Disciplinary Action Impact on Consumer Protection

Practitioners often expressed reservations about what they perceive to be rigid enforcement of regulations and rigid approaches to disciplinary actions as counterproductive to consumer protection. In some cases, they described ways that disciplinary actions seem to be decided or implemented without regard for the impact on specific clients or the availability of mental health care to the public in general.

As addressed in Appendix F, some participants expressed concern that clients with criminal records or seeking help with addiction may be negatively affected if MHRA, OBOP and OBLPCT practices discourage clinicians who have relevant personal experiences.

Appendix F also notes the potential impact of disclosures and background checks on practitioners or potential applicants with past criminal records or substance abuse.

Participants reported concern that disciplinary action against people who have these experiences, or fail to disclose them, may push clinicians out of the field when a preferable path that is more protective of clients, would be to find a way to support and retain them.

If there are mistakes in the relicensing process, like a credit card charge that did not go through or a late reapplication because of a family crisis, there is no protection of the public in taking the license away …. It limits [mental health] care to Oregonians.

White, male licensed professional counselor

I had a client who [experienced a mental health crisis] because after the board disciplined me, insurance [company] panels removed me from their panels [of covered providers]. The insurance companies didn't contact me or the clients. It's a horrible thing to rip someone's counselor away from them …. That is not protecting the public.

White, female mental health professional

Expecting clinicians to continue coughing up money just to keep their license is ridiculous. Paying that fee doesn't make me a better clinician, but it can prevent me from serving clients if I can't make that payment when it's due.

Hispanic American, female marriage and family associate

[The board takes a] punitive stance toward clinicians with substance use disorders.

American Indian, male mental health professional

H. Equitable Protection — Participant perspectives

Protecting the Public by Protecting Professionals

Professionals frequently spoke of the board's orientation toward consumer protection as happening at the expense of supporting and protecting professionals too. Many described effective support for mental health professionals as an important way to protect the public.

Some pointed out that professionals are members of the public too but feel that the boards' focus on protection excludes them. Comments reflected a desire to feel more supported by the boards.

The perception has been that the board is there to protect the public and not necessarily there to support the counselors and therapists, and that perception is problematic because the goal of the board is to support the counselors and therapists, so that the public is protected, right? But … I think the message is that the board's main concern is to protect the public, so in some ways it's almost like if you were a parent the way you perceive CPS (child protective services) is how many counselors and therapists perceive the board.

Mental health professional and educator of color

You can protect and serve the public while … working with [licensees] as a supportive entity. I don't think OBOP does that and so I just try to put my head down, do my work, and stay under their radar.

Female licensed psychologist of color

The board is set up to support consumers, but this should include supporting professionals to learn and grow. It does not seem to impart that balance.

Female licensed psychologist

The general public includes ourselves [as practitioners] …. We're not the stand-alone group out there.

Hispanic American, male licensed psychologist

… I've divested emotionally from the board and regulatory process …. I don't feel like there's a level of advocacy out there for me. I don't really feel like they care whether or not I fall through the cracks or whether or not I can access the system and it can work for me.

White, female professional counselor associate

H. Equitable Protection — Participant perspectives

MHRA, OBOP and OBLPCT as unsupportive Some participants described feeling unsupported by the boards. Some described feeling the boards are adversarial toward professionals.

Participants described the attitude of MHRA, OBOP and OBLPCT as a factor that may deter mental health professionals from practicing in Oregon and connected the feeling of neglect or scrutiny by the boards to adverse impacts on people from marginalized groups.

When the big House bill in Oregon came out to support us [BIPOC clinicians] in the work we do, there was very little information about it. We called the Oregon board to [confirm], 'We hear there's a lot of OHA money that can support BIPOC supervisors.' The pushback that we got [was intense] …. It felt like we were being put in our place. It was a jarring realization that when we call that line or send a check to that address we're not being represented on the other end.

African American mental health professional

I respect the board's responsibility to protect consumers, but … it feels as though the board is against its own professionals. This can make any interaction with the board feel precarious, rather than facilitative.

White, male licensed psychologist

I am shocked at how this board handles 'investigations.' It's a game of 'gotcha' that aligns with any claim a consumer makes. There is no support of those in the field.

White, LGBTQ+, female licensed professional counselor

I have talked to many people who have said they're moving to other states because they see the board here as being more of a detriment to practicing and less as the support to practicing.

White, LGBTQ+, non-binary licensed professional counselor

The board historically has reflected the prejudices of the community, rather than protect providers who are from and/or who serve marginalized communities.

LGBTQ+ licensed professional counselor

OBOP [Oregon Board of Psychology] can come across as overly punitive. It is difficult to foster diversity, particularly with historically targeted populations, in an environment in which they feel scrutinized rather than supported.

White, male licensed psychologist

APPENDIX I. Board Composition

This appendix synthesizes feedback from professional counselors, marriage and family therapists and psychologists in Oregon about the composition of their professional boards.

Practitioners licensed and regulated by the Oregon Mental Health Regulatory Agency (MHRA), the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) provided input via interviews, focus groups and responses to a virtual workshop (similar to a survey, with more opportunity for open-ended comments).

For information about the demographics of OBOP and OBLPCT members, see Appendix B. Appendix J provides additional discussion of opportunities and barriers related to board membership and composition.

Information in this appendix includes:

- Quantitative analysis of virtual workshop responses regarding the impact of board composition on diversity;[1] and
- Qualitative analysis of participant perspectives about board composition as a factor that may impact diversity.

Sample comments from research participants throughout this appendix are drawn from the virtual workshop as well as from focus groups and interviews. In some cases, participants also emailed the study team with comments. As in other appendices, identifying information is excluded.

Throughout our qualitative analysis of participant perspectives, we include comments even if they do not explicitly name an impact on diversity or equity. As noted in prior appendices, such comments are included because of the context in which they were provided (in response to questions about diversity and equity) and because marginalized groups may experience amplified effects of challenges that are present for everyone.

[1] A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

I. Board Composition — Quantitative analysis of virtual workshop responses

Impact of Board Composition on Diversity

The virtual workshop asked participants to indicate how the demographic composition of their respective licensing board affects the diversity of the mental health profession in Oregon. Respondents were given the following options:

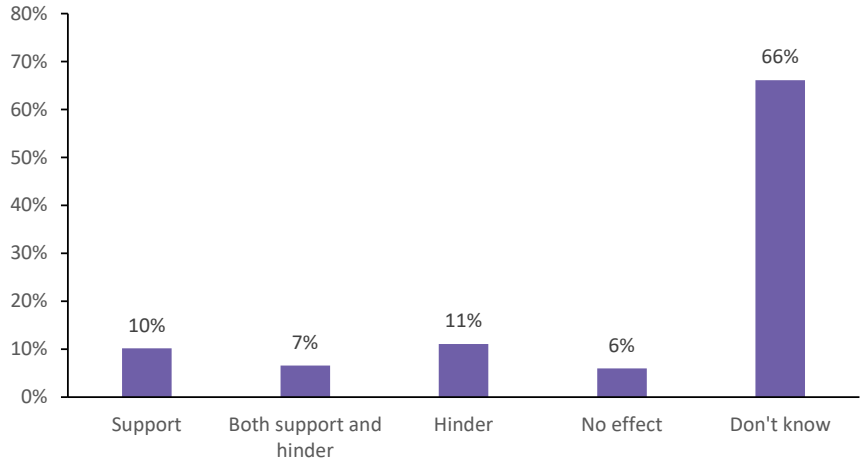
- Support;
- Both support and hinder;
- Hinder;
- No effect; and
- Don't know.

For all subgroups we examined, 50 percent or more of the respondents indicated that they did not know how board composition affected diversity.

Overall results. Figure I-1 shows displays how participants indicated board composition influences diversity in the mental health profession.

The vast majority of respondents indicated that they did not know if board composition influenced the diversity of the profession (66%). About as many participants indicated board composition hindered diversity (11%) as said it supported it (10%).

I-1. All respondents — indications of how board composition affects diversity in the mental health profession



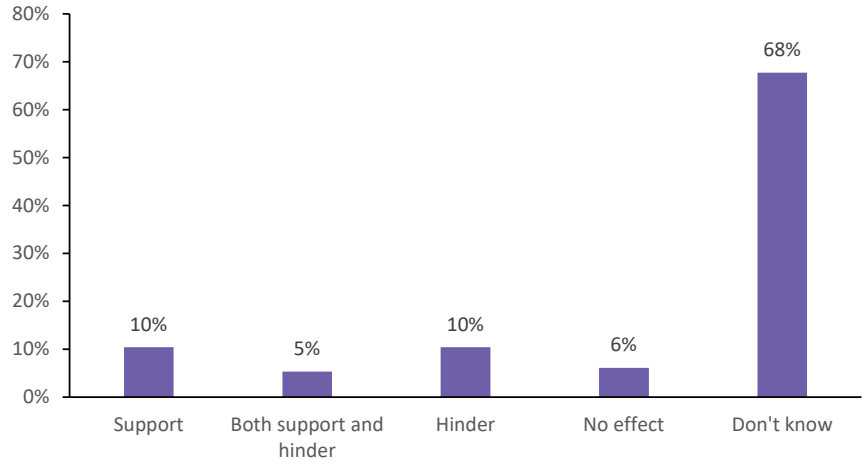
Note: N = 1,651.

Source: Keen Independent Research.

I. Board Composition — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). As LPCs made up the majority of respondents, the distribution of their answers is typical of the average among all participants for this question. Most responded "don't know" to this question. Of LPCs who gave a response other than don't know, there were about as many responses that board composition supported diversity as said it hindered diversity.

I-2. LPCs — indications of how board composition affects diversity in the mental health profession

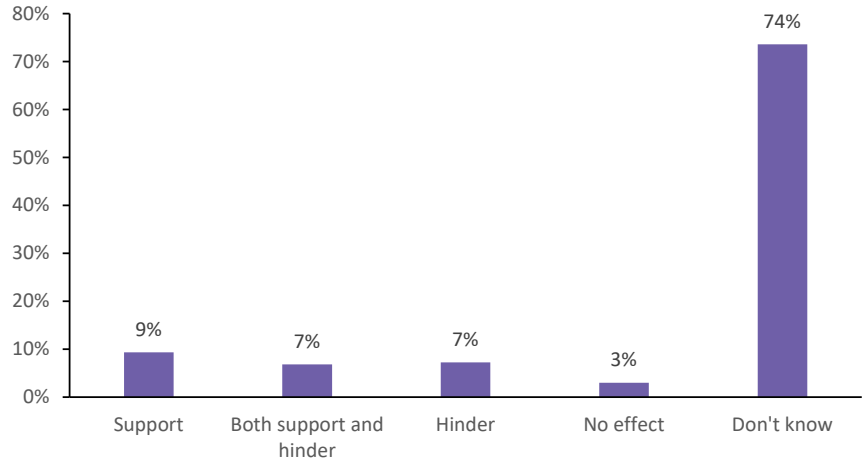


Note: N = 980.

Source: Keen Independent Research.

Marriage and family therapists (LMFTs). Of the subgroups we examined, LMFTs had the highest percentage of respondents indicate they did not know whether board composition impacted diversity in the profession (74%).

I-3. LMFTs — indications of how board composition affects diversity in the mental health profession



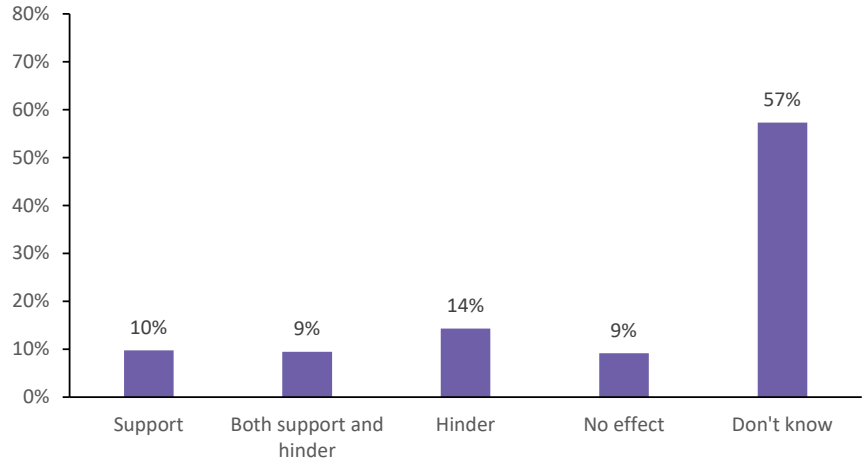
Note: N = 235.

Source: Keen Independent Research.

Psychologists. Compared with other practitioners, relatively fewer psychologists reported "don't know" to the question about whether board composition affects diversity (57%).

Slightly more responses from psychologists indicated that board composition hinders diversity compared to the overall response (14% and 11%, respectively).

I-4. Psychologists — indications of how board composition affects diversity in the mental health profession



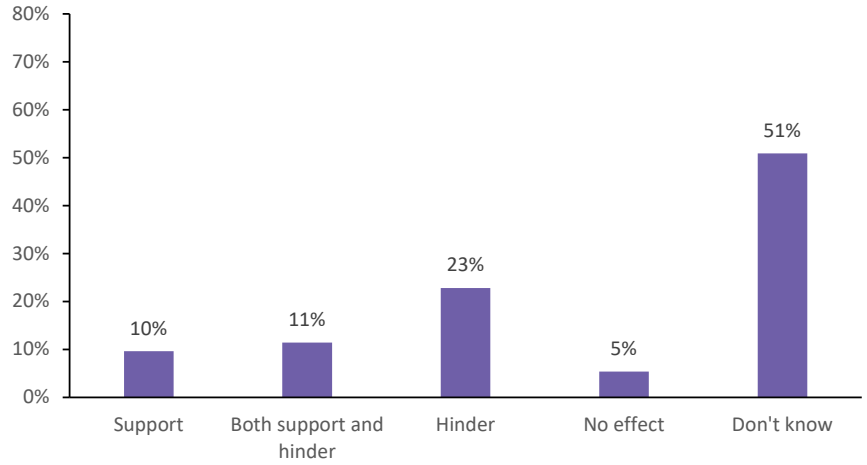
Note: N = 328.

Source: Keen Independent Research.

I. Board Composition — Quantitative analysis of virtual workshop responses

People of color. Compared to respondents overall, relatively more people of color indicated that board composition hinders the diversity of the mental health profession (23% compared to 11% overall).

I-5. People of color — indications of how board composition affects diversity in the mental health profession

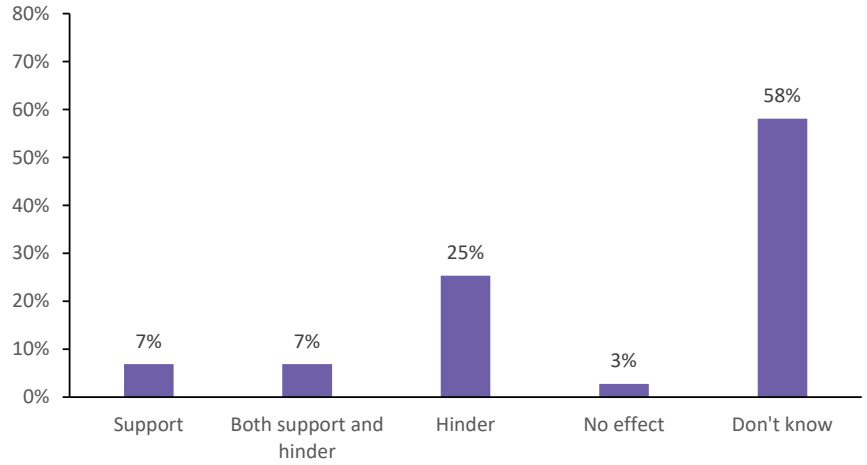


Note: N = 281.

Source: Keen Independent Research.

LGBTQ+ respondents. LGBTQ+ respondents indicated that board composition hinders diversity in the profession at the highest rate of any subgroup we examined (25%).

I-6. LGBTQ+ respondents — indications of how board composition affects diversity in the mental health profession

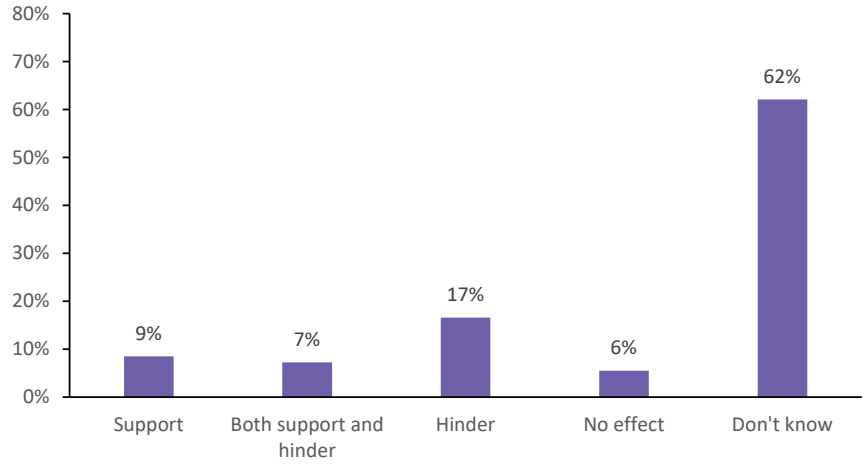


Note: N = 363.

Source: Keen Independent Research.

