Mental Health Workforce Crisis

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There has nearly always been a shortage of mental health professionals. President Eisenhower noted in his seminal report that there was a severe shortage of child psychiatrists. Since then, national and state reports have noted the shortages of not only psychiatrists but all types of clinical mental health professionals.

In 2013 NAMI Minnesota successfully advocated for a bill that required Minnesota State Colleges and Universities (MnSCU) to hold a mental health summit and to write a state workforce plan. The summit would involve the Department of Human Services, MnSCU, U of M, private colleges, mental health professionals, special education representatives, child and adult mental health advocates and providers, and community mental health centers. The purpose was:

• to develop a comprehensive plan to increase the number of qualified people working at all levels of our mental health system,
• ensure appropriate coursework and training and
• create a more culturally diverse mental health workforce

There was a Steering Committee, 290+ community forum participants, and 500 people who completed an online survey offering more creative ideas and input. The Mental Health Summit was attended by 150 mental health stakeholders who spent the day discussing solutions for Minnesota's mental health workforce challenges. That report can be viewed here. Several, but not all, of the recommendations have been implemented. There were 23 recommendations. Critical recommendations that are still relevant today include:

- Ensure access to and affordability of supervisory hours.
- Improve collection and dissemination of mental health workforce data at all levels.
- Require all third-party payers/commercial insurers to reimburse in the same way that Medical Assistance does for supervision/internships so that services provided by mental health trainees, under the supervision of a mental health professional, are reimbursable by third-party payers/commercial insurance plans.
- The Minnesota Private College Council, HealthForce Minnesota, and the Office of Rural Health and Primary Care will co-convene a discussion with representatives from Minnesota's higher education institutions to assess the availability of higher-level mental health degree programs in rural areas of the state.
- Expand capacity to train Certified Peer Specialists and Family Peer Specialists throughout the state with a particular emphasis on recruitment from communities of color
- Develop a faculty fellowship model to engage faculty in the newest understanding and treatment of mental illness in children, youth, adults, and older adults
- Examine ways technology can be used to streamline paperwork and ensure necessary data capture.

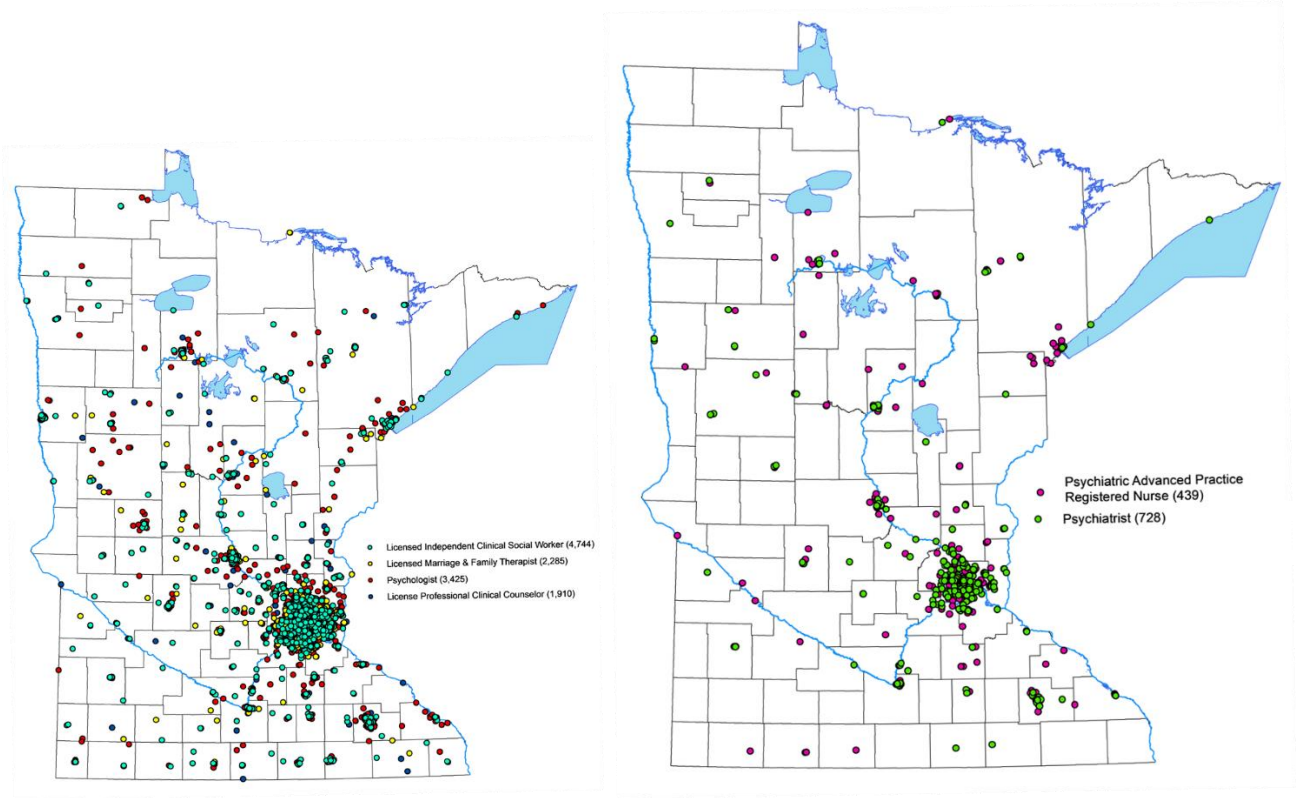
During the 2021 Legislative Session, significant changes were made to address the capacity and diversity of Minnesota's mental health workforce:

