INVESTING IN A CULTURALLY DIVERSE MENTAL HEALTH WORKFORCE IN MINNESOTA

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BROADEN, STRENGTHEN, SUPPORT A DIVERSE MENTAL HEALTH WORKFORCE.

Issue Statement

Minnesota's mental health workforce lacks in both cultural diversity and cultural responsiveness. Each is critical for providing equitable mental health care to Minnesota's increasingly diverse population. Without ensuring that Minnesota's mental health workforce is culturally diverse, culturally responsive mental health care for Black, Indigenous and People of Color (BIPOC) will not be attainable. Minnesota must broaden, strengthen, and create structures to support a racially and ethnically diverse mental health workforce.

The State of Our Mental Health Workforce

"Our supply is not close to meeting the demand for mental health professionals in Minnesota, and those shortages are even worse when looking at providers who are Black, Indigenous, or People of Color."— Sue Abderholden, NAMI Minnesota

Minnesota, not unlike the rest of the country has a mental health workforce shortage with demand far exceeding supply.

Minnesota's mental health workforce is overwhelmingly white. In 1993, the Minnesota legislature mandated the collection of information about an array of licensed or registered health-related care professionals. The most recent numbers reported by the Minnesota Department of Health shows just how far Minnesota has to go to create a culturally diverse mental health workforce.

- Social workers are the largest single group of mental health providers in Minnesota, with 92% white and 93% only speaking English.
- 87% of licensed Drug and Alcohol Counselors (LADC) are white.
- 90% of licensed Marriage and Family Therapists (LMFT) are white.
- 89% licensed Professional Counselors and Clinical Counselors are white.
- 88% of licensed Psychologists are white.
- 88% of licensed Psychiatrists are white.

This makes it almost impossible for BIPOC folks to find mental health providers who look like them, talk like them, and can relate to their lived experiences and struggles.

The Need for a Culturally Diverse Mental Health Workforce

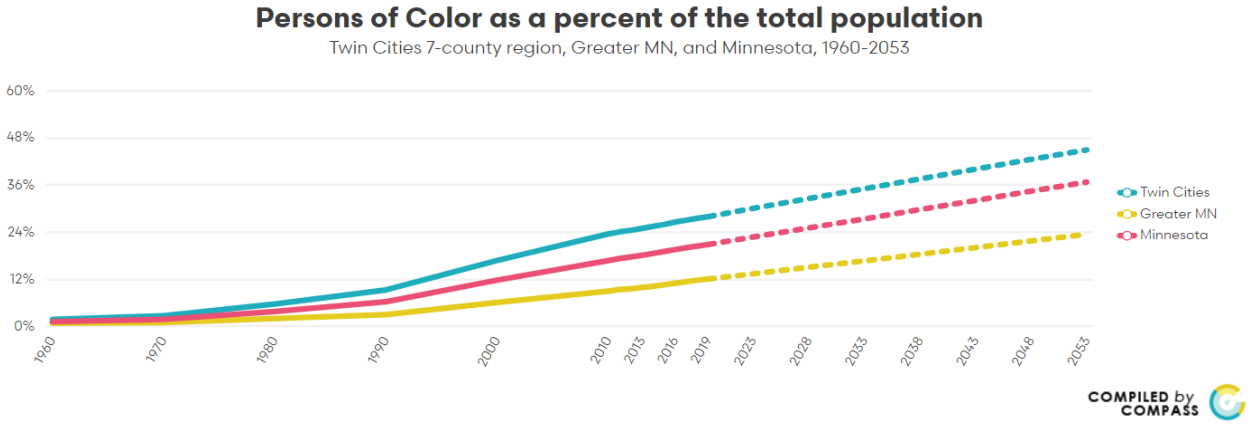
"There is absolute need and value in trying to advocate for a more diverse workforce" Rep. Luke Frederick (19B) Vice Chair of the MN House Behavioral Health Policy Division.

People from racial/ethnic minority groups are less likely to receive mental health care and typically experience more negative long-term effects of mental illness, such as more persistent depression and higher rates of posttraumatic stress. BIPOC individuals are less likely to seek out services by mental health professionals due to a shortage of providers of similar cultural backgrounds, high service costs, and inadequate insurance coverage. BIPOC folks are more likely to utilize services, build a stronger therapeutic alliance, and are more likely to return to therapy for subsequent sessions when meeting with providers of similar cultural backgrounds.[1] Alternatively, a lack of cultural understanding from health care providers contributes to underdiagnosis and/or misdiagnosis of mental illness in people from racially/ethnically diverse populations.

Expanding towards a more culturally diverse workforce is more vital than ever considering the global pandemic, the murder of George Floyd, and the current cultural and political unrest, all of which are disproportionately harming BIPOC folks and exacerbating an already strained mental health care system. Not only is our system failing BIPOC communities; it is also costing billions of dollars in lost productivity, school dropouts, failed medical treatments, and incarceration.[2]

Diversity and Disparity. Minnesota has two sides: One of prosperity and one of disparity. Minnesota is continuously ranked in the top 5 of the "Best States to Live in the U.S." Yet, also ranked as the 47th state in terms of racial integration and 44th in racial progress on indicators of employment, wealth, education, social/ civic engagement, and health. The Twin Cities metro area was ranked as the 4th worst city for Black Americans based on disparities in socioeconomic outcomes. Minnesota continues to become a more racially/ethnically diverse state. Current estimates indicate that BIPOC communities represent 20.5% of the state's population and is expected to rise to nearly 37% by 2053, with the Twin City 7-county region growing to 45% by 2053 (see Figure 1).