Respondents with disabilities. Compared to the overall responses, relatively more participants with disabilities indicated that board composition hinders diversity in the mental health profession (17% compared to 11% overall).

I-7. Respondents with disabilities — indications of how board composition affects diversity in the mental health profession



Note: N = 235.

Source: Keen Independent Research.

I. Board Composition — Participant perspectives

The next section of this appendix provides qualitative analysis and sample quotes related to board composition.

This analysis draws on comments submitted through the virtual workshop as well as interviews and focus groups with mental health professionals.

Findings are organized by theme as follows:

- Diverse representation matters;
- Positive impressions;
- Negative impressions;
- Defining diversity broadly; and
- Diverse representation alone doesn't cut it.

I. Board Composition — Participant perspectives

Diverse Representation Matters

Professionals frequently spoke of diverse representation on OBOP and OBLPCT. They noted value of visible leaders of color in further diversifying the mental health fields in Oregon and bringing new ideas and perspectives.

Comments were closely intertwined with trust in the fairness of board decisions regarding complaints (see Appendix G.)

How well does the board demographics represent the client demographics? If they do not map well onto this, it is hard to ensure that we are serving our clients well.

Asian American/Pacific Islander, female licensed psychologist

Having leaders of color, of marginalized identities or groups [and having] a diverse set of board members or people in positions of power is important for both inspiring new individuals into the field and at the same time representing a much more diverse set of perspectives and views.

Asian American/Pacific Islander, non-binary mental health professional

If you're looking to transform the way a regulatory body regulates and you don't have voices at the table that can bring in ideas that have not been valued or listened to before, you're gonna get the same thing over and over and over again …. You really need to have representation from diverse groups so that you can create some [form of] cultural democracy, where different cultural perspectives can be seen as important and effective.

White, female licensed marriage and family therapist

You need more BIPOC (Black, Indigenous and People of Color) folks in positions of power. PERIOD. I don't need a bunch of white people looking for their good job cookies because they're so woke or they're initiating these conversations.

Hispanic American, female mental health professional

Different perspectives, different cultures, different backgrounds different ideas—that's what makes something well-rounded and balanced. If you only have cisgender white male[s], you're gonna have [a] very different perspective than if you have all black females. …. We really need representation from across the board in order to have equitable decision making.

Licensed professional counselor with a disability

When [the board says] I will be judged by a jury of my peers, I always think to myself, 'If more than half of these people don't look like me [then] they're not my peers.'

African American, female mental health professional

I. Board Composition — Participant perspectives

Positive Impressions

Some participants observed recruitment efforts and current composition of their board as positives.

I have seen when they have [posted] a recruitment of board members, or [been] asking … for board members to be from a racial and ethnic diverse background.

Hispanic American, female mental health professional

A couple of recent new board members have been non-white women.

White, female licensed psychologist

They have a few Asian people on the board.

Asian American/Pacific Islander, female licensed psychologist

The current composition of the OBLPCT is quite diverse. I would think that it is more diverse than the current configuration of the population of the State of Oregon.

Hispanic American, male licensed professional counselor

I. Board Composition — Participant perspectives

Negative Impressions

Some practitioners mentioned that board members are predominantly white and male. They also perceive that positions are typically held by socioeconomically advantaged private practitioners.

The most senior [board] members are predominantly old white men.

Asian American/Pacific Islander, female mental health professional

I look at one of the board meetings — I feel like I've walked into 1952.

Hispanic American, male licensed psychologist

Traditionally, the OBLPCT has been Eurocentric and also [primarily composed of] private practice, upper middle class [practitioners].

White, male licensed marriage and family therapist

[The] board is disproportionately male …. [It] should better reflect the demographics of the profession, which is predominately female.

White, female professional counselor associate

The people who have historically been on the board have occupied other positions of power in the community. I find that questionable.

Multiracial mental health professional

I. Board Composition — Participant perspectives

Lack of representation. Many pointed out the absence or underrepresentation of board members from specific demographic groups as a negative factor.

Invisibility of representation. Some participants indicated that race and ethnicity may be visible or evident, but other indicators of diversity may be invisible. They pointed out that it's unclear if the board is inclusive in terms of demographics that are not always apparent such as gender identity, sexual orientation, neurodiversity or disability.

As a Black psychologist, there is no one [on] the board who I see myself in or who represents me.

African American licensed psychologist

Five of the seven board members are white, [and] four of [the] seven [are] white males. Indigenous communities are not represented at all, and there is no department to advocate and support the professionals who fund this board.

Female licensed professional counselor

There is no Hispanic representation [on the board].

Hispanic American, mental health professional

Are there people on the board who are gender and sexual minorities? …. From what I can see, it doesn't feel like that is reflected …. [There are] a lot of able-bodied, seemingly cis[gender] white people who are on the board.

African American licensed psychologist

It is unclear if there is LGBTQ representation [on the board].

Non-binary licensed professional counselor

Everywhere I look … I can see a white person, but for me it's important to be able to see … not that we can tell just by looking at someone but see other people with half their heads shaved and their head not, like queer folks, or people that talk about being neurodivergent, or people that talk about their disabilities or have disabilities. [It shows me] that we can still show up and lead and work in systems too.

White, non-binary mental health professional with a disability

I. Board Composition — Participant perspectives

Defining Diversity Broadly

Many participants noted that there is value in conceiving of diversity more broadly than top-of-mind demographic groups.

They mentioned the value of a range of factors including:

- Age;
- Experience;
- Professional characteristics including discipline or expertise, part-time status or client focus;
- Geographic range across Oregon, including rural areas; and
- Diversity of thought.

Just as important to having race and culture diversity, the age, experience, and focus of interest should be considered.

Biracial, female licensed professional counselor

You still need to increase the number of younger board members.

Asian American/Pacific Islander, male mental health professional

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I think having several different disciplines, including non-professionals, on the board is a great way to include as much diversity as possible.

White, LGBTQ+, female licensed professional counselor

I see a lot of academics and folks with agency experience [on the boards], which inherently leaves out folks who work part time.

White, LGBTQ+, female licensed professional counselor

I would like to see more [board] members who have direct work experience with military members.

Hispanic American, male licensed professional counselor

[The board] doesn't seem to have an equitable representation of rural practitioners.

Multiracial, male licensed professional counselor

[There are] no requirements for [different] regions of the State to be represented [on the board] that I am aware of.

White, male licensed professional counselor

The is no diversity on the board if you look beyond sex and color. There are no different opinions.

Female licensed professional counselor

I. Board Composition — Participant perspectives

Diverse Representation Alone Doesn't Cut It

Participants described the importance of adopting inclusive practices. Some noted that without this, the ability to attract, retain and benefit from new perspectives will be limited.

One challenge of diverse representation on the board as a primary strategy is evident in the range of comments reported earlier in this appendix about demographic groups not perceived to be present on the board at any given time. To create diversity through direct representation, how many board seats must there be? If board seats are finite, who is left out? If board focus is on who fills the seats at the table alone, underrepresented groups may always have grounds to complain that the board does not include them.

Some participants described limitations to focusing on diverse representation alone and emphasized the importance of strategies that foster inclusion and belonging on the boards.

If I were not me, I would wonder, 'Would I want to sit on that board?' Because this one person, even though they made a very important point, was a lone voice. It was acknowledged, but it wasn't given the gravitas … it deserved. I think that's part of the reason people of color don't want to be on boards where it's just one or two of you…. people don't intend to disregard what you're saying, but they do …. And if this is happening in a in a meeting where the public can attend, I could see that as a barrier why people wouldn't tell themselves, 'Hey, I should be on the board too.'

Mental health professional of color

The only board members explicitly discussing diversity, equity and inclusion are people of color. This does not give me confidence that the board as a whole is upholding [these] values. If the white board members were to more openly discuss their commitments to equity, diversity and inclusion, my position may change.

African American, female mental health professional

The problems are systemic and not addressed by tokenization and filling the board with a diverse group of people who are largely aligned with the board as it already is.

White, LGBTQ+ licensed professional counselor

APPENDIX J. Opportunities and Barriers

This appendix synthesizes feedback from mental health professionals about opportunities and barriers related to improving diversity and equity in Oregon's professional counselor, marriage and family therapy and psychologist professions.

Practitioners licensed and regulated by the Oregon Mental Health Regulatory Agency (MHRA), the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and the Oregon Board of Psychology (OBOP) provided input via interviews, focus groups and responses to a virtual workshop (similar to a survey, with more opportunity for open-ended comments).

Also included here where relevant are findings from interviews with contacts for similar state regulatory groups in Oregon or elsewhere and national professional association contacts.

Information in this appendix includes:

- Quantitative analysis of virtual workshop responses about opportunities to improve diversity and equity;[1] and
- Qualitative analysis about opportunities and barriers to improving diversity and equity.

Sample comments from research participants throughout this appendix are drawn from the virtual workshop as well as from focus groups and interviews. In some cases, participants also emailed the study team with comments. As in other appendices, identifying information is excluded.

Throughout our qualitative analysis of participant perspectives, we include comments even if they do not explicitly name an impact on diversity or equity. As noted in prior appendices, such comments are included because of the context in which they were provided (in response to questions about diversity and equity) and because marginalized groups may experience amplified effects of challenges that are present for everyone.

Many comments from participants reflect misunderstandings of agency and board policies and procedures or do not match current facts. We include these comments as important data points about the challenges facing MHRA and the boards in their relationships and communications with professionals. Professionals are sharing information with each other, whether accurate or not, that contributes to a narrative about how boards treat professionals, including professionals from diverse backgrounds. That narrative can be a factor in whether professionals perceive that the boards are welcoming and equitable. To help to prevent perpetuating inaccurate information about polices or practices, we note discrepancies in accompanying narrative or footnotes.

[1] A study about limited diversity in a profession is expected to yield small numbers of participants in underrepresented demographic groups. We use numbers and percentages to describe participants and responses, not to generalize results from subgroups. For additional information see Appendix C.

J. Opportunities and Barriers — Quantitative analysis of virtual workshop responses

Quantitative Analyses of Coded Responses

The virtual workshop asked participants to think of strategies or policies that would promote diversity among mental health professionals in Oregon. We used the following codes to categorize the responses:

- Existing policies suffice;
- Interstate compact;
- Provide financial support;
- Change licensing rules;
- Reduce workplace stressors; and
- Diversify supervisors.

Overall ratings. Participants overall mentioned changes to licensing rules (33%) and providing financial support (30%) most frequently in their responses. In general, few respondents mentioned an interstate compact. As seen later in the appendix, interview participants were more likely than virtual workshop participants to mentions this change.

J-1. All respondents — mentions of strategies or policies that would promote diversity among mental health professionals in Oregon

Note: N = 1,106.

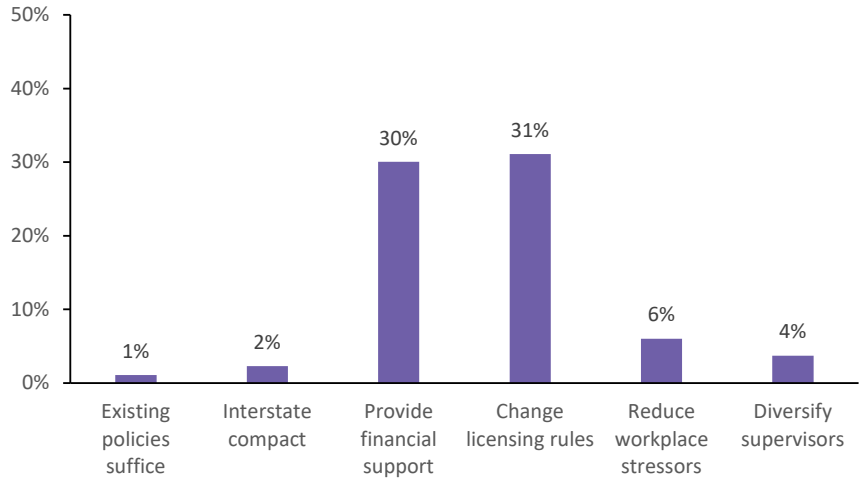
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

J. Opportunities and Barriers — Quantitative analysis of virtual workshop responses

Licensed professional counselors (LPCs). Similar to overall responses, LPCs mentioned changes to licensing rules and financial support the most in terms of policies that would impact the diversity of the mental health profession (30% and 31%, respectively).

J-2. LPCs — mentions of strategies or policies that would promote diversity among mental health professionals in Oregon



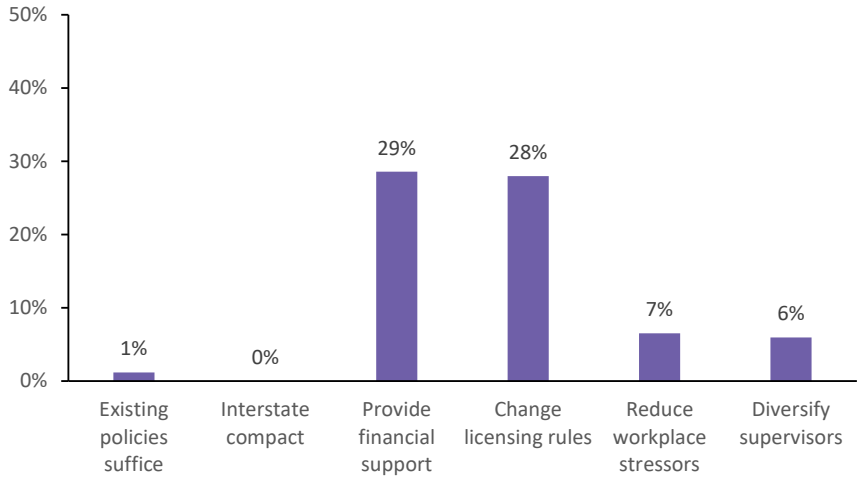
Note: N = 646.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

Marriage and family therapists (LMFTs). Of the three professional license types, LMFTs mentioned reducing workplace stressors the most (7% of responses). Financial support and changes to licensing rules were the most frequently mentioned measures (29% and 28%, respectively).

J-3. LMFTs — mentions of strategies or policies that would promote diversity among mental health professionals in Oregon



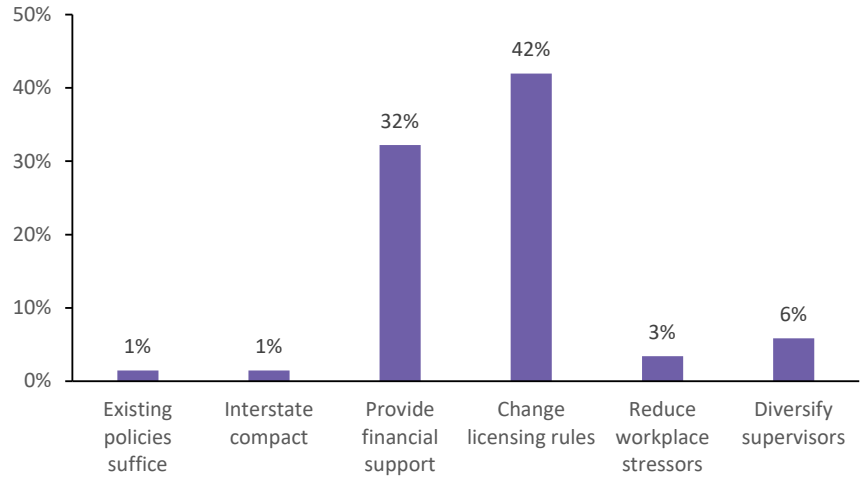
Note: N = 168.
Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

J. Opportunities and Barriers — Quantitative analysis of virtual workshop responses

Psychologists. For psychologists, the most frequently mentioned factor that would improve the diversity of the mental health profession was changes to licensing rules at 42 percent, which was 9 percentage points higher than the average among all professional license types.

J-4. Psychologists — mentions of strategies or policies that would promote diversity among mental health professionals in Oregon



Note: N = 205.

Participants' responses could contain more than one code, so percentages do not add up to 100.

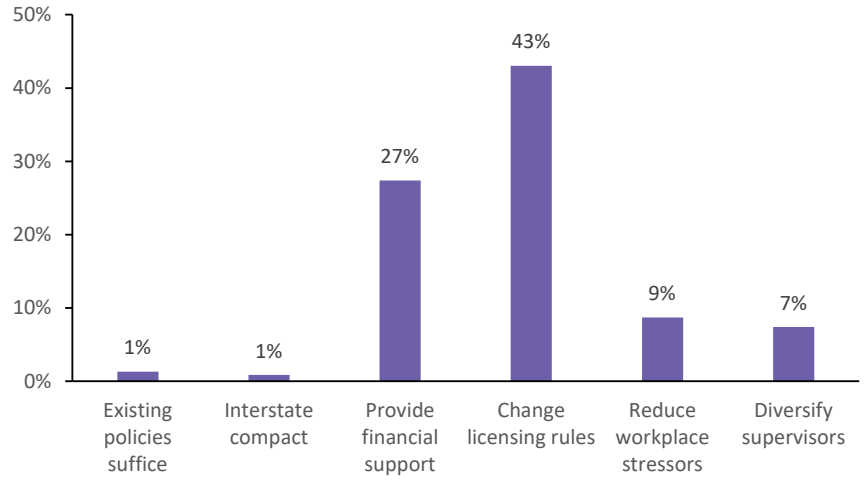
Source: Keen Independent Research.

J. Opportunities and Barriers — Quantitative analysis of virtual workshop responses

People of color. Due to the relatively small numbers of participants in individual racial and ethnic groups, we combined participants who identified themselves as Asian American or Pacific Islander, Black or African American, Hispanic or Latino, American Indian or Alaska Native and multiracial into one group representing people of color.