- **Continuing Education:** Requires continuing education for psychologists, Licensed Marriage and Family Therapists (LMFTs), social workers, and Licensed Professional 'Clinical Counselors (LPCCs) to include at least four hours on addressing the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. Topics include under understanding culture, its functions, and strengths that exist in varied

cultures; understanding clients' cultures and differences among and between cultural groups; understanding the nature of social diversity and oppression; and understanding cultural humility. These standards are effective July 1, 2023. (SS Chapter 7, Article 4)

- **Culturally Informed and Responsive Mental Health Task Force**: Creates a task force to make recommendations on recruiting diverse mental health professionals, training all mental health providers on cultural competency and cultural humility, assessing the quality of current efforts to provide culturally competent care, and to increase the number of mental health organizations owned, managed, or led by someone from the Black, Indigenous, and people of color (BIPOC) community. The task force membership includes the licensing boards, education programs, providers, advocates, and others. Annual reports must be provided to the legislature. The task force ends in January 2025. Appropriates $222,000 in FYs 22-23 and $194,000 in FY 24 to fund this task force. (SS Chapter 7, Article 11)
- **Increasing Diversity of Mental Health Supervisors**: Requires MDH to work with relevant licensing boards to develop a grant program for mental health professionals of color or from underrepresented communities to become supervisors. This includes social workers, marriage and family therapists, psychologists, and professional clinical counselors. Eligible grantees must provide services in the community where at least 25% of their patients are on a public health program like MA or a formal sliding fee schedule. This work is supported with a one-time appropriation of $1 million in FYs 22-23. (SS Chapter 7, Article 4) In addition, funding under children's mental health grants can be used to pay for supervision or clinical trainees who are BIPOC. (SS Chapter 7, Article 11)
- **Internationally Trained Professionals**: Provides $1M each year to help internationally trained professionals obtain the training needed to take the license exams. Includes providing English instruction and supportive services. (SS Chapter 10)
- **Loan Forgiveness**: Expands MDH's health professional loan forgiveness program to licensed alcohol and drug counselors that practice in rural or underserved urban communities. This change is temporarily authorized in statute and not permanently added until July 1, 2025. Appropriates $6.624 million in FYs 22-23 and $7.624 million in FYs 24-25 and adds that these funds are for medical residents, LADCs and mental health professionals – including pediatric psychiatry - who agree to deliver at least 25% of their patient encounters to people on MA or MinnesotaCare or through formal sliding fee scales. (SS Chapter 7, Article 3)
- **Mental Health Practitioners**: Expands who can be a mental health practitioner to include someone in the process of completing a practicum or internship as part of their undergraduate or graduate level program in social work, psychology, or counseling. This means that a mental health agency can bill for the work being provided by people doing a practicum or internship and the intern can be paid for their work. (SS Chapter 7, Article 11)
- **Mental Health Professional Licensing Boards**: Requires licensing boards for psychologists, LMFTs, and LPCs to have members from outside of the seven-county metro, people of color, and underrepresented communities (defined as a group that is not in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability). (Note the Board of Social Work adopted these standards a year ago). (SS Chapter 7, Article 4)
- **PSYPACT:** Authorizes Minnesota to enter the Psychology Interjurisdictional Compact or PSYPACT. Under this agreement, a psychologist licensed in one compact state can provide treatment via telemedicine or limited in-person treatment in any compact state. (Chapter 27)

Despite these efforts, we are still experiencing huge shortages. The maps below show where we have prescribers for mental health medications and the location of mental health professionals.