Figure 1



The more diverse Minnesota becomes, the greater the need for a racially/ethnically diverse, culturally responsive mental health workforce to serve BIPOC communities throughout the state.

MINNESOTA'S EFFORTS TO INCREASE MENTAL HEALTH WORKFORCE DIVERSITY

In 2014, the National Conference of State Legislatures (NCSL) issued Racial and Ethnic Health Disparities Workforce Diversity identifying state policy options to increase workforce diversity. Recommendations centered on five key strategies: 1) Invest in a pipeline beginning with students in K-12, through college and into community practice, 2) Provide loan repayment and financial incentives, 3) Use workforce data to drive policy and planning, 4) Engage in professional education curricular development strategies, and 5) Create community health teams.

Current efforts in Minnesota recommend incorporating elements from all five NCSL policy option strategies.

GEAR UP FOR ACTION: 2015 MENTAL HEALTH WORKFORCE PLAN

Was led by MentalHealth Workforce on behalf of Minnesota State Colleges and Universities, with extensive input from mental health stakeholders throughout the state. Recommendations included: 1) Replicating and expanding the Diversity Social Work Advancement Program to include additional mental health disciplines and practice locations, and 2) Expanding the capacity to train Certified Peer Specialists and Family Peer Specialists throughout the state, with a particular emphasis on recruitment from communities of color.

STATE ADVISORY COUNCIL ON MENTAL HEALTH AND THE SUBCOMMITTEE ON CHILDREN'S MENTAL HEALTH 2020 REPORT TO THE GOVERNOR AND LEGISLATURE

Made 13 recommendations for improving the mental health system and continuum of care in Minnesota. Recommendations included: 1) Create a loan forgiveness pilot program to increase the representation of Black, Indigenous, and People of Color (BIPOC) mental health professionals on par with Minnesota's existing student loan forgiveness programs; 2) Allocate resources to support Local Mental Health Advisory Councils (LMHC), and 3) Enhance the role of LMHC by requiring their involvement in the Adult Mental Health Grant application process. Notably absent is a recommendation that LMHCs be made up of diverse individuals that are representative of the communities they serve.

CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL (CECLC) 2020 LEGISLATIVE REPORT.

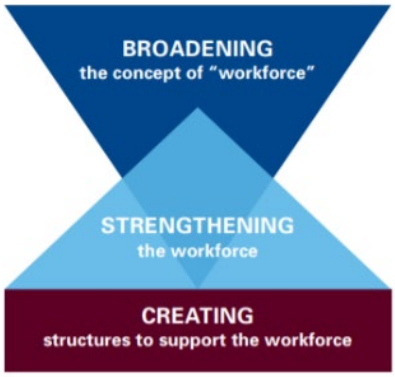
The purpose of the Council is to advise the Commissioner of the Minnesota Department of Human Services (DHS) on ways to reduce disparities and inequities that effect racial/ethnic groups in DHS programs. In 2019, the CECLC engaged with DHS legislative directors on their list of legislative policy ideas for the very first time. Most of the recommendations focused on creating a more culturally responsive human services system, with two recommendations related to workforce diversity: 1) Modify rules, regulations and incentives relating to equity/disparities reduction, and 2) Increase recognition of foreign trained health care professionals.

STRENGTHENING OUR APPROACH: THE ANNAPOLIS FRAMEWORK

Minnesota would benefit from a conceptual framework to guide it's investment.

The **ANNAPOLIS FRAMEWORK** is a three-part approach for systems to plan and develop their mental health workforce to meet future needs (Figure 2) — including creating a more culturally diverse workforce. This framework anchors SAMHSA's Action Plan for Behavioral Health Workforce Development. The plan consists of seven goals, with Goal 3 "systematic recruitment and retention" and Goal 5 "fostering leadership among all segments of the workforce" particularly beneficial for creating a culturally diverse mental health workforce.

Figure 2



POLICY POSITION STATEMENT

Minnesota is increasingly become a more racially/ethnically diverse state. Without ensuring that Minnesota's mental health workforce is culturally diverse, culturally responsive mental health care for Black, Indigenous and People of Color (BIPOC) will not be attainable. Minnesota must broaden, strengthen, and create structures to support a diverse mental health workforce.

For these reasons we recommend:

- **BROADENING** the definition of mental health provider to be more inclusive and representative of those who are providing care, expanding the capacity to train Certified Peer Specialist and Family Peer Specialists, with a particular emphasis on recruitment from communities of color, and recognizing foreign-trained mental health care professionals.
- **STRENGTHENING** the mental health workforce by implementing and investing in systemic recruitment and retention strategies in students K-12 through college and into community practice.
- **SUPPORTING** the mental health workforce by providing loan repayment and financial incentives for BIPOC mental health professionals, allocating resources to support LMHCs that are made up of racially/ethnically diverse individuals that are representative of the communities they serve, and providing community-specific solutions to issues impacting mental health.

To access this and other policy advocacy briefs go to: http://link.mnsu.edu/mswbriefs

References

To the extent possible, full text online sources were used to create this policy advocacy brief and are linked throughout the document.

[1]Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537-554.

[2] Covino, N. A. (2019). Developing a behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*, 689-695.