Of all subgroups we examined, people of color mentioned changes to licensing rules (43%) and diversity of supervisors (7%) the most often. Additionally, people of color mentioned reducing workplace stressors (9%) more often than most other groups.

J-5. People of color — mentions of strategies or policies that would promote diversity among mental health professionals in Oregon



Note: N = 230.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

J. Opportunities and Barriers — Quantitative analysis of virtual workshop responses

LGBTQ+ respondents. LGBTQ+ respondents most frequently mentioned licensing rules (42%). This group mentioned providing financial support as a factor that would improve the diversity of the mental health profession most often compared to other subgroups at 38 percent.

J-6. LGBTQ+ respondents — mentions of strategies or policies that would promote diversity among mental health professionals in Oregon

Note: N = 256.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

J. Opportunities and Barriers — Quantitative analysis of virtual workshop responses

Respondents with disabilities. Along with people of color, 9 percent of responses from participants with disabilities mentioned reducing workplace stressors. As with other groups, changes to licensing rules and financial support were frequently mentioned as factors.

J-7. Respondents with disabilities — mentions of strategies or policies that would promote diversity among mental health professionals in Oregon

Note: N = 170.

Participants' responses could contain more than one code, so percentages do not add up to 100.

Source: Keen Independent Research.

J. Opportunities and Barriers — Participant perspectives

The remainder of this appendix will provide qualitative analysis and examples of opportunities and barriers related to increasing diversity and equity among Oregon's mental health practitioners.

This analysis draws on comments submitted through the virtual workshop as well as interviews and focus groups with mental health professionals.

Where relevant, findings from interviews with contacts for similar state regulatory groups and national professional association contacts are also incorporated.

Examples of comments are provided for each topic.

The first section includes perspectives about factors external to the boards that may affect diversity in the mental health professions. This section includes points similar to those described in Appendix E (Factors Affecting Diversity). In many cases, participants made suggestions without regard for the purview or authorized scope of the boards.

Synthesis includes suggestions made by participants about how the board could influence these external factors. Where participants were aware that the actions they suggest are beyond the authority of the board, they often suggested that the boards should be engaging in advocacy or other activities to influence change.

Subsequent sections of this report will describe opportunities and barriers for:

- Licensing;
- Complaints and investigations; and
- Board composition and commitment.

Oregon and Oregon's Climate for Diversity, Equity and Inclusion (DEI)

As discussed in Appendix E, participants see Oregon itself as a barrier to equity in the profession. For example, the state's history of racism was noted as a barrier. Many participants describe how challenging unifying people toward diversity, equity and inclusion can be.

Some participants believe that present racism will impact whether clients select clinicians of color. Specific suggestions for the boards related to this topic included offering relevant and timely information and resources related to DEI and issuing a statement acknowledging Oregon's racist origins and the ongoing challenge of systemic racism.

In many ways, Oregon is a land of long-standing contradictions and segregation … There is a lot of history to overcome, and it's going to take a willingness to dialogue between 'opposing' sides to find common ground.

White, female licensed professional counselor

We live in a time of polarization. If policies appear to [explicitly] favor a minority, it might cause a backlash.

White, male licensed professional counselor

Pushback from people who are struggling with issues of white fragility and racism would be a big [barrier].

Biracial, female licensed psychologist

Getting everyone 'on board' with a [DEI] task or idea [will be a challenge]. I've been a part of a workgroup and it was difficult as people lost focus on the core goal and seemed [distracted] by only wanting their own agenda ….

African American, female licensed psychologist

Racism and the patriarchy [will be a barrier to increasing diversity].

African American, female licensed professional counselor

White egos [will be a challenge to increasing diversity] … The way that white people want to do better, but then still end up doing really racist things and get upset when we get called out for doing racist things because we were trying and want points for that.

White, female licensed psychologist

The reality of who consumers would choose to work with [could be a barrier]. There are pervasive biases in our culture that run deep. I'm very aware of racism in my community and while we are pushing back on it, it's [still] quite present.

White, LGBTQ+, female licensed professional counselor

The state often feels like it is about seven years behind … Information changes quickly, and the state needs to keep pace and support [DEI] efforts with relevant and timely information and resources.

American Indian, female mental health professional

It can be as simple as the board making an acknowledgement about the racist beginnings of the State of Oregon and how that has continued to permeate systemic racism. [They should also] acknowledge that they are part of a system that comprises that systemic racism.

Biracial, female licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on external factors

Career Interest

Participants described the need to address stigma related to accessing mental health services as a barrier to diversity in the field.

They also described the need for outreach to high school age or younger students and suggested working with school counselor education programs for assistance.

The stigma and access to services in early childhood education are the primary obstacles [to increasing diversity].

Biracial, female licensed professional counselor

There needs to be conversations [with students] on this stigma concerning mental health among clinicians. Just because you've had your own experience with mental health [problems] doesn't mean that you're ineligible to be a mental health clinician.

White, female professional counselor associate

The more outreach we can do to normalize mental health [care] in [diverse] populations, [the more it] might also normalize people from those populations becoming mental health professionals.

Male professional counselor associate of color

It is likely time to survey the students in high school and undergraduate programs to see what they consider obstacles to joining the profession.

White male licensed psychologist

[The boards should be] promoting the field of mental health with [culturally] specific values [in mind].

Asian American/Pacific Islander, male mental health professional

There seems to be a disconnect with recruitment and retention strategies. Has anyone thought to reach out to local counselor education programs for help with this?

African American, female licensed professional counselor

Help in applying to these colleges [would be beneficial]. I wanted to be a counselor since the time I was 15, [but] when I went [to apply to school] no one said, 'There's all kinds of counseling schools.'

Hispanic American, female licensed marriage and family therapist

[There need to be more] scholarships [and] mentors for minority youth to become interested in counseling.

Biracial, female mental health professional

J. Opportunities and Barriers — Participant perspectives on external factors

Degree Programs and Pipeline

Participants described opportunities and barriers related to graduate degree programs and related training.

Recruitment to graduate programs. Participants described opportunities to diversify the pipeline of students graduating from relevant degree programs. Specific suggestions included focusing on Spanish language majors and minors, replicating the Indigenous Educators Program for mental health and outreach to certified alcohol and drug counselors.

[There needs to be] active recruitment of baccalaureate students to graduate programs in [areas like] counseling [and] psychology.

White, male licensed professional counselor

[There should be] more outreach at the undergraduate level to encourage students with a major [or] minor in Spanish to apply to graduate programs [in the mental health field]. Incentives such as a scholarship for bilingual graduate students would be helpful.

White, female licensed professional counselor

I do know of an education program through [state university] where they have an Indigenous Educators Program. That's what we need to be replicating, [creating] Indigenous Social Work or Indigenous Counselors [programs].

Multiracial, female licensed professional counselor

It might help to have alternative pathways to completing the master's and licensing process. For example, the pool of certified alcohol and drug counselors (CADCs) in Oregon is probably more diverse, but I don't know if there's anyone in the state actively encouraging CADCs to continue their education and become fully licensed at a master's or doctorate level.

White, LGBTQ+, female licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on external factors

Support for internship, postdoctoral residency and job placement. Participants described internships, postdoctoral training and job placement support as opportunities to support mental health professionals and increase diversity in the field.

[The boards should] subsidize moving costs and provide other incentives for minority postdoctoral positions.

White, male licensed psychologist

[The board should be] hosting mental health job fairs, where organizations can have a booth [and] interns and those looking for work can meet directly with organization owners/leaders/reps.

White, female licensed professional counselor

I have found that internship programs have a key role to play in recruiting diverse trainees, who then ultimately become the [mental health] workforce.

Asian American/Pacific Islander, male licensed psychologist

J. Opportunities and Barriers — Participant perspectives on external factors

Degree program content. Participants discussed opportunities for education programs to reduce barriers by threading cultural competency throughout programs and by adding guidance on licensing. One suggested running a licensing program and exam in Spanish.

A little more weight could be put on cultural competency in the education process, but also [should include lessons on] dealing with the board and going through the associate [process]. I didn't have any guidance of what that was gonna look like.

Biracial, female licensed professional counselor

Everyone's teaching multi-culture counseling in one very specific class …. [In reality] it's in everything that we do. So, from your theories class to your ethics class, we should be using these concepts on the regular.

African American, female licensed professional counselor

It would be great if a university would offer a licensing program completely in Spanish, as well as having licensing testing in Spanish or another [language based on population].

White, female licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on external factors

Education and Related Expenses

Participants described barriers related to education related expenses. They suggested board advocacy for funding and scholarships, additional support for childcare costs and loan forgiveness programs for professionals working in community mental health.

[The boards can help] by advocating for aggressive changes to funding for higher education. I benefitted from grants covering tuition [and] would not have been able to afford decreased income and [the high] costs of [my] graduate program without this.

White, female licensed professional counselor

Having scholarships open to minorities, specifically the BIPOC (Black, Indigenous People of Color) community, in Oregon might increase the equitable opportunities for [minorities to complete] both undergrad and grad school.

Hispanic American, female mental health professional

Supporting single parent graduate students with daycare or other resources when they are training to become a therapist or counselor [could increase diversity in the field].

Female licensed professional counselor

… loan forgiveness programs come to mind for me [as an opportunity to increase diversity]. I suspect that due to socioeconomic factors the proportion of counseling graduate school graduates who have student loan debt, who are minority groups, would be higher than for white folks. …you [may] have a student loan obligation from your undergraduate studies and also from your graduate studies. [An opportunity for] loan forgiveness if you work with an underserved community [could help]. Those are policy decisions. We see [examples like this] in substance use all the time.

American Association of State Counseling Boards representative

… the State of Minnesota has developed grant programs … for loan repayment if you are somebody that comes from an underserved community [or are] working with clients that come from underserved communities, or if you are working [in] rural Minnesota, where … there are huge gaps in the number of providers per the number of people that are in need of services …

Minnesota Board of Behavioral Health and Therapy representative

If a job in a public sector mental health agency offered some level of forgiving student loans for grad school, this would be a strong incentive for recruiting applicants of diversity.

Hispanic American, female licensed psychologist

J. Opportunities and Barriers — Participant perspectives on external factors

Compensation

Participants described improvements in compensation and pay equity as areas of opportunity. Some also focused specifically on pay and hours for early career professionals and the importance of paid internships.

[The boards need to do more] advocacy for higher pay across the board but especially for agencies.

White, LGBTQ+ professional counselor associate

[The boards should] offer grants [and] funds for mental health professionals who are actively serving historically marginalized communities.

African American, female mental health professional

[The boards should] have someone who goes around practices to make sure that BIPOC clinicians are being paid what they're worth.

Hispanic American, female mental health professional

Because of the current policies regarding insurance billing, supervisory requirements, and hours requirements, agencies feel very comfortable paying early-career clinicians very little for the work that they do.

White, LGBTQ+, female licensed professional counselor

Old ways of thinking that newbies have to start out in the trenches and earn their rank and will be minimally compensated [hinder the promotion of diversity within the field].

White, LGBTQ+, female licensure applicant

Interns in their master's [degree] programs need to be paid.

White, LGBTQ+, female licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on external factors

Insurance Reform

Some participants described advocacy and reform related to insurance reimbursement as important strategies to increase diversity and equity in the mental health professionals.

Limitations to how much/if you can lobby [will be a barrier]. Commercial insurance companies [prioritizing] profit over people will take legislator intervention [to fix] or there won't be much [left] to fight for in a few years.

White, LGBTQ+, female licensed professional counselor

[Boards] can MANDATE insurers to pay the full amount to associates just as they do to independently licensed practitioners.

White, female professional counselor associate

[The boards should be] advocating for associates to be able to bill OHP insurers from private [or] non-agency practice settings.

White, male marriage and family therapist associate

[The boards should engage in more] advocacy for therapist rights when faced with insurance audits. [They should also enforce] appropriate regulation of insurers per federal parity laws.

White, LGBTQ+ licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on external factors

Employers And Colleagues

Some participants described efforts that they believe should be made by employers or others related to improving equity and inclusion in workplaces. Ideas included statements of commitment, training, and offering internships to students from marginalized groups. One participant suggested unionizing the profession as an opportunity to increase diversity.

[Employers should publish] clear statements of support that work environments of mental health professionals support the inclusion of [people of color], people with disabilities [and] women.

Biracial, female licensed psychologist

[There should be] more training around barriers [in the workplace] and how they affect diverse individuals.

Biracial psychologist resident

Recruiting of BIPOC students for graduate internships [helps promote diversity in the field].

Female professional counselor applicant of color

Unionizing the profession to advocate for better pay and ensure diverse representation [will help increase diversity].

White, female licensed marriage and family therapist

J. Opportunities and Barriers — Participant perspectives on external factors

Professional Stressors and Burnout

Some participants described the toll of mental health work particularly in pandemic times as a barrier to diversity. Structured support for practitioners from marginalized backgrounds was recommended as an area of opportunity.

We know that the Black and brown populations [are] more susceptible [to COVID] and the impact that it has had on mental health [is severe] …. How can we create a space to address the mental health component of the pandemic in these communities that it's affecting most?

African American, female mental health professional

A society that does not care about mental health and consistently undervalues that work that we do [will pose a challenge].

White, non-binary licensed professional counselor

It would be extremely helpful to have structural and institutional support for providers who are more likely to reach a state of burn out at a faster rate.

Asian American/Pacific Islander, female licensed psychologist

J. Opportunities and Barriers — Participant perspectives on external factors

Funding

Some participants highlighted budgetary constraints as a barrier. Many ideas for increasing diversity and equity listed in previous pages require financial support.

In some cases, those familiar with the boards or having experienced delays they perceived to be due to resource constraints expressed reservation about the idea of the boards tackling a larger scope than they already have without additional resources.

The next section of this appendix focuses on opportunities, barriers and ideas more squarely within, or at least more closely related to, one of the current mandates of the boards: licensing.

Money [is] always the number one barrier.

Biracial, female licensed professional counselor

It's better OPOB [Oregon Board of Psychology] not take more on their plate without a much wider mandate and funding.

Male licensed psychologist with a disability

J. Opportunities and Barriers — Participant perspectives on licensing

Licensing Systems and Service

Participants described opportunities for the initial licensing experience to be welcoming and inclusive. Ideas included service, user-friendly systems and accessible welcoming language. Some boards such as the Oregon Board of Licensed Social Workers conduct outreach to graduate student programs to introduce licensing.[2]

Oregon Medical Board representatives discussed ways they respond with solution-oriented service and flexibility to address barriers and circumstances that may impact applicants and licensees. Examples included extra efforts to aid international applicants and payment plans, both of which are described later in this appendix.

One issue described in Appendix F, timeliness of application processing, was addressed by an interviewee from the Association of State and Provincial Psychology Boards as a widespread challenge in the field. The interviewee reported that many jurisdictions are suffering from staffing shortages and are working to find efficiencies and improve response times.

It would be nice if the tone from the board was, 'Hey, we're so excited to have you! Here is this resource for how to get started in private practice. Here is this nice, updated, streamlined [and] accessible website that actually makes sense …. Choose your identity and intersections, [then] here are supervisors who meet that and where to find them.'

Biracial, LGBTQ+ mental health professional

Adequately staff OBLPCT so everyone can get reasonable responses to inquiries.

Asian American/Pacific Islander, female mental health professional

[Using clearer] and more layman's terms about the application would be one of the places I would focus.

LGBTQ+ professional counselor associate

[Online systems for] reporting supervised hours via user friendly databases and paying dues prompted by automated reminders would make it easier for people.

White professional counselor associate

[As a licensing board] we can make contacts and reach out and interact with groups of students, particularly from Portland State, because that's the largest producer, and introduce the whole concept of professional licensure to them to make sure that that they understand what's involved, what it is, what the benefits are, what the drawbacks are, how the process works, how they'll be interacting with the board.

Oregon Board of Licensed Social Workers representative

… when a problem does arise, if we see a barrier, we're willing to take a look at it even if it means it's only a barrier to five licensees it's something that we are willing to consider.

Oregon Medical Board representative

[2] MHRA staff report that they make one or more outreach visits to at least seven degree programs, some as many as four times per year. Prior to COVID-19, outreach included three additional degree programs where MHRA visits have not yet resumed.

J. Opportunities and Barriers — Participant perspectives on licensing

Education and Experience Requirements

Some participants described the value of offering licensure that accommodates different educational levels and paths. Some expressed that the licensure process should find ways to value skills and experience more heavily.

[Not accommodating those who] complete graduate school through military or peace corps, which does not provide credits but graduate level experience, creates a barrier for anyone [from] lower economic backgrounds. Oregon's requirements without individualized lenses [for] differing school programs or international backgrounds creates a significant barrier for licensure ….

Mental health professional

Lowering the bar for QMHAs [qualified mental health associates] to having an associate's instead of a bachelor's [would be beneficial].

Middle Eastern, female mental health professional

I hope that one day we have … more qualified mental health professionals (QMHPs) that are not people with master's degrees, bachelor's degrees or doctoral degrees. [I hope] that we have different levels of people serving the community and that they can be supported through that process so they can be certified and licensed in an equitable way based on the training [and] their experiences.

Hispanic American, female mental health professional

[I recommend] changing licensure requirements to emphasize practical skills more heavily.