We know that low wages also make it difficult for people to complete their education and the number of supervised hours needed to become licensed. According to the Minnesota Department of Employment and Economic Development, a Marriage and Family Therapist makes $29.71 an hour versus a dental hygienist at $37.41; a social worker makes $31.00 an hour versus a respiratory therapist making $34.97an hour.

We continue to have a shortage of culturally specific providers. The MN Department of Health found that 73.4% of psychiatrists, 88.3% of mental health clinicians, and 86% of LADCs were white. Data also show that providers of color serve a higher percentage of people from culturally diverse communities, people who are low income and people who need interpreters.

The pandemic is resulting in increased numbers of children and adults struggling with their mental health, and the workforce shortages are causing our already fragile mental health system to collapse. NAMI Minnesota began reviewing data. One of the key issues identified by the Minnesota Department of Health (MDH), was that about 50% of people who complete a master's degree in one of the mental health professions, don't become licensed. According to The Minnesota Department of Employment and Economic Development, the job vacancy rates in mental health and substance use counseling professions was 26% in 2021 versus 8% in 2019 and had the highest vacancy rate compared to all other health care professionals. Clearly, mental health providers are struggling to find the people they need to meet the increased needs.

NAMI Minnesota created a survey in December 2021 to learn more from people who are current mental health professionals and from people that were or are on the path to become one. The information from the surveys is being used to develop legislation for the 2022 Legislative Session.

The survey was taken by nearly 400 people. We asked about which master's degree program they were enrolled in and 42% stated social work, 7% psychology, 16% marriage and family therapy, 27% counseling, less than 1% advance practice nursing. Other degrees mentioned included occupational therapy, applied behavior analysis, public health, art therapy, addiction counseling, dance therapy and administration. Undergraduate degrees varied quite a bit, with the highest

number being in psychology, followed by social work. There was a smattering of people whose degrees were in sociology, criminology, education, and human development. The remaining were extremely varied including business, journalism, ministry, health education, home economics, and anthropology.

Most of the people who responded were newer graduates. Of the 331 respondents who provided the year they completed their master's degree, 44% had graduated since 2016, 29% between 2011 and 2015, and 17% between 2001 and 2010. When asked if they had become licensed, only 71% responded that they had.

Barriers to licensure included finding someone to provide supervision (34%), paying for supervision (52%), and low or no pay to complete the number of hours required for supervision (69%). In the comments people included:

- Cost of the exam and license
- Inadequate or ineffective supervision
- Trouble finding someone in the same field to supervise me
- Paperwork
- Number of hours to complete supervision
- Delays by the boards in completing applications, not allowing online applications
- Knowing all the requirements to become and stay licensed
- Test was difficult because English is not my first language
- Cost of test preparations
- Transportation, time commitment
- Time provided to complete required hours and supervision is too tight
- Trouble finding culturally informed and diverse supervisors
- Lack of paid internships, low pay while completing number of required hours
- CEU costs
- Difficulty accepting licenses from other states

The length of time to complete the requirements to become license varied. Over 50% said it took between 2-3 years, 19% said it took between 3-4 years, 16% took over 4 years, and about 9% said under 2 years.

Hearing that the cost of supervision was a barrier, we asked how much people had to pay. Of the 290 who responded to this question, 43% were able to obtain supervision for free. For the others, 17% paid under $50 an hour, 21% between $51 and $75, 11% between $76 and $100. Some people did mention that they took a lower paying job in order to obtain free supervision. One person mentioned that she paid $45-$50 an hour for supervision but was being paid $25 an hour. Others paid a percentage out of their paycheck or had to sign a contract to stay with the provider for a certain length of time in exchange for free supervision. In talking with providers and professionals, paying a total of $7,500 or more to obtain the supervision hours for licensure was not uncommon.