White, female professional counselor associate

We shouldn't [have a] one size fits all [model of licensure]. If people have previous background experience, I think that should come to consideration towards their licensure …. [The boards should] not just put a block in there [saying], 'No, you can't have a license. You can't do this. You can't do that.'

Female professional counselor associate of color

In the field of substance abuse treatment, there are master's level workers and people without higher education but [who have] training and life experience working with people in recovery programs. This approach could [also] be adopted in the [mental health] field.

White, LGBTQ+, female licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on licensing

Exams

Some participants recommended alternatives to exams or provisional licensure while professionals re-test as opportunities to reduce barriers.

Other participants focused on language barriers in testing and challenges around securing accommodations for professionals with disabilities.

A contact for the National Board of Social Workers shared that after a report by the Association of Social Work Boards found evidence of disparity in their credentialing exams, at least one NASW chapter waived all exam prep course fees for its members in an effort to level the playing field for applicants from marginalized groups.

[There should be] consideration for professionals [who] have worked in the field for several years but [have been] unable to pass [the licensing] exam for various reasons. Maybe [a solution is] a provisional [license] being granted until [the] person is able to pass.

Female marriage and family associate of color

I was just talking to a counselor the other day who all he does now in this latter part of his career is supervision, and he asked me, had there ever been any consideration about an alternative to passing the licensing exam because he's had some very capable people, and he said most of them were from minority groups who just can't pass the exam … whether it's test taking anxiety or cultural bias, or whatever the issue is, there is an added barrier for people from diverse backgrounds and passing a licensing exam.

American Association of State Counseling Boards representative

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Other states offer a little bit more support in that process [of verifying disabilities for testing accommodations]. They offer forms that say [things like], 'A letter from the medical provider should include these details.' I think there's room for that kind of accommodation support that gets missed [in Oregon].

White, LGBTQ+, male licensed psychologist

[Licensure applicants should be] given the opportunity to take [the] licensing exam in one's native language.

Hispanic American, female mental health professional

[If you don't speak] English as your first language or if you have any sort of language or processing disabilities, then multiple choice exams can really discriminate…. They do give additional time to people who've got documented disabilities. We've been told to make sure our students get documented for their disabilities before they graduate so they're more likely to get the extra time for the licensing test. … Some of the students are hesitant to get tested [to document disabilities], and so that can create some barriers for them. Some of that might be cultural or just their own sense of pride …. But when it comes to a very long multiple-choice exam, that's a big issue.

Professor and national professional association committee chair

J. Opportunities and Barriers — Participant perspectives on licensing

Licensing Fees

Participants described opportunities to modify licensing fees in ways that would promote equity and diversity.

Income-based fees or fee waivers. Some participants suggested a sliding scale for license renewal to help support professionals in low paying jobs, working in community mental health or with marginalized communities.

Payment plans. Payment over time was suggested as a strategy to promote equity. This was more frequently suggested by psychologists where the renewal fee is high (see Appendix A).

The Oregon Medical Board, which licenses psychiatrists among other medical practitioners, described payments plans as one way they have responded with flexibility to address barriers as they arise, noting the value of offering payment plans to acupuncturists who were hard hit during Covid.

[It would help] if they can take into account where people are providing services …. If [a therapist] works in an area where it's underserved, and therefore [the] pay [is] less, is there anything where they can help those mental health professionals with the [licensure] fees?

Hispanic American, female licensed psychologist

Providing scholarship of licensure fees for clinicians of marginalized communities would be a step in the right direction.

White, LGBTQ+, licensed professional counselor

It would be helpful to offer assistance or sliding scale [for licensure fees] to ensure more inclusion of professionals in the industry.

LGBTQ+, female licensed professional counselor of color

[It needs to be] less cost prohibitive to obtain and maintain licensure. Adding options for a payment plan or reduced fees for qualifying individuals [could be a solution].

White, LGBTQ+, female licensed psychologist

Board should offer payment plans for licensure/renewal fees as well as disciplinary fees (in the case of sanctions that involve a fine).

White, female licensed psychologist

[During covid our acupuncture licensees] hadn't been working for a while and [some] couldn't afford to pay their license [renewal] fees …. so, we came up with a payment plan to [ease] that financial barrier …. We realized the issue of Covid, and not being able to practice and bring in money …. For most of our physicians, paying a license fee is not a significant cost to them, but for our acupuncturists it was.

Oregon Medical Board representative

Other modifications to license renewal fees. Practitioners described specific ways the licensing renewal fees might be adjusted to be more inclusive. Examples included waiving the fee for veterans and charging a single fee for dually licensed professionals.

Some suggested prorating fees when birthday-based renewal follows closely after initial licensure. Neither board prorates fees but both boards offer a free grace period after the initial licensure date. The grace period may range from one to 13 months depending on the proximity of the licensure date to the birth month. [3] Information about this policy is not readily evident on either board website. Participants may object to the policy as is because it does not equally benefit all professionals, or they may be objecting to not having been able to make an informed decision about timing their licensure to achieve a more generous grace period.

It cost me nothing to get my [license in two other states] because I'm a veteran. …. I look at Oregon and go, 'Hey, what's up? I've already done my service to the community and to our country' …. Any veteran should not be charged for a state licensure.

Biracial, male licensed professional counselor

For people who are double licensed, [the boards should be] collapsing that fee [into one], because they're doing the same work [for both].

Mental health professional

My LPC [licensure] was fully done about four months before my birthday. Then, I had to pay another … registration fee. I would love to see prorated amounts for people who get their licensure and are gonna have to renew within a certain period of time.

White, LGBTQ+, female licensed professional counselor

[3] Renewal fees are paid to cover licensure for the 12 months following the licensee's birth month. Both boards offer a grace period of free licensure after initial licensure that lasts until the first renewal in the birth month of the licensee. Practitioners who are initially licensed in their birth month receive the most generous grace period, about 13 months if their birthdate is late in the month. Their renewal will be due at the end of their birth month the following year. Practitioners who are initially licensed late in the month prior to their birth month receive the least generous grace period, about one month of licensure free before their first renewal is due. According to MHRA staff, most other boards prorate the charge for the time period that OBOP and OBLPCT currently offer without charge.

J. Opportunities and Barriers — Participant perspectives on licensing

Criminal Backgrounds

Participants discussed opportunities to reconsider what information related to criminal backgrounds is requested and how it is used in the licensing process. Some noted that asking for the information without clarity may give the impression that practitioners with criminal background records are not welcome.

One participant suggested that reporting data on this subject could create transparency about approvals and denials for applicants with criminal background issues.

There needs to be some policy changes around what the board and regulatory agency is allowed to do in terms of having discretion over what applications they hold up and why …. If someone has their record expunged, and there's no evidence to the contrary, there shouldn't be … discretion for them to hold up applications ….

White, female professional counselor applicant

It's very common in the substance use world for people to have a criminal background as part of their time when they were active in their addiction so certain states make it very difficult for people to become licensed or access the educational system. If they have felony convictions or really any criminal history [that] can be a barrier …. We know that in this country the criminal justice system disproportionately handles folks from diverse backgrounds.

American Association of State Counseling Boards representative

When [our board asks] what appears on its face to be a very neutral question about a criminal background check, it may not be neutral to an individual who's lived experiences are very different than mine [as a white man] …. We have been trying to figure out how we ask that question and meet that need in a way that isn't creating an obstacle …. I have the sense that there are applicants who see the question … and assume that … they're going to be denied. That's highly unlikely, but unless we have an opportunity to explain our process to them, we've lost them. They're going to find a job that doesn't require a license. So [we are trying to] make sure that … everyone understands what our requirements and our process are, and that we don't ask questions [or ask them in a way] that will drive people away from even beginning an application ….

Oregon Board of Licensed Social Workers representative

[The boards should] list [the percentage] of approved applicants with something on their criminal background check.

Female licensed psychologist

J. Opportunities and Barriers — Participant perspectives on licensing

Access to Relevant Clinical Supervision

Participants described opportunities for increasing access to supervision for practitioners of color. As discussed in Appendices E and H, many participants of color or from other marginalized groups felt supervision from professionals from similar backgrounds or serving similar client populations would be helpful, but they were on their own to procure this support. Academic research also suggests supervision may be more effective when supervisee and supervisor have a common cultural understanding.[4]

When asked about opportunities to increase diversity, some again raised ideas for fostering supervisors of color or from other underrepresented backgrounds. In Minnesota, grant funding supported a program to train supervisors from underrepresented backgrounds.[5]

[Boards] providing a list of supervisors that would be willing to waive supervision fees for BIPOC or [members of] other marginalized groups would help them have more access to actually getting independently licensed.

White, female licensed professional counselor

One thing that came out was not having enough supervisors from underserved communities. [So] the State of Minnesota did develop a grant program that pays for the training for individuals coming from underserved communities, so that they can become approved supervisors.

Minnesota Board of Behavioral Health and Therapy representative

The state should subsidize BIPOC supervision.

Asian American/Pacific Islander, female licensed psychologist

[An idea that comes] to mind for me would be if there was a network of supervisors … saying, to folks, we really want to advance the profession and make it easier for people from diverse backgrounds to attain this license, so we'll offer free or discounted supervision.

American Association of State Counseling Boards representative

[4] Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: A rapid evidence review. *BMJ Open, 11*(9), e052929. https://doi.org/10.1136/bmjopen-2021-052929

[5] One representative of a national mental health professional association explained that clinical supervision is typically approached as an entrepreneurial endeavor in which the cost to attain licensure to be a supervisor is weighed against the potential return from offering supervision as a paid service in addition to direct client work.

J. Opportunities and Barriers — Participant perspectives on licensing

Independent supervision. One professional suggested that employers should be mandated not just to provide supervision, but to provide independent supervision that is separate from the employee/employer relationship.

Academic research suggests supervision may be more effective when clinicians can choose their supervisor.[6] In addition, as described in Appendix G, associates may feel that the hours they need for licensure are at risk if they bring a complaint against their supervisor. The opportunity to observe reportable violations is ostensibly higher when the associate and the supervisor work together, potentially as employer and employee.

I think there needs to be some sort of rule from the board that supervisors or employers need to provide supervision that's external from the people who employ you, and they need to pay for it. I don't think they should they always make us pay for it if we want external supervision. Employers say, 'We'll provide free supervision, but if you want unbiased supervision, you need to pay for it.'

White, LGBTQ+, female licensed professional counselor

[6] Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: A rapid evidence review. *BMJ Open, 11*(9), e052929. https://doi.org/10.1136/bmjopen-2021-052929

Modifications to Clinical Supervision Requirements

As described related to licensing requirements in Appendix F, some participants suggested lowering the number of hours of supervised clinical experience required for licensure. Others focused on the cost and the resulting wait for better compensation and becoming reimbursable by private insurers as the primary barriers related to clinical supervision.

Some interviewees cautioned against easing the burden of supervision by reducing the requirement rather than addressing cost and compensation issues. They noted that reducing the hours could be counterproductive, leaving early career professionals less supported and more vulnerable to mistakes that could harm clients and/or result in disciplinary action.

One interviewee whose academic expertise includes disciplinary action in the social work field, suggested alternative modifications to clinical supervision requirements:

- Expecting supervision or peer consultation throughout a practitioner's career; and
- Allowing some portion of supervision to be group based rather than one-to-one.

I don't think most people are actually able to practice independently after just two years …. There should be a model where … people continue to have other supervision or peer consultation or something throughout their careers. [In our studies of social workers who received disciplinary action we heard that] … private practitioners just didn't have somebody to bounce ideas off of or to help them to realize that there was counter transference or something going on …. [It would be helpful to set an] expectation whether it's professional or it's legally imposed [so] people don't feel like, 'Okay, I've done my two years, I don't need any more help ever from anyone else to make sure my practice is competent, ethical and so on.'

Professor and national professional association committee chair

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To reduce costs, some states will allow group supervision. Some do not. Some have minimum amounts [for one-to-one supervision but allow a combination of individual and group supervision]. There's really good value to group supervision. It's not … just cheap supervision It can actually be very effective. I think it'd be nice if [group supervision] was offered to help more people … gain access at a reasonable cost. [Some agencies have] one supervisor for 6-10 frontline workers. Does it really make sense for all of their [supervision] to be done individually? [Supervision requirements that don't allow group work] can be taxing on agencies as well as individuals.

Professor and national professional association committee chair

J. Opportunities and Barriers — Participant perspectives on licensing

Applicants from Outside Oregon

As described in Appendix F, some participants would like to see easier licensing processes for professionals coming to Oregon from other states or countries. Some expressed support for Oregon joining interstate compacts. Similar themes arose in discussion of opportunities, barriers and suggestions. Ideas ranged from simply aligning requirements with other parts of the country to create an expeditious process across state lines to fully automating interjurisdictional transfers of licensure.

Contacts at other regulatory boards described efforts to welcome international applicants such as special website sections and offering forms and information in multiple languages.

Oregon Medical Board described efforts to respond with flexibility and proactive service to support diversity in psychiatry and other professions they license. One example was creating a procedure for issuing temporary licenses with provisional timeframes to solve a chicken and egg dilemma of a visa requiring a license and a license requiring a visa. They also described working on behalf of applicants to obtain primary documentation when it was unavailable from schools in applicants' home countries.

Some participants referenced programs that can meet the needs of underserved communities while helping to diversify the field. One example was a residency program that provides support for internationally trained applicants and includes placements in underserved rural areas.[7]

I would adjust the licensure requirements to make sure that they're in sync with the rest of the country …. It needs to be standardized. It needs to be smooth. It needs to be fast.

White, male licensed professional counselor

[There should be] automatic license transfer [when moving to Oregon from another state] to attract licensed clinicians from out of state.

Male licensed professional counselor of color

We recently had applicants from Nigeria and Iran who have had difficulty obtaining primary source documentation from those countries to verify their training and education. We go out of our way to assist them …. In Nigeria, the medical schools often are closed [because the professors are on strike] and they can't process paperwork that we [request] for a license application. [Staff] contact other state medical boards, where those documents may already be, and ask for those documents directly from there. Recently with this applicant from Nigeria we reached out directly to the Washington Medical Board, and we were able to get those documents that had already been submitted to Washington several years ago …. If we approached [licensing] always as one size fits all that would be a hindrance. The Nigerian applicant is a really good example of that.

Oregon Medical Board representative

[7] Minnesota offers an International Medical Graduates Residency Preparation Program (BRIIDGE). See https://www.health.state.mn.us/facilities/ruralhealth/img/briidge.html

J. Opportunities and Barriers — Participant perspectives on licensing

License Renewals

Participants suggested modifications to renewals including changing the frequency for LPCs and LMFTs from annual to every two years. MHRA and OBLPCT have identified annual renewal, required by statute, as problematic and are introducing a legislative proposal for 2023 that if passed will allow two-year renewals for counselors and therapists.

Participants also suggested increasing communication about renewal. Some also suggested offering status options to allow professionals to maintain affiliation at different stages of life.

Renewing every year is taxing. Make it every two years with CEU reporting included on those renewals.

Asian American/Pacific Islander, male licensed professional counselor

Maybe [there can be] an automated phone recording to get voicemails about licensure renewal rather than just emails.

White, female licensed professional counselor

We have active and inactive licenses [as well as] emeritus status. The emeritus license is $50 a year, and you keep that license to be able to do volunteer work only. A lot of our licensees who are nearing retirement, or have retired, would like to keep something to be able to go back and help out at a community health care or at a mass vaccination clinic, [so] they'll keep that emeritus license to be able to practice just on a volunteer basis.

Oregon Medical Board representative

If I'm taking a year or two off for maternity leave, am I allowed to step out of my licensure or insurance without having to go through extra costs and other hurdles getting back into it.

Professor and national professional association committee chair

Continuing Education

Participants spoke about ways continuing education (CE) requirements could better support diversity and inclusion. Suggestions included offering any required content for free and allowing remote participation. Some saw an opportunity to increase understanding of licensing by offering continuing education about MHRA and the boards.

Practitioners also described ways that professional development and education, apart from the CE requirement, could be deployed to address specific challenges related to diversity, equity and inclusion. Suggestions included training for opening private practices, serving specific populations and addressing bias in the workplace.

[For] any CEUs that are required by the board, [they] should offer a free opportunity for that training.

White, LGBTQ+, female licensed professional counselor

[The board needs to] stop with the prohibitive costs and the in-person CE requirements when y'all can't be bothered to host something outside of Portland or Bend.

Hispanic American, female licensed psychologist

It would be really useful to offer a CE on the structure of OBOP, MHRA, and how these organizations fit into the structure of the state, policymaking practice, and its impact on individual clinicians.

Hispanic American mental health professional

[The board should fund] business start-up scholarships for diverse counseling student graduates who want to begin a private practice.

Biracial, female professional counselor associate

Extra funding [should be provided] to do something with education, [such as] learning how to [go about] treating the deaf population.

Multiracial, licensed professional counselor

[It would help] if there could be more education or trainings for people who have been in the field, doing [therapy] in person for decades, on how to adapt those skills to online …. I know a lot of people that dropped out [of the field] because … [they] couldn't get past the technology barriers.

Biracial, male professional counselor associate

They need more regular trainings on diverse populations. In a staff meeting, somebody presenting had used the word 'ghetto' and it made me cringe. I told my supervisor that we need to have more trainings on appropriate language.

White, female licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

In the following section of this appendix, we synthesize perspectives related to opportunities and barriers related to complaints and investigations.

Prevention and Support

Participants described a role for regulatory boards in prevention of violations. Some also discussed the importance of considering causes of violations in determining whether supportive approaches may be more useful than punitive ones.

Some noted the value of thinking differently about early career practitioners whose violations may be because they are still learning. Others noted that caseloads that concentrate the most difficult cases with the least experienced professionals can be a set up for failure. Notably, academic research on licensed marriage and family therapists across multiple state boards found that most violations occur among practitioners with between two and five years of experience.[8]

It can help if the boards are educational and helpful rather than punitive to those who are trying to navigate the system and provide quality services in good faith.

White, female licensed professional counselor

[Some regulatory boards] actually give people advice on what to do or not do, and they publish those [recommendations]. [It's helpful] that the public gets to know about consultations. Other organizations could do the same thing. We don't even have to share identifying information. But just say, 'Hey, this is an issue that came up, and this is our advice on how to proceed.' Preventative action is probably a lot more effective than responding after … an alleged violation occurs.

Professor and national professional association committee chair

When you've got a registered associate … they're still in the learning process, right? So, they make a mistake with a release or they make a mistake clinically with the client. We should be helping them [learn]. These people have been busted harshly and lost their licenses when, in fact, they're brand new at this. Can we help them [instead]?

White, male licensed professional counselor

I did see some cases where [the least experienced practitioners working with the hardest cases such as in-home counseling with Medicaid clients] ended up with complaints. And you think, did we set them up, for success or did we set them up for failure? We put them in situations that anybody would have found problematic. And did they have the right training? [Striving] for lower cost services sometimes puts people who don't have adequate training in risky situations, so that to me would be the crux of this question.

American Association of State Counseling Boards representative

[8] Rollins, P., Grames, H. (2021). Sanctioned licensing board violations for marriage and family therapists spanning a 10-year period. *Journal of Marital and Family Therapy, 48* (I2), 621-642. https://doi.org/10.1111/jmft.12523

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

An academic researcher and national association contact noted that the National Association of Social Workers has added support for the well-being of professionals to their code of ethics. This step recognizes that the toll of mental health work if left unaddressed can contribute to circumstances that end up manifesting in complaints.

Sometimes [violations are because] people just didn't know the rules. But often it's other things that are going on in their life. They're going through a tough patch in a marriage or divorce, and they you know overstep their boundaries with clients or things like that, or there's some financial taking exploitation of clients that wouldn't be there if there weren't personal issues in people's lives …. How do we make sure that agencies are trying supervision, professional development, managing caseloads, managing the challenging aspect of caseloads, giving trauma informed supervision? We talk about trauma a lot with clients, [but] we don't always talk about what impact vicarious or secondary trauma has on our workers. That can turn into issues [that] end up in complaints as well.

Professor and national professional association committee chair

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

Alternative Models

Some participants suggested alternatives to current complaint and investigation processes. As noted in Appendix G, some professionals believe that punitive outcomes may miss the mark. Academic researchers document negative personal and professional impacts from disciplinary action that may not be true from rehabilitation efforts.[9]

In some cases, participants suggested drawing on options such as mediation, collaborative problem solving, conflict resolution and restorative justice. One participant noted that broadening the options may create possibilities that feel safer to some marginalized complainants than a one complaint against one respondent model (e.g., handling five allegations of discrimination in a restorative justice forum).

I would love to see something in statute that would say, 'The focus of the board is to protect the public through restorative justice whenever possible, not punitive justice.'

White, male licensed professional counselor

Utilizing a transformative justice model for ethical violations or complaints against clinicians [could improve equity in the field].

White, LGBTQ+ professional counselor associate

What can we do for healing and what can we do [to make] things better for the future? Rather than resorting to these adversarial processes, we could draw from the restorative justice literature [with] things like healing circles and family group conferencing.

Professor and national professional association committee chair

[9] Gricus, M. (2019). "Of all the social workers … I'm the bad one": Impact of disciplinary action on social workers. *Social Work Research, 43*(1), 5–16. https://doi.org/10.1093/swr/svy023

Mediation. One interviewee drawing on his experience with the National Association of Social Workers (NASW), recommended models that offer mediation. Most complaints filed with NASW now go to mediation. Certain transgressions go directly to a hearing. NASW includes someone to represent the interests of the social work profession in mediation. Disputes unresolved by mediation may subsequently go to hearing.

Complaint intake. This interviewee recommended complaint intake processes that educate complainants about their options. This process may point complainants through informal or formal doors or redirect them based on their desired outcomes. For example, complainants may be advised that regulatory boards don't provide compensation, but courts may, which agencies have purview over employment law violations, or areas in which professional associations may have latitude that regulatory boards do not.[10]

… a lot of times when cases go to mediation, you can come up with some creative things … Sometimes clients just need their voice to be heard to be validated. We heard over and over from professionals [who were disciplined that when] there's an investigation against them, they often don't know what the evidence is against them [or] who provided [it], so there's all these suspicions …. Maybe it has to do with a child, so [they're] speculating, 'Well, is it … the parents or somebody else … ?' It can be really impairing to their practice. If you just had a sit down and let people talk it out, you could avoid all sorts of issues with disruptions in their practice, their reputation ….

Professor and national professional association committee chair

[10] For example, NASW or APA may find ethical violations against practitioners conducting "conversion therapy" with LGBTQ+ mental health consumers despite state regulatory boards lacking statutory grounds for enforcement in many cases.

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

Complainant and Respondent Experiences

Regulatory and national contacts noted the difficulty of striking a balance that protects consumers against potential harm while fostering the availability of mental health services. When allegations of wrongdoing occur, complaint handling can be difficult for both consumers and professionals.

Some participants familiar with the impact of complaint processes on complainants described concern about the experiences of complainants. As noted in Appendix G, some participants expressed concern about the lack of whistleblower protection for professionals who file complaints.

Participants also expressed concern about the impact of complaint handling on professionals who are respondents in investigations. Uncertainty or lack of communication can create stress that impacts their practice. Oregon Medical Board acknowledges this by supporting the statewide Oregon wellness program and suggesting investigation respondents access confidential, free counseling.

The majority of individuals never come before a regulatory board. You renew a license, you turn in your CEUs, and you are good to go. The numbers [of victims] are small, but a victim is a victim whether there's one or whether there are one million, we really don't want another victim. In a perfect world, you … maintain high standards for ensuring competence but also improve access to the profession ….

Association of State and Provincial Psychology Boards representative

People of color can be afraid to come forward and speak up [about unfair treatment] because of prior experiences of being marginalized, alienated, publicly snubbed, silenced, [or potential] retaliation.

Biracial, female licensed psychologist

There needs to be a clear and effective whistleblower policy for handling complaints to the board, especially when [they] are about agencies, organizations or individuals in positions of power.

Female licensed professional counselor of color

More communication would be helpful [during an investigation]. For my complaint processes, [I] emailed somebody, left voicemail, called the investigator back several times. He never picked up to return my call. I was kind of stuck in this [limbo of not knowing], 'Am I gonna get in trouble? What's going on?'

Asian American/Pacific Islander, male mental health professional

We financially support the statewide Oregon wellness program which is available for confidential free counseling for all of our licensees. So, if they need some additional support, to go through a difficult situation, an investigation would be a great example of a difficult situation, they can … access that confidential, free counseling.

Oregon Medial Board representative

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

Process and Expectations for Respondents

As discussed in Appendix G, participants who had experience as respondents in investigations often felt that they had not been well-treated and that the process lacked transparency. MHRA and other regulatory contacts agreed that outcomes are likely better for professionals who seek representation from attorneys who have experience in this arena.

In discussions of opportunities and barriers, participants suggested clear communications about processes and rights. An interviewee who studied the experiences of social workers in complaint investigations described the importance of professionals understanding the need to take investigations seriously and engage qualified representation even when allegations seem unfounded.

The OBOP web page should describe very clearly the complaint, investigation, and ruling processes and procedures. Also, the legal rights and protections of therapist[s] should be specifically detailed.

Hispanic American, male licensed psychologist

One of the biggest complaints [of the respondents we interviewed which] they didn't necessarily label as 'due process,' was… 'how can I defend against the case against me.' [One interviewee] said, 'Oh, this is such a bogus allegation.' They didn't take it seriously. They didn't hire an attorney …. Encouraging people to have attorneys, making sure that they have real access to attorneys would be helpful, … somebody who specializes in that area … if you just get an attorney who is in generalist practice, they're not really gonna know what the expectations are for these investigations and hearing processes. People need to know what the system is and the potential seriousness of it right from the beginning. Even if they don't think it's serious from the beginning.

Professor and national professional association committee chair

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

Investigators

Participants discussed concerns about diversity and avoiding ethical conflicts related to investigatory personnel. As described in Appendix G, many also discussed the optics and impact of using former law enforcement personnel to investigate allegations against mental health professionals. Many participants who made suggestions related to investigatory staffing strongly urged the use of investigators with clinical expertise drawn from the mental health or related professions.

National and regulatory interviewees confirm that use of investigators with a law enforcement background is not uncommon but does raise particular challenges for boards and agencies. Primary among these challenges is being perceived as inclusive and fair, particularly for practitioners of color. Interviewees with experience in two different national organizations underscored that it is extremely important for investigators to be well-trained in the discipline they are investigating.

A contact for the Association for State and Provincial Psychology Boards recognized that jurisdictions vary in their use of investigators with law enforcement backgrounds and pointed out that some jurisdictions may at least initially assign investigators with clinical expertise before a case might move to an investigator with law enforcement experience.

Ensure that you have investigators that are also BIPOC.

Biracial, female licensed professional counselor

The board needs processes for vetting investigators and intervening in cases of multiple relationships and conflicts of interest.

White, female licensed psychologist

I question the dynamic of having law enforcement personnel do investigations because of everything we're dealing with in this country. [Is having law enforcement investigate] triggering or fair? There's obviously a clear power differential. This is someone who has the ability to take away your license. There could be very aggressive investigatory action. I'm more familiar with a health background being trained to [investigate] as opposed to law enforcement.

American Association of State Counseling Boards representative

… a lot of the people that we interviewed were concerned that the [investigators] didn't really understand what clinical social work was, so how could they make a good decision around that? Some of the investigators did have [criminal justice] backgrounds ….

Professor and national professional association committee chair

To have a board of peers … do the investigation, critiquing and examining of any complaints seems more logical than to have other professionals who are not mental health driven [and] trained [and are not] informed on what either the client or the therapist could be dealing with ….

African American, female mental health professional

The investigators need to be from our profession and that needs to be statutory ….

White, male licensed professional counselor

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

One national professional association contact who has studied the experiences of respondents in social work, noted that use of empathy in investigations may lead not only to reducing perceptions of bias but may also yield better cooperation and information from participants.

[Respondents] who felt that they were listened to and heard at least felt the process was more fair … it doesn't have to be like a court case where the judge doesn't give any indication of you know hearing people. Investigators might even get more information if they show some empathy …. Some of the investigators and maybe the trainers of investigators think they have to show that they're completely neutral and by neutral they may be training some of them to not even acknowledge what they're hearing from [respondents], just gathering information. [When that happens] it almost feels like they're an advocate for the for the clients or whoever was complaining and that's why there are these perceptions of bias.

Professor and national professional association committee chair

J. Opportunities and Barriers — Participant perspectives on complaints and investigations

Fairness and Efficacy of Sanctions

Some participants suggested that sharing data on sanctions by offense and demographics may be a helpful in demystifying board actions and safeguarding against inconsistencies.

Mental health professionals and regulatory contacts both frequently described board diversity as an important factor in fostering fair and equitable disciplinary actions.

The final section of this appendix will synthesize participant perspectives related to board composition and commitment to diversity, equity and inclusion.

[It should be required for] OBOP to produce statistics of its actions by demographics, [such as the number] of minority practitioners sanctioned, including [groups like] LGBTQ and BIPOC, compared to non-minorities.

LGBTQ+, male licensed psychologist of color

It would be really beneficial if they did some statistical analysis and categorized what type of offenses or violations occurred, and then also paired that with what the penalties or disciplinary actions were.

White, female professional counselor associate

It's kind of embarrassing to say that …the profession doesn't really seem to have [evidence about the efficacy of sanctions]. You can look on the Federation of State Physician Health Programs, FSPHP. They show outcomes of close to 90 percent of people who go through professional monitoring stay in practice, so there's some good data there. They're called the blueprint studies. That's the only thing I'm, aware of though that attempted to even look at [whether] sanctions produce the desired results.

American Association of State Counseling Boards representative

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We [have] informal retrospective analyses to make sure that we're being consistent, and then also developing some matrices to make sure that we are fairly consistent. However, every single, case is unique, and it's really hard to fit into a box. There are always so many aggregating and mitigating factors …. The board is a huge safeguard against any discriminatory impacts …. As we diversify the board, they're more willing to say, 'Are we taking this position because this person is an international graduate?' Or, 'Let's look at the reason why this person may have had … criminal convictions …..'

Oregon Medical Board representative

J. Opportunities and Barriers — Participant perspectives on board composition and commitment

Board Membership and Composition

Participants suggested sharing information more readily on the website about board members.[11] OBLPCT members are listed on the website with short biographies and photos. OBOP members are listed with a name and photo only. Some aspects of diversity on the board are evident from photos, but others are not.

Other ideas from participants included creating "Board Apprenticeship" roles, increasing the size of the board or implementing term limits to open up seats that can be filled by members from marginalized groups.

Like MHRA, other regulatory groups described efforts and challenges in recruiting members from underrepresented groups. Oregon Medical Board representatives noted that they do board recruitment in collaboration with professional associations which they viewed as a helpful. They also stated they would like to do more outreach in partnership with community organizations for board nominations, particularly for public seats.

OBLPCT members' [and] Oregon psychological board members' professional biographies, photos, and reasons for serving on the board should be published and easily viewed on the board website.

Hispanic American licensed psychologist

The board would do better to create 'Board Apprenticeship' positions and invite people from minority communities to 'come learn how to be a board member.'

White, non-binary licensed professional counselor

BIPOC must be part of the power structure in order to reduce bias from strategies and policies.

White, female licensed professional counselor

There should be more positions [on the board] and more effort made [by the board] to hire diverse professionals who are working in the field with clients and not [just] sitting in an academic chair.

Multiracial, LGBTQ+, licensed professional counselor

Maybe the board could increase the number of diverse individuals on it by increasing the number of seats.

Male professional counselor associate

Limit the terms for all board members.

White, female psychologist resident

[11] See Appendix I for additional discussion of board composition and Appendix B for analysis of board demographics.

J. Opportunities and Barriers — Participant perspectives on board composition and commitment

Give Anti-Bias Efforts a Priority Focus

Some participants suggested the boards would benefit from a fresh start and a new emphasis on recognizing biases at play in the work of the boards. Recommendations included equipping the boards through training and recruiting members willing and ready to work on DEI issues.

As described in the discussion of board composition (Appendix I), participants noted that diverse board membership alone is insufficient without sustained effort to reduce barriers and a commitment to meaningful inclusion of new perspectives. As one participant noted, the boards need to not just offer seats at the table but also "be willing to change the table."

We need to educate board members about implicit biases and how to identify biases in themselves and other board members.

African American, female licensed psychologist

[The boards need to] remove old policies and people who uphold them and replace them with people who are willing to put in the work.

African American, female mental health professional

They really need to establish specific criteria for eligibility and participation as board members. There's an alarming lack of necessary sophistication and professional experience related to … the complexities and nuances of [ethical and clinical dilemmas].

Male licensed psychologist

Doing an ongoing assessment of where systemic discrimination shows up and working to dismantle it within the mental health bureaucracy is critical.

White, female licensed marriage and family therapist

It would take a sustainable, focused, resourced, ongoing process [for the boards] to become anti-racist, anti-sexist, anti-colonialist and a dedicated leadership. Possible, but damned hard.

White, female professional counselor associate

Representation means involving people from marginalized backgrounds in leadership in meaningful ways. It is not enough to invite people to the table. You have to be willing to change the table itself if you want genuine change to occur.

White, LGBTQ+, female mental health professional

Oversight, Audits and Data Sharing

In discussion of opportunities and barriers and as described in prior appendices, some participants believe the boards lack appropriate checks and balances.

Some described external audits and data sharing as ways to monitor for bias, particularly regarding complaints and investigations. As noted previously with information about criminal background checks, data collection sharing was also suggested to help create transparency about license approvals and denials related to criminal background issues.

Other state and national regulatory and professional association contacts noted data collection and reporting as absent in their past regulatory experiences. Using data to monitor for disparate impact in complaints and investigations may be a common shortcoming and area of opportunity among regulatory boards.

The board and MHRA need regular oversight to stop and prevent corruption, abuse of power, unfair and unethical complaint and investigation processes.

White, female licensed psychologist

[I support the] hiring of external EDI consultants to audit [the] licensure process.

Asian American/Pacific Islander, female licensed psychologist

It would be wise to do a review of how complaints and investigations are handled [by the board] for white and non-white people and see if they're equitable.

White, LGBTQ+, female licensed psychologist

Someone should do an audit on people who are investigated. I'd bet underrepresented groups are overrepresented in that population, particularly people with disabilities and non-white folx.

Biracial, female licensed psychologist

We have no idea [what] the identities [are] of people who are investigated [by the board]. Are BIPOC investigated at a rate higher than white clinicians?

White, LGBTQ+, licensed professional counselor

If we aren't collecting data, we haven't measured how we are doing as a board. Are we disciplining more people from underserved communities? We don't really know.