For those who did not obtain their license, we asked them to share why. Some of the reasons included:

- Cost of supervision
- No time to study for exam
- Not counting time working as an OT in mental health
- Rigid professional boundaries
- Failures to protect clinicians' wellbeing – high caseloads, etc.
- Graduate schools that were only in person and am living in rural area
- Boards not supportive of people who are balancing work, families, etc.

- Keep missing passing the test by just a few points, you can't find out which questions you answered incorrectly making it hard to pass the second or third time around. Need to wait 90 days to take test again.
- Master's level rehabilitation counselors not considered mental health professionals
- Waiting long periods of time – months – for application to be acted upon
- Gave up license since too few insurance plans pay for LPCC
- Too many hours needed for licensure
- No clear directions as to steps needed for licensure. Very confusing

Finally, we asked people to share their thoughts on what could help more people become licensed. The answers were incredibly thoughtful. Grouping them into categories, with the highest frequency of comments first, revealed the following:

- **Supervision:** provide free supervision, allow for cross-discipline supervision, reduce number of hours required, use video for supervision, create more opportunities for group supervision, have more culturally diverse supervisors, reduce emeritus licensure fees so more people can provide supervision, count master's level hours towards supervision hours, pay for organizations to provide the 8 hours of supervision so they don't lose out due to the person not being able to bill for those hours, have boards maintain roster of people who can supervise, ensure higher quality supervision, issue with "relational hours" requirement, do not require someone licensed in another state to complete full number of supervision hours, be more flexible in type of work that meets internship requirements
- **Exams:** offer better preparation, lower fees, create alternate pathway for people who miss passing by a few points, take into consideration whether the tests are culturally responsive or when English isn't the person's first language (including providing oral exams)
- **Costs:** increase loan forgiveness programs, provide tuition reimbursement, provide paid internships, pay for master's degrees, allow people providing supervision to be eligible for loan forgiveness program, increase pay for people providing supervision
- **Licensure issues:** lower fees especially for initial license, more flexible/longer timeframe to complete requirements, create one stop shop to help people navigate through the licensure process, allow people to take the exam upon graduating, increase responsiveness of boards, allow applications to be submitted online, allow post master's clinical trainees to be considered mental health professionals, streamline or make it easier to submit documentation
- **Recruitment and retention**: allow flexibility for career changes for people from similar careers, have the boards create "affinity" groups so people from diverse communities can connect and support each other; increase pay for clinical trainees and clinicians, better coordination between border states so clinicians licensed in them can provide treatment in Minnesota, build in self-care for clinicians, take into account "lived experience" towards hours needed, lower caseloads, offer reduced tuition costs to mental health practitioners to obtain their master's degree and count their experience towards the degree/licensure, eliminate unpaid supervision hours, allow LPCs to be mental health professionals, require Medicare to pay for LMFTs and LPCCs
- **Misc.:** Better define what "counts" toward clinical work, more online classes to complete degree, look at making OTs a mental health professional

NAMI Minnesota recommends the following for the 2022 Legislative Session:

- Provide grants to mental health organizations, where a large percentage of their clients are on Medicaid and/or are from diverse communities, to provide free supervision of interns and clinical trainees and to subsidize the costs of licensing exams.

- Establish a mental health professional scholarship program to assist people currently working in the field in obtaining their master's degree to become a mental health professional. The fund would subsidize tuition, childcare, and transportation.
- Increase funds to the health professional loan forgiveness program to assist more mental health professionals and make it easier for people conducting clinical supervision to qualify for the program.
- Increase funding to train family and peer specialists.
- Fund cultural healers
- Increase funding to the Cultural and Ethnic Minority Infrastructure grant program (CEMIG).
- Allow mental health practitioners to be case managers.
- Create a website to be a clearinghouse to assist people to navigate the various mental health licensure programs, learn about the different loan forgiveness and scholarship programs, access licensing exam study tools, information on where to find supervision, links to loan forgiveness programs and tuition reimbursement programs, and other topics that would be beneficial to people wanting to become a mental health professional.
- Create incentives for more nurse practitioners to specialize in mental health.
- Allow supervision to be virtual.

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