Minnesota Board of Behavioral Health and Therapy representative

In the cases that I was involved [on the board in another state], there was probably an overrepresentation of minority counselors brought before the board, but I don't know that statistically.

National professional association board member

Get Curious

Some participants described opportunities for the boards ask more questions about existing ways of operating, to listen to community stakeholders and gather information from external sources.

There seems to be a commitment to doing things as they always have been done, even if [members of the board] do not know why they are done that way.

Asian American/Pacific Islander, female licensed professional counselor

What they [on the board] need to grapple with is [that] even if they could make the case that [they] want to make all these changes, the perception [in the field] is that they're not [genuine about it]. That's what they need to get more curious about. If they are doing everything 'so well,' why is it that almost every [clinician] would tell you they don't trust the board?

Hispanic American mental health professional

The board has to have some type of connection with a community that is actively [doing intracommunity work to] understand the issues around retaining diverse professionals to meet the community's needs …. It takes being on the ground and knowing the actual living challenges of various individuals to know what can help support someone to stay in the area as a professional.

Biracial, female licensed marriage and family therapist

I would encourage the boards to talk to more folks and seek more feedback. If there are not a lot of diverse clinicians in a particular area, why? Is it reflective of our state demographics? How does the board engage with training programs and clinicians? Who is the board seeking advice from?

Hispanic American, female mental health professional

[MHRA should] ask other states' boards, [especially states] with larger minority populations, about [how they address] these issues.

White, male licensed psychologist

APPENDIX K. Definition of Terms

To ensure consistent understanding of MHRA's diversity study, this appendix provides definitions for key terms and concepts.

Definitions and Key Concepts

Diversity. Variation of a group based on both visible and invisible traits such as race and ethnicity, gender identity or expression, age or life stage, nationality, veteran status, language, religious affiliation, sexual orientation, disability, lived experience, income, neighborhood, communication style and more. Diversity includes all the ways in which people differ.

Equity. Access to opportunities for all people achieved by addressing barriers that differ for some groups compared to others. This principle recognizes the need for fairness in addressing unbalanced conditions for historically underserved and underrepresented populations.

Inclusion. The act of creating conditions where individuals and groups are valued, respected and supported as they contribute to or seek services from the professions.

Inequities. Differences that disadvantage an individual or group in favor of another.

Disadvantaged. Being in a powerless position in a community or group.

Disparity. A disparity is an inequality, difference, or gap between an actual outcome and a reference point or benchmark. For example, a difference between an outcome for one racial or ethnic group and an outcome for non-minorities may constitute a disparity.

Marginalized or historically marginalized. Groups that face exclusion from full participation and access to opportunities based on long-standing patterns of bias or discrimination. Examples include people of color, women, LGBTQ+ individuals, people with low incomes, people with disabilities and senior citizens.

Racially or ethnically minoritized. Groups that are non-dominant in a culture due to race or ethnicity. This term acknowledges that inequities in social power and privilege are not exclusively tied to demographic majority or minority status.

Gatekeeping. Granting or denying access by those who hold power informally or formally. Gatekeeping by regulatory bodies such as MHRA and the boards, is a formal, sanctioned mandate to protect the public from harm. Gatekeeping can perpetuate inequities when practices err on the side of exclusion to prevent potential harm without weighing the harm of disparate impact to professionals and consumers.

Self-advocacy. Speaking up and taking actions for oneself and one's interests. The term is often associated with actions by persons with disabilities to advocate for their needs and rights. We use the term broadly to reflect actions professionals of any background take to resolve barriers or challenges related to interactions with official bodies.

Stakeholders. Individuals or groups who are impacted by, have expertise in or are concerned with a particular issue.

Underrepresented. A subgroup of the population that is present in lower proportions than would be expected based on the numbers of that subgroup in the general population.

Underserved. People, places and communities that have not had or do not have equitable resources or access to services, in general. These groups may have disparities in both services and outcomes.

Final Report
December 16, 2022

OREGON MENTAL HEALTH REGULATORY AGENCY
Topical Analysis: Supervised Clinical Experience Requirements

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KEEN INDEPENDENT RESEARCH

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements

Introduction

Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT), with support from the Oregon Mental Health Regulatory Agency (MHRA), is assessing the supervised clinical experience requirements for licensed professional counselors and licensed marriage and family therapists in Oregon.

MHRA engaged Keen Independent to analyze Oregon's requirements relative to other states and to provide qualitative information relevant to this topic collected from research with mental health practitioners, educators, and other state and national mental health professional association or regulatory contacts.

This analysis includes the following.

Comparative analysis. Keen Independent collected and analyzed state requirements for supervised clinical experience for licensed professional counselors and marriage and family therapists. We place Oregon's requirements in the context of other states across the country.

Stakeholder perspectives. Keen Independent is conducting a diversity study for MHRA that is expected to be completed by January 2023. As part of this study, practitioners and others were asked about opportunities and barriers to diversity in the mental health professions in Oregon. Keen Independent asked about requirements of MHRA and its licensing and regulatory boards. This information draws on:

- Sixty in-depth interviews with industry contacts and mental health practitioners in Oregon, 27 of whom were counselors or marriage and family therapists;
- Four focus groups totaling 18 counselors or therapists; and
- An on-line virtual workshop (similar to a survey but with more opportunity for open-ended responses) sent to all professionals under the purview of MHRA, which had responses from 1,063 professional counselors and 263 marriage and family therapists.

Sample comments from research participants in this report are drawn from the virtual workshop, focus groups and interviews. In some cases, participants also emailed the study team with comments. Identifying information is excluded.

Comparative Analysis for Licensed Professional Counselors (LPCs)

The Keen Independent study team compiled supervised clinical experience requirements in all U.S. states.[1] A summary table of the compiled data is provided at the end of this section in Figure 1-5.

Total supervised hours. On average, states require 2,758 total hours of supervised experience. Most states (72%) require 3,000-3,999 hours (see Figure 1-1).

Oregon's requirement for 2,400 hours is below the average requirement across 50 states. Oregon is one of 12 states requiring fewer than 3,000 total hours of supervised clinical experience.

Direct client contact hours. Thirty-eight states specify what portion of supervised experience must be spent in direct contact with clients. States that specify client contact hours require, on average, 1,409 hours. The 1,500-1,999 range for direct contact hours is most common among states that specify this requirement (see Figure 1-2).

Oregon requires all 2,400 supervised hours be spent in direct client contact. This makes its direct client contact hours requirement the highest total among all U.S. states. As discussed on the next page, Oregon allows credit for 400 hours earned prior to graduation. Looking at post-degree hours specifically, Oregon's requirement for direct client contact hours is not the highest in the U.S. but is among the top five.[2]

1-1. LPC total supervised hours requirements by state

Total hours	States	Percent of total
< 1,000	1	2 %
1,000-1,999	5	10
2,000-2,999	6	12
3,000-3,999	36	72
4,000 ≤	2	4
Total	50	100 %

Note: Both New Jersey and Maryland require 4,000 or more total hours but credit pre-degree experience at levels that make their requirements closer what is typical in other states.

Source: Keen Independent Research.

1-2. LPC direct client contact hours requirements by state

Direct client contact hours	States	Percent of total
< 500	2	5 %
500-999	3	8
1,000-1,499	10	26
1,500-1,999	18	47
2,000 ≤	5	13
Total	38	100 %

Source: Keen Independent Research.

[1] Clinical supervision data used for this analysis was collected from state agency and regulatory board websites as of October 4, 2022.

[2] Alabama requires more post-degree hours than Oregon. North Carolina and Vermont require 2,000 hours post-degree, the same as Oregon.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LPCs

Allowable experience accrued prior to degree completion. Nine states allow a portion of the supervised hours requirement to be fulfilled using hours earned prior to graduate degree completion (see Figure 1-3). The nine states that offer this option allow an average of 731 hours acquired prior to degree completion to count toward licensure.

Oregon's allowance is up to 400 pre-degree hours and one year. This falls in the most frequently found range of allowable hours (less than 500 pre-degree hours).

Minimum years of supervision. Thirty-eight states require a minimum number of years over which supervision must be completed (see Figure 1-4). Most states that have this requirement specify a minimum of two years supervision for licensure (71%).

Oregon is one of just five states that require a minimum of three or more years.[3]

1-3. LPC pre-degree allowable supervised hours by state

Pre-degree hours	States	Percent of total
< 500	4	44 %
500-999	2	22
1,000-1,499	1	11
1,500 ≤	2	22
Total	9	100 %

Source: Keen Independent Research.

1-4. LPC minimum years of supervised experience by state

Minimum years	States	Percent of total
1	6	16 %
2	27	71
3	4	11
4	1	3
Total	38	100 %

Note: Four of the six states listed with a one year minimum require either 1.5 or 1.75 years.

Georgia and Maryland allow credit for one year of pre-degree experience reducing their post-degree requirements to three and two years respectively.

Source: Keen Independent Research.

[3] Oregon statute requires three years of supervised experience. Administrative rules allow one year and 400 hours of pre-degree experience to be credited toward this requirement. Most applicants will have a qualifying year of experience from their degree programs making the necessary post-degree years of supervision more equivalent to other states at two years.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LPCs

Neighboring states. As they are other Pacific Coast states, Washington and California are sometimes referenced as comparison points. They may be of interest as clinicians who live near state borders may wish to hold licenses and serve clients from both states.

California's requirement for total hours at 3,000 is slightly higher than Oregon's but its direct client contact requirement of 1,750 hours is slightly lower. California requires two years of minimum supervision which is lower than Oregon's requirement. However, Oregon credits a year experience completed prior to graduation. Most applicants qualify for this pre-degree year.

Washington's total hours requirement (3,000) is higher than Oregon's, but Washington's direct client contact requirement is 1,200 hours, substantially less than in Oregon. Washington also offers the option to meet either the 3,000 hour requirement or three years of supervision.

Summary of most common requirements. States have many variations in their requirements regarding hours of experience for licensed professional counselors. This makes it challenging when comparing Oregon to other states. To simplify this analysis, Keen Independent examined states that do not have either exceptionally low or high standards to find a "typical" combination of requirements. They are:

- 3,000 total hours of supervised experience;
- 1,500 of that experience being fulfilled in direct client contact with no allowance for pre-degree hours to count toward licensure; and
- Taking place over a minimum of two years.

Oregon's LPC requirements compare to the above as follows:

- 2,400 total hours (600 less than is typical);
- 2,400 direct client contact hours (900 more than is typical) of which 2,000 client contact hours must be post-degree (500 more than is typical); and
- Three year minimum of supervised experience (1 year more than is typical, but Oregon credits a year of pre-degree experience which most applicants have).

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LPCs

1-5. LPC supervised clinical experience requirements by state (part 1 of 2)

State	Minimum years	Total hours	Direct client contact hours	Pre-degree hours allowed
Alabama	-	3,000	2,250	-
Alaska	2	3,000	1,000	-
Arizona	2	3,200	1,600	-
Arkansas	3	3,000	1,700	-
California	2	3,000	1,750	-
Colorado	2	2,000	-	-
Connecticut	1	3,000	-	-
Delaware	2	1,600	1,600	-
Florida	2	1,500	1,500	-
Georgia	4	2,400	-	600
Hawaii	2	3,000	-	-
Idaho	-	1,000	400	280
Illinois	2	1,680	960	-
Indiana	2	3,000	-	-
Iowa	2	3,000	1,500	-
Kansas	2	3,000	1,500	-
Kentucky	-	4,000	1,600	400
Louisiana	2	3,000	1,900	-
Maine	2	3,000	1,500	-
Maryland	3	3,000	1,500	1,000
Massachusetts	2	3,360	960	-
Michigan	2	3,000	-	-
Minnesota	1	2,000	-	-
Mississippi	1.5	3,000	1,200	-
Missouri	2	3,000	1,200	-

Source: Keen Independent Research.

1-5. LPC supervised clinical experience requirements by state (part 2 of 2)

State	Minimum years	Total hours	Direct client contact hours	Pre-degree hours allowed
Montana	-	3,000	1,000	1,500
Nebraska	-	3,000	1,500	-
Nevada	2	3,000	1,500	-
New Hampshire	2	3,000	-	-
New Jersey	-	4,500	-	1,500
New Mexico	2	3,000	-	-
New York	-	3,000	1,500	-
North Carolina	-	3,000	2,000	-
North Dakota	2	400	400	-
Ohio	2	3,000	1,500	-
Oklahoma	-	3,000	1,050	-
Oregon	3	2,400	2,400	400
Pennsylvania	2	3,000	-	-
Rhode Island	2	2,000	-	-
South Carolina	2	1,500	1,380	-
South Dakota	-	2,000	800	-
Tennessee	2	3,000	1,500	-
Texas	1.5	3,000	1,500	-
Utah	2	3,000	1,000	-
Vermont	2	3,000	2,000	-
Virginia	1.75	3,400	2,000	300
Washington	3	3,000	1,200	-
West Virginia	1.6	3,000	1,500	600
Wisconsin	-	3,000	1,000	-
Wyoming	-	3,000	1,200	-

Source: Keen Independent Research.

Comparative Analysis for Licensed Marriage and Family Therapists (LMFTs)

The Keen Independent study team also analyzed supervised clinical experience requirements for LMFTs in all U.S. states.[4] A table of the compiled data is provided at the end of this section in Figure 1-11.

Total supervised hours. On average, states require 2,357 total hours of supervised experience, with about half requiring 3,000-3,999 hours (see Figure 1-6).

Oregon's requirement of 2,400 hours is close to the average for all 50 states.

Direct client contact hours. Forty-six states specify what portion of supervised experience must be direct contact with clients.

Those that specify client contact hours require, on average, 1,315 hours. Of the states that specify direct client hours 25 require less than 1,500 direct contact hours and 21 require 1,500 hours or more (Figure 1-7).

Oregon requires all of the 2,400 supervised hours be spent in direct client contact. This makes its direct client contact hours requirement the highest among all U.S. states. As discussed on the next page, Oregon allows credit for 400 hours earned prior to graduation. Looking at post-degree hours specifically, Oregon's requirement for direct client contact hours is not the highest in the U.S. but is among the top four.[5]

1-6. LMFT total supervised hours requirements by state

Total hours	States	Percent of total
< 2,000	18	36 %
2,000-2,999	5	10
3,000-3,999	24	48
4,000 ≤	3	6
Total	50	100 %

Source: Keen Independent Research.

1-7. LMFT direct client contact hours requirements by state

Direct client contact hours	States	Percent of total
500-999	1	2 %
1,000-1,499	24	52
1,500-1,999	16	35
2,000 ≤	5	11
Total	46	100 %

Source: Keen Independent Research.

[4] Clinical supervision data used for this analysis was compiled from information aggregated by the American Association of Marriage and Family Therapy (AAMFT) and accessible through aamft.org. The Keen Independent team compared a subset of 15 state requirement listings on AAMFT's site against state regulatory websites to verify it was reasonably up-to date as of October 4, 2022.

[5] Arkansas requires more post-degree hours than Oregon. Idaho and Vermont require 2,000 hours post-degree, the same as Oregon.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LMFTs

Allowable experience accrued prior to degree completion. Ten states allow a portion of the supervised hours requirement to be fulfilled using hours earned prior to graduate degree completion (see Figure 1-8). The states that offer this option allow an average of 580 hours acquired prior to degree completion to count toward licensure.

Oregon's allowance of 400 pre-degree hours and one-year is slightly lower than other states that offer this option. The most frequent range of allowable hours is 500-999.

Minimum years of supervision. Thirty-four states require a minimum number of years over which supervision must be completed (see Figure 1-9). Most states that have this requirement specify a minimum of two years supervision for licensure (91%).

Oregon requires a minimum of three years, making its requirement among the two highest in the U.S.[6]

1-8. LMFT pre-degree allowable supervised hours by state

Pre-degree hours	States	Percent of total
< 500	1	10 %
500-999	8	80
1,000 ≤	1	10
Total	10	100 %

Source: Keen Independent Research.

1-9. LMFT minimum years of supervised experience by state

Minimum years	States	Percent of total
1	1	3 %
2	31	91
3	2	6
Total	34	100 %

Source: Keen Independent Research.

[6] Oregon statute requires three years of supervised experience. Like requirements for LPCs, the requirements for LMFTs set by administrative rules allow one year and 400 hours of pre-degree experience for LMFTs to be credited toward this requirement. Most applicants will have a qualifying year of experience from their degree programs making the necessary post-degree years of supervision more equivalent to other states at two years.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LMFTs

Couple and family client hours. Twenty-four states specify a minimum number of client contact hours that must take place with couples or families in order to quality for LMFT licensure (see Figure 1-10). On average these states require 675 hours.

Oregon requires 1,000 hours of couple/family contact for LMFT licensure, higher than average.

1-10. LMFT required hours with couples and families by state

Couple/Family hours	States	Percent of total
< 500	3	13 %
500-999	13	54
1,000-1,499	7	29
1,500-1,999	1	4
Total	24	100 %

Source: Keen Independent Research.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LMFTs

Neighboring states. Washington and California, as neighboring states, are sometimes referenced as comparison points.

As is the case for LPCs, both California and Washington require a higher total number of supervised hours at 3,000 than Oregon does at 2,400. Both states require fewer direct client contact hours than Oregon. California requires the same client contact hours for LMFTs as it does for LPCs, 1,750. Washington's requirement for LMFTs at 1,000 Is slightly lower than its requirement for LPCs at 1,200 and is substantially lower than Oregon's requirement of 2,400 direct client contact hours.

Both California and Washington require 500 hours of work with couples and families. Oregon requires 1,000.

Both California and Washington require two years of supervision compared to Oregon's three. However, Oregon credits a year experience completed prior to graduation. Most applicants will qualify for this pre-degree year.

Most common requirements. States have many variations to their requirements, which makes direct comparison challenging. Based on states that do not have either exceptionally low or high standards, a typical combination of requirements for LMFT licensure () is:

- 3,000 total hours of supervised experience;
- 1,500 of those experience hours being fulfilled in direct client contact (with no pre-degree hours credited);
- 500 of the experience hours accrued working with couples and families; and
- Taking place over a minimum of two years.

Oregon's LMFT requirements compare to the above as follows:

- 2,400 total hours (600 less than is typical);
- 2,400 direct client contact hours (900 more than is typical) of which 2,000 hours must be post-degree (500 more than is typical);
- 1,000 hours of the direct client contact hours accrued working with couples and families (500 more than is typical); and
- Three year minimum of supervised experience (1 year more than is typical but Oregon credits a year of pre-degree experience which most applicants qualify for).

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LMFTs

1-11. LMFT supervised clinical experience requirements by state (part 1 of 2)

State	Minimum years	Total hours	Direct client contact hours	Pre-degree hours allowed	Couple/family hours
Alabama	2	1,000	1,000	-	-
Alaska	-	1,700	1,700	-	-
Arizona	2	3,200	1,600	-	1,000
Arkansas	-	3,000	2,200	-	1,500
California	2	3,000	1,750	1,300	500
Colorado	2	2,000	1,500	-	1,000
Connecticut	1	1,000	1,000	-	-
Delaware	2	1,600	1,600	-	500
Florida	2	1,500	1,500	-	-
Georgia	3	2,500	-	500	-
Hawaii	2	1,000	1,000	-	-
Idaho	-	3,000	2,000	-	1,000
Illinois	-	3,000	1,000	-	350
Indiana	2	1,000	1,000	-	500
Iowa	2	3,000	1,500	-	-
Kansas	-	4,000	1,500	-	-
Kentucky	2	1,000	1,000	-	-
Louisiana	-	3,000	2,000	500	-
Maine	2	3,000	1,000	-	1,000
Maryland	2	2,000	1,000	-	-
Massachusetts	2	3,360	1,000	-	500
Michigan	-	1,000	1,000	-	500
Minnesota	2	4,000	1,000	-	500
Mississippi	2	1,000	1,000	-	100
Missouri	-	3,000	1,500	-	-

Source: Keen Independent Research.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — LMFTs

1-11. LMFT supervised clinical experience requirements by state (part 2 of 2)

State	Minimum years	Total hours	Direct client contact hours	Pre-degree hours allowed	Couple/family hours
Montana	-	3,000	1,000	500	500
Nebraska	-	3,000	1,500	-	-
Nevada	2	3,000	1,500	-	-
New Hampshire	2	3,000	1,000	500	-
New Jersey	2	3,000	-	-	-
New Mexico	2	1,000	1,000	-	1,000
New York	-	1,500	1,500	-	-
North Carolina	-	1,500	500	500	500
North Dakota	2	3,000	1,500	-	-
Ohio	2	1,000	1,000	-	500
Oklahoma	2	1,000	1,000	-	250
Oregon	3	2,400	2,400	400	1,000
Pennsylvania	-	3,000	-	-	-
Rhode Island	2	2,000	-	-	-
South Carolina	2	1,500	1,380	-	-
South Dakota	2	1,700	1,700	-	-
Tennessee	2	1,000	1,000	-	-
Texas	2	3,000	1,500	500	750
Utah	2	4,000	1,000	-	-
Vermont	2	3,000	2,000	-	1,000
Virginia	-	3,400	1,000	600	-
Washington	2	3,000	1,000	500	500
West Virginia	2	3,000	1,500	-	750
Wisconsin	-	3,000	1,000	-	-
Wyoming	-	3,000	1,200	-	500

Note: Virginia requires 2000 hours of work in couples or family counseling, but this requirement is not direct client contact.

Source: Keen Independent Research.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — Participant perspectives

The next section of this analysis presents participant perspectives relevant to the clinical supervised experience requirement. Comments come from: [7]

- Sixty in-depth interviews with industry contacts and mental health practitioners in Oregon, 27 of whom were counselors or marriage and family therapists;
- Four focus groups totaling 18 counselors or therapists; and
- Virtual workshop with responses from 1,063 professional counselors and 263 marriage and family therapists.

In addition to qualitative analyses, Keen Independent coded and analyzed open-ended responses provided in the virtual workshop. The following results are relevant to supervised clinical experience.

- Financial issues were one of the two most frequently cited factors that might hinder diversity of the mental health professions (mentioned in 33% of open-ended comments).
- Financial concerns were also frequently mentioned in the open-ended responses about ways the boards can support/ hinder diversity as graduates enter the profession and seek initial licensure (28% mentioned financial concerns).
- Of responses about ways the boards can support or hinder diversity as graduates seek initial licensure, 8 percent mentioned clinical hours; most did not.

The remainder of our analysis of participant comments is organized as follows:

- Financial challenges for registered associates;
- The importance of support for clinicians;
- Perspectives on clinical supervision requirements; and
- Cross-jurisdictional parity.

[7] Quantitative analysis of virtual workshop responses includes psychologists, counselors and therapists.

Financial Challenges

Participants frequently described financial challenges that may impact the viability of the counseling and therapy professions as options for people without socioeconomic advantages. They noted that financial considerations impact diversity both in terms of socioeconomic status but also on other aspects of diversity because socioeconomic differences tend to advantage white, heterosexual practitioners without disabilities.

Many research participants described the time in which new graduates are accruing supervised experience as a time of financial strain. They often pointed out the cost to attain advanced degrees as just the beginning.

Participants explained that compensation in the registered associate stage can be low or may be contingent on a fee-for-service model. They reported that insurers (with the recent exception of Oregon Health Plan) will not cover services provided by registered associates, which means that clients must be willing to pay out-of-pocket to see less experienced clinicians.

These financial challenges provide important context for understanding the urgency registered associates feel as they work toward licensure.

The following pages present additional analysis and descriptions of financial challenges grouped as follows:

- Education and training costs;
- Compensation; and
- Insurance reimbursement.

The cost of clinical supervision as a financial issue is included in the discussion of clinical supervision requirements later in this analysis.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — Participant perspectives

Education costs. The professions licensed by OBLPCT require master's or doctoral degrees. The cost of required education and training is a substantial factor that sets the context for the financial pressure counselors and therapists face while they accrue clinical experience hours.

I come from a very low-income family. I had to pay for everything out of pocket.

White, female licensed professional counselor

I have over $100,000 in student loan debt ….

Biracial, LGBTQ+, mental health professional

The cost to become a mental health professional and to maintain your licensure has risen in the last 20-30 years. People who identify as minorities are often of lower socioeconomic status or experience financial hardship in this country. They may be barred from the profession given the [large] amount of money required to obtain a formal degree, licensure and continuing education.

White, LGBTQ+, female licensed marriage and family therapist

Graduate education for a social service field requires a lot of upfront financial assistance with limited return on investment. Historically marginalized groups may find that they do not have the social and financial support to undertake the endeavor or may wish to move directly to higher paying fields

White, LGBTQ+, female licensed marriage and family therapist

… lack of financial access, lack of generational wealth and the cost of entering the profession are massive hurdles. I saw incredibly talented, brilliant clinicians of color … drop out or prolong their program because they couldn't afford textbooks [or] childcare.

White, LGBTQ+, non-binary professional counselor associate

We just spent two years doing [a] graduate program …. Right at the tail end, we're asked to do six months of unpaid internship. We're working up to 32 hours a week for free while also going to school and having to pay bills.

White, female professional counselor associate

Compensation for registered associates. Participants described low pay relative to their education levels as a factor that may make entering or staying in the mental health professions or in clinical service roles difficult. In some cases, participants stated that it is not possible to earn enough from counseling or therapy alone during the registered associate stage.

To earn a reliable salary, registered associates may work in community mental health settings, where salaries are low. In private practices, compensation is typically fee-for-service. Private insurers will not reimburse for services provided by registered associates (a topic addressed separately in this analysis). As a result, registered associates often bill clients at low hourly or sliding scale rates to secure direct client service hours required for licensure. These factors contribute to a desire to reach full licensure quickly.

Starting jobs in mental health don't pay very well. It's really hard to want to go into a field that isn't necessarily very lucrative, especially when you need to get a master's degree [and] get licensed.

White, female licensed professional counselor

To pay off school loans, someone [in this industry] may need to work extra hours or have a second job.

White, female licensed professional counselor

… when you're a physician and become a resident, you get a minimum salary and can bill for your time. [You work] alongside a physician, and your services are reimbursable to employers. If you're a counselor, you have no defined path … to obtain the thousands of … hours of experience needed … for a license …. The easiest path [is working] in a day treatment or hospital treatment program, where they bill in bundles [so they can] afford to hire and pay you. [A private practice has] no set program to ensure consistent hours and [pay you] a reasonable wage. A pre-licensed therapist will mostly see patients who are self-paying … a reduced fee. It is difficult to keep a consistent caseload and those services are yielding very low income …. There's a high level of vulnerability and naivete for new counselors — most do not understand how hard it will be to obtain the required supervised clinical hours ….

National mental health professional association board member, out-of-state private practice owner

They [mental health providers] are living at the same poverty level as the clients they are seeing.

African American, female licensed professional counselor

Because of the current policies regarding insurance billing, supervisory requirements, and hours requirements, agencies feel very comfortable paying early-career clinicians very little for the work that they do.

White, LGBTQ+, female licensed professional counselor

Old ways of thinking that newbies have to start out in the trenches and earn their rank and will be minimally compensated [hinder the promotion of diversity within the field].

White, LGBTQ+, female licensure applicant

Insurance reimbursement. Many participants who cited financial challenges discussed the impact of insurers on compensation. Participants often noted that insurers other than Oregon Health Plan (OHP) will not reimburse for services provided by registered associates.

Some licensed professional counselors described inequitable reimbursement rates and the exclusion of LPC services from Medicare reimbursement.[8] They also pointed out inferior pay compared to other mental health professions with similar education and experience requirements.

Some participants pointed to Oregon Health Plan, which recently extended coverage to registered associates, as a positive. In community mental health agency settings, clinicians may secure direct clinical experience hours working with Oregon Health Plan clients.

Lack of insurance reimbursement for associates [hinders diversity].

White, male licensed professional counselor

If I'm qualified to work with clients while I'm being supervised, why shouldn't I be able to take insurances and work with more people?

Middle Eastern, female professional counselor associate

Low pay for therapists doing community mental health work, in part due to the poor reimbursement rates for those with OHP, [hinders diversity in the field].

White, LGBTQ+, non-binary mental health professional

Medicare sets reimbursement standards at the federal level and private insurers base their reimbursement rates on CMS (Center for Medicare and Medicaid Services). [Their standard] is a huge issue for professional counselors. Medicare will not credential and reimburse a professional counselor. Medicare pays psychiatrists, physicians and psychologists — people with their doctorates — 100% of the set rate. Master's level providers in other disciplines are paid at 85% of the doctoral rate, but master's-level social workers are only paid at 75% of the doctoral rate and professional counselors aren't even credentialed by Medicare so they aren't eligible to provide reimbursable counseling services. That's federal policy. It is an enormous disadvantage. People going into the counseling field don't know that when they … choose to go to graduate school.

National mental health professional association board member, out-of-state private practice owner

Working as an intern is tough because many of the insurances will not panel with us while we're an associate. Recently, Oregon Health Plan has changed the policy there so we can now work with them. They will pay us. Other insurances are not doing that.

White, LGBTQ+, non-binary professional counselor associate

[8] Medicare reimbursement excludes services provided by licensed professional counselors. The advocacy arm of the American Counseling Association has advocated for bipartisan legislation to make LPC services reimbursable under Medicare.

The Importance of Support

Participants frequently mentioned the challenges of mental health work and the exacerbating factors of inadequate support, high caseloads and long hours. Many also spoke about the added demands of practicing during COVID-19 and the conditions that are specific to clinicians early in their careers. Participants described these conditions as contributors to burnout and attrition.

Respondents frequently pointed out that these stressors are amplified by issues that come with being part of a marginalized group, often taking an even greater toll on clinicians of color and LGBTQ+ clinicians.

Inadequate support. Participants described the emotional toll of working with mental illness and trauma. They cited inadequate support as a factor that may hinder diversity.

When you're working in the field, you're seeing so many clients. You're doing therapy [for clients], and [yet] you can't afford your own therapist …. How are you gonna sustain yourself in this field when you don't have support?

Biracial, LGBTQ+, male licensed professional counselor

It's [an] extreme [amount of work], especially if you're working with a certain demographic of people who have a particular diagnosis, whether it's severe mental health struggles [or] trauma. The number of hours [required] in a lot of these places [and] the lack of flexibility [are challenging]. A lot of places don't even have mental health days [for practitioners].

African American, female mental health professional

Working in trauma-inducing environments can be difficult. How people are [maintaining] health and balance in jobs or positions where they may not feel [valued] is another [difficult] thing.

Hispanic American, female mental health professional

Inexperience as a risk. When asked about complaints and investigations, some participants noted that some violations are due to inexperience and that early career practitioners are still learning. Others noted that caseloads that concentrate the most difficult cases with the least experienced professionals can be a set up for failure.

Notably, academic research on licensed marriage and family therapists across multiple state boards found that most violations occur among practitioners with between two and five years of experience.[9]

When you've got a registered associate … they're still in the learning process, right? So, they make a mistake with a release or they make a mistake clinically with the client. We should be helping them [learn].

White, male licensed professional counselor

I did see some cases [on a state board other than Oregon] where [the least experienced practitioners working with the hardest cases such as in-home counseling with Medicaid clients] ended up with complaints. And you think, did we set them up, for success or did we set them up for failure? We put them in situations that anybody would have found problematic. And did they have the right training? [Striving] for lower cost services sometimes puts people who don't have adequate training in risky situations, so that to me would be the crux of this question.

American Association of State Counseling Boards representative

[9] Rollins, P. & Grames, H. (2021). Sanctioned licensing board violations for marriage and family therapists spanning a 10-year period. *Journal of Marital and Family Therapy, 48* (I2), 621-642. https://doi.org/10.1111/jmft.12523

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — Participant perspectives

Caseloads and hours. Participants described large caseloads and long hours of work as stressors that could hinder diversity in the field. They also highlighted the way these demands impact early-career professionals before they are licensed.

They require therapists to see … up to 25 or 27 people a week. While that seems normal, when I graduated, I remember my program said 15 people a week is a full case load.

Hispanic American, female licensed marriage and family therapist

I have a case load of over a hundred [clients]. It's pretty much the norm here in [rural county].

White, female licensed professional counselor

Most [mental health] clinics are understaffed and underpaid, so there is more burn out [than in other health professions].

White, female licensed professional counselor

Practices sort of treat unlicensed folks as if they're starting from scratch in terms of experience up until the day they meet the 2,400 [clinically supervised experience] hours. Suddenly, you get more money, you get to see different kinds of clients and you make it over this hurdle. So many of us are exhausted trying to get to that wall [that] we lose … people before they even become licensed because of burnout.

White, LGBTQ+, female licensed professional counselor

There is a HUGE power imbalance in the field between licensed professionals who own and operate agencies and their counselor associate employees who carry larger caseloads, earn less money and work with the most-acute clients.

White, LGBTQ+, female licensed professional counselor

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — Participant perspectives

COVID-19. Participants described the pandemic as a time that placed extreme demands on mental health professionals leading to burnout for many. They noted this time of acute pressure as a possible hinderance to diversity in the field.

Added stressors for marginalized professionals. Participants described an extra layer of stress and work for professionals from marginalized backgrounds. This work may consist of navigating the stress and practical impacts of discrimination and bias.

After two years of [the] pandemic, we're fried. We're just toast. That's going to be another reason we're gonna bail out [of the industry].

Multiracial, female licensed professional counselor

The last two and a half years, being a psychotherapist, has been extremely challenging. We're humans and we're all going through the same trials and tribulations, [but] we need to show up five days a week for our clients. There are mornings I just don't have it in me.

Middle Eastern, male licensed professional counselor

As human beings experiencing discrimination, there's very little give in our profession to not be 'on' and have it together all the time.

White, LGBTQ+, non-binary professional counselor associate

Due to the overall significant lack of diversity in Oregon, it can be challenging for BIPOC (Black, Indigenous and people of color) to explore the mental, emotional, physical, and social health of clients when the general environment rarely seeks to understand how bio-socio-cultural factors affect the wellness of BIPOC mental health professionals.

Multiracial licensed professional counselor applicant

Supervised Clinical Experience

Participants who commented on Oregon's supervised clinical experience requirement frequently described it as a barrier to diversity.

Comments throughout this discussion illustrate how financial concerns are intertwined with perspectives on supervised clinical experience requirements.

Supervised clinical experience hours as a financial challenge. Participants sometimes suggested lowing the clinical hours requirement. Notably not a single participant described supervised clinical experience as unhelpful or lacking value. Comments indicated that registered associates may value supervision as a source of support and learning as they enter a challenging field. However, the requirement delays their ability to be reimbursable by private insurers, negatively impacts their compensation and creates a sizable out-of-pocket cost for some professionals[10].

In some interviews and focus groups when participants suggested lowering the requirement, study team members asked them to clarify the reason. In cases where this topic was probed more deeply, participants said the issue was financial, not the value of or need for the supervision as a source of training or support.

[The boards should] change licensure requirements to 1,200 [hours of supervision] so more therapists will enter into this field and stay.

White, female professional counselor associate

The high number of supervised hours required for associates, [as well as] the lack of specific criteria for supervisors who can oversee the quality of supervision for associates, [both hinder diversity].

Asian American/Pacific Islander, female licensed professional counselor

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The supervision structure is too rigid and relies on [the assumption that] people have steady streams of discretionary income ….

LGBTQ+, female licensed marriage and family therapist

[There is] no path for submittable hours other than 'qualified supervision' which, if not adequately provided in an agency setting, costs $100-400 OOP (out of pocket) per month.

White, LGBTQ+, non-binary licensed professional counselor

I think that the price of supervision is (a hinderance) … the supervision (itself) is very helpful, depending on … the cost. Personally, I like supervision, but it is expensive.

White, LGBTQ+, non-binary professional counselor associate

I think training [and supervised clinical experience] is great. Where it falls short is the compensation piece. Train me like crazy, and please pay me for my time …. We should be supervised until we retire.

White, male, out-of-state professional counselor resident

[10] ORS 675.661 requires employers to pay for clinical supervision. See discussion on page 26 of why some professionals may describe supervision as an expense.

Supervision as training and support. Some interviewees cautioned against easing the burden of supervision by reducing the requirement rather than addressing cost and compensation issues. They noted that reducing the hours could be counterproductive, leaving early career professionals less supported and more vulnerable to mistakes that could harm clients and/or result in disciplinary action.

Instead of limiting supervision to early career professionals, an educator and national leader in a related mental health profession suggests models that recommend or support supervision or peer consultation throughout a clinician's career. This educator and national leader also proposes models that incorporate more group supervision.

… those two years of training post postgraduation are vital. They really are their formative and developmental years [so] the students or the new graduates still need that that very close eye of the supervisor to guide them and their confidence level, is not there …. I don't even think the students and new graduates are really worried about the hours, because there's an understanding that you need that training … there's only so much we can teach in three years.

African American mental health professional and educator

I don't think most people are actually able to practice independently after just two years …. There should be a model where … people continue to have other supervision or peer consultation or something throughout their careers. [In our studies of social workers who received disciplinary action we heard that] … private practitioners just didn't have somebody to bounce ideas off of or to help them to realize that there was counter transference or something going on …. [It would be helpful to set an] expectation whether it's professional or it's legally imposed [so] people don't feel like, 'Okay, I've done my two years, I don't need any more help ever from anyone else to make sure my practice is competent, ethical and so on.'

Professor and national professional association committee chair

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To reduce costs, some states will allow group supervision. Some do not. Some have minimum amounts [for one-to-one supervision but allow a combination of individual and group supervision]. There's really good value to group supervision. It's not … just cheap supervision It can actually be very effective. I think it'd be nice if [group supervision] was offered to help more people … gain access at a reasonable cost. [Some agencies have] one supervisor for 6-10 frontline workers. Does it really make sense for all of their [supervision] to be done individually? [Supervision requirements that don't allow group work] can be taxing on agencies as well as individuals.

Professor and national professional association committee chair

Access to relevant clinical supervision. Many participants of color or from other marginalized groups felt supervision from professionals from similar backgrounds or serving similar client populations would be helpful, but they were on their own to procure this support. Academic research also suggests supervision may be more effective when the supervisee and supervisor have a common cultural understanding.[11]

Lack of diversity among clinical supervisors was often mentioned as a hinderance to diversity in the mental health professions. Some described a sense of isolation and lack of support as a result.

In some cases, small pools of people with similar demographic backgrounds working in mental health in Oregon make it challenging for practitioners to find clinical supervision specific to their personal backgrounds or clientele that are not considered 'dual relationships,' pre-existing personal relationships that create a conflict of interest.

When asked about opportunities to increase diversity, some again raised ideas for fostering supervisors of color or from other underrepresented backgrounds.[12] In Minnesota, grant funding supported a program to train supervisors from underrepresented backgrounds.[13]

… research has shown that in both the therapeutic relationship and in the supervisory relationship, clients do not return to counseling because of culturally related … therapeutic ruptures or supervisees give up on becoming counselors because of ruptures that happen in the supervisory relationship.

African American mental health clinician and educator

I am a clinician of color and find that most of the classrooms, consult groups and professional [meetings] that I step into are either exclusively white or white dominant.

Male professional counselor associate of color

The lack of diversity among supervisors and overall staff has a negative impact. It feels like working in cultural isolation.

Female professional counselor associate of color

It is rare that a supervisor and/or clinical supervisor asks clinicians about their cultural background. Instead, it is assumed you come from a privileged background and subscribe to mainstream Caucasian Americans [beliefs and cultural values].

Hispanic American, female licensed professional counselor

[11] Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. *BMJ Open*, 11(9), e052929. https://doi.org/10.1136/bmjopen-2021-052929

[12] One representative of a national mental health professional association explained that clinical supervision is typically approached as an entrepreneurial endeavor in which the cost to attain licensure to be a supervisor is weighed against the potential return from offering supervision as a paid service in addition to direct client work.

[13] The Mental Health Cultural Community Continuing Education Grant Program (MHCCC), authorized by Minnesota Sessions Law, 2021 Chapter 7, section 44, was established for the purpose of assisting mental health professionals to pursue a course of study, through post–secondary training or continuing education, that is expected to lead to recognition as a board–approved Licensing Supervisor. The program is administered through the Minnesota Department of Health. See www.health.state.mn.us/facilities/ruralhealth/funding/grants/mhccce.html

Having more diversity in mentors and supervisors could help. As a Latina woman, I never had a teacher, supervisor or mentor who was Latinx.

Multiracial, female licensed professional counselor

The majority of our supervisors … are white. If you are a person of color, … you are most likely going to have a white supervisor in [an] all-white institution while you're seeing Black, brown and [other] disenfranchised clients.

African American, female licensed professional counselor

[There needs to be increased] availability of mentors of diverse backgrounds to support increased representation.

Biracial, female professional counselor associate

If you're a disabled clinician, good luck finding a supervisor who is also disabled and who you don't know from other places.

White, female licensed professional counselor with a disability

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One thing that came out was not having enough supervisors from underserved communities. [So] the State of Minnesota did develop a grant program that pays for the training for individuals coming from underserved communities, so that they can become approved supervisors.

Minnesota Board of Behavioral Health and Therapy representative

Clinical supervision costs. Participants frequently mentioned the number of hours of clinical supervision required for licensure as a financial challenge. Participants reported that some employers may provide clinical supervision as a benefit, but many do not.[14] Some participants reported that employers that offer clinical supervision as a benefit may do so contingent upon having a licensed supervisor on staff with availability to provide supervision, which is not always the case.

Many participants said that supervision is up to the registered associate to procure and pay for. This expense occurs while they are not yet billable to payers other than Oregon Health Authority, which makes the net earnings on time worked difficult to sustain.

Some participants described reasons clinicians of color, those who are LGBTQ+, or disabled clinicians may wish to secure supervision from someone who can help them navigate specific challenges related to race/ethnicity, sexual orientation or disability status. Participants reported that obtaining supervision relevant to a clinician's personal identity and experiences or their intended client specialization may only be possible if the registered associate pays out-of-pocket.

Duration to accrue supervised clinical experience hours. As previously discussed, prior to licensure, associates are not reimbursable by private insurance. Those working in private practices are typically on a fee-for-service model and may have difficulty attaining direct client service hours. Some may find it difficult to meet the required number hours and work toward it over a prolonged period.

You have to pay to meet with a supervisor. All that [supervised] time [required by the board] comes out of your pocket unless you have an employer that pays for that.

Asian American/Pacific Islander, female licensed professional counselor

For those of us seeking licensure, non-white therapists have to pay out of pocket to receive supervision that is even somewhat racially relatable to our own professional experiences.

Female professional counselor associate of color

The time between education and licensure is extremely long. For those without [financial resources], this time of paying a clinical supervisor without being able to collect on insurance creates a disadvantage economically.

LGBTQ+, male licensed professional counselor

It took me nearly seven years to complete my [supervised] hours ….

Biracial, female professional counselor associate

[14] Recent legislation, ORS 675.661, in Oregon requires employers to pay for clinical supervision. Participant comments about the cost of supervision may reflect that employers are not yet complying or that many clinicians who raised this point are unaware of the new legal requirement. The statute is silent on who selects the supervisor and whether supervision comes from inside or outside the workplace. The statute is also silent on enforcement which may contribute to lack of compliance.

Independent supervision and protecting supervisee hours. One professional suggested that employers should be mandated not just to provide supervision, but to provide independent supervision that is separate from the employee/employer relationship.[15]

Academic research suggests supervision may be more effective when clinicians can choose their supervisor.[16] In addition, registered associates may feel that the hours they need for licensure are at risk if they bring a complaint against their supervisor. The opportunity to observe reportable violations is ostensibly higher when the associate and the supervisor work together, potentially as employer and employee.

Participants also noted the vulnerability of hours based on factors related to their supervisor that are beyond their control

Inequitable requirements for professionals who serve couples and families. Some participants noted that the requirement for supervised work with couples and families is difficult to attain, may be high relative to other jurisdictions and puts LMFT candidates at a disadvantage compared to LPC candidates. They noted that LPCs can work with couples and families but do not have to meet direct experience requirement specific to relational practice.

I think there needs to be some sort of rule from the board that supervisors or employers need to provide supervision that's external from the people who employ you, and they need to pay for it. I don't think they should they always make us pay for it if we want external supervision. Employers say, 'We'll provide free supervision, but if you want unbiased supervision, you need to pay for it.'

White, LGBTQ+, female licensed professional counselor

I have a colleague who's a clinician of color. [He] found out after his six-month report that his supervisor's license had actually lapsed, so he lost almost 500 hours.[17] That's not okay. That should have been caught and that should not have been on my colleague to be watching what his supervisor was doing.

Biracial, LGBTQ+, non-binary mental health professional

The MFT licensure requirements are completely inequitable compared to LPC licensure requirements. … MFTs [must] obtain 1,000 relational hours. LPCs do not have to obtain a specific number of relational hours and are still considered competent to treat couples, which begs the question of why the relational hour requirement is so high for MFTs at all.

Biracial marriage and family therapist associate

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[15] Oregon's new statute that requires employers to pay for supervision does not specify who selects the supervisor or whether supervision options apart from the supervisees employer must be permitted.

[16] Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. *BMJ Open*, 11(9), e052929. https://doi.org/10.1136/bmjopen-2021-052929

[17] MHRA confirms that clinical supervisors letting licensure lapse while actively supervising associates will disqualify hours for associates under their supervision. This has happened and resulted in sanctions on the supervisors at fault.

Cross-Jurisdictional Parity or Flexibility

Supervised clinical experience hours are one aspect of licensing requirements that participants discussed as a challenge related to portability of credentials for clinicians and Oregon's ability to compete for and retain mental health practitioners.

Participants said that alignment of requirements with other states would be valuable for a number of reasons:

- Keeping Oregon competitive as place to do graduate work and early career training;
- Making it easier for clinicians from outside Oregon to attain licensure in Oregon; and
- Preventing attrition due to clinicians pursuing licensure in nearby states rather than in Oregon.

Participants described challenges and opportunities related to how Oregon's supervised clinical experience requirement compares to neighboring states. They also suggested greater flexibility in allowing remote supervision by practitioners in other states.[18] These topics are addressed on the following pages.

[There should be] automatic license transfer [when moving to Oregon from another state] to attract licensed clinicians from out of state.

Male licensed professional counselor of color

I would adjust the licensure requirements to make sure that they're in sync with the rest of the country …. It needs to be standardized. It needs to be smooth. It needs to be fast.

White, male licensed professional counselor

As a [bilingual professional] with 12 years of clinical experience outside [the] US and seven years in the US, the barriers [have] been enormous …. All the clinical direct contact hours [I've accrued] weren't counted toward my license [and] countless ones I provided in my country of origin as a psychologist are LOST.

Hispanic American, female professional counselor associate

Upon moving to Oregon, [I was] already licensed in another more racially and culturally diverse state with a notoriously rigorous licensure process …. Jumping [through] the board's hoops [in Oregon] was a costly and poor use of my time. I am very vocal with my licensed out-of-state queer and BIPOC colleagues not to move here [because of this].

Multiracial, LGBTQ+, male licensed professional counselor

It's odd to me that I can serve clients in California, which is [a state with an] incredibly rigorous process to be a marriage and family therapist, and then move here and be told … I [cannot] be a marriage and family therapist right away.

Biracial, LGBTQ+, male licensed professional counselor

[18] OBLPCT previously required a portion of supervision to be in-person. In 2020, the board amended this requirement to allow all supervision to be virtual.

Lower supervision requirements "next door." Some participants pointed out that Washington state may draw clinicians away from Oregon because it requires half the supervised direct client contact hours that Oregon does.

Oregon's requirement of 2,400 direct client contact hours makes it much more difficult for individuals to become licensed here than in other states. It makes a lot more sense for a new grad making low wages to go to Washington, where only 1,200 [supervised] hours are required for full licensure.

Non-binary professional counselor associate

It's a long process to attain your license in Oregon and that's why a lot of interns choose to go to Washington to get their hours because they will get licensed faster. I have several friends who graduated with me who already have their license (and have had [it] for seven months) in Washington and I am still five months out from mine.

Biracial, LGBTQ+, female professional counselor associate

Out-of-state supervisors. Some participants described greater flexibility in clinical supervision across geographic boundaries through solutions such as interstate compacts as potentially valuable for registered associates in Oregon.[19]

Things like an interstate compact would be really helpful for more diversity, especially in supervision …. practitioners are formed by supervisors …. as a as a therapist and a counselor educator of color, one of the reasons I became a counselor educator was to … bring in and mentor and encourage therapists and counselors of color right? If there's that opportunity to be able to do that [across] borders, I know many therapists of color would choose to … because we know our struggle so to speak ….

African American, female mental health professional

Allowing for supervisors from out of state to supervise candidates would be huge. There are less than a handful of black supervisors and I already have pre-existing relationships with most of them, which automatically eliminates my access to culturally specific supervision.

Biracial, LGBTQ+ mental health professional

[19] State statute requires Oregon licensure to practice clinical supervision for behavioral health professions.

TOPICAL ANALYSIS. Supervised Clinical Experience Requirements — Recommendations

Summary

This report shows considerable variation in requirements for supervised clinical experience among U.S. states. However, there is little empirical information to inform decisions about supervised clinical experience requirements.

- As previously noted, one academic article links disciplinary action to inexperience. This finding might support arguments that less oversight early in the licensure process is a risk.
- However, the Keen Independent team did not find any studies of the relationship, if any, between supervision and complaints or disciplinary action.

In the absence of that research, ideal levels of experience requirements cannot be identified based on evidence of their impact on outcomes such as client well-being, reductions in complaints or improved well-being, support and retention for mental health professionals.

Qualitative information presented here indicates the following:

- Supervised clinical experience is helpful to clinicians who need support for the challenging and stressful work they do, particularly early in their careers and this support may be especially useful for clinicians from marginalized groups.
- Structural changes such as education funding and Medicare/private insurance reform could improve the financial outlook for registered associates but are outside the authority and resources of the boards.
- The supervised clinical experience hours requirement is within the purview of the boards and is contributing to the financial pressures facing some counselors and therapists.

MHRA and OBLPCT should consider revising supervised clinical experience requirements to be comparable to other states that also have rigorous standards.

- Requirements that are substantially higher than other states create a burden on professionals that can be difficult to justify based on the available evidence.
- Requirements that are on the lower side introduce unknown risks for practitioners, consumers and education programs. For example, will less experienced practitioners make more mistakes that result in complaints and sanctions as well as potential harm to consumers? Might decreased support for workers increase attrition? Could licensure statistics for graduates of Oregon degree programs compare unfavorably to programs in other states if Oregon graduates have difficulty relocating and sustaining licensure in other jurisdictions due to lower standards in Oregon? Each of these questions might arise if Oregon adjusted its standards to less than what is typically found for other states.

Potential Changes to Current Requirements

If MHRA and OBLPCT were to consider changes to supervised clinical hours requirements, they might be to require:

- 1,500 post-degree direct client contact hours;
- 500 of which for LMFT candidates would be direct couple, family or group hours.

As more information about optimal requirements may be forthcoming in the future, MHRA and OBLPCT should retain the flexibility to adjust requirements through administrative rules. Keen Independent recommends that the requirements not be established in state statute.

If MHRA and OBLPCT adopt changes, they should also consider options to mitigate potential risks. For example, strategies that increase the rate of practitioners using supervision, peer consultation or other forms of clinical support throughout their careers might offset the possible downsides of reducing supervised experience prior to licensure.

MHRA and OBLPCT should also adopt a plan to monitor for and respond to any unintended consequences, for example tracking the rate of complaints against early career professionals before and after the change in requirements.[20]

[20]MHRA staff expect that increased complaints would impact caseloads resulting in a need for additional resources. Costs associated with increased caseloads include investigation personnel, Department of Justice resources and Administrative Law Judge costs. In the current funding model, budgets for licensing and regulation related expenses come from licensing fees. In monitoring, for unintended consequences, care should be taken to ensure that the response to a possible increase in caseloads does not exacerbate factors that contribute to socioeconomic barriers in the professions.