Gearing Up for Action:

Mental Health Workforce Plan for Minnesota

Report to the Minnesota Legislature

January 2015

HealthForce Minnesota was honored to lead this important work on behalf of Minnesota State Colleges and Universities. It is our hope that this plan is the start of significant changes that will benefit all Minnesotans.

— Valerie DeFor, Executive Director and
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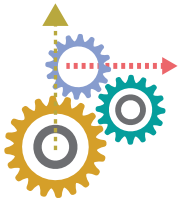

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APPENDICES CAN BE FOUND AT www.healthforceminnesota.org

ACKNOWLEDGMENTS

This state plan would not have been possible without the participation of hundreds of individuals, associations, institutions and state agencies. The Steering Committee thanks the 290+ community forum participants, from Worthington to Brainerd to Grand Rapids to Northfield, for their insights and suggestions. More than 500 people 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.

This plan, and the process leading to its development, were guided by a Steering Committee whose members met monthly from September 2013 through December 2014. It would not have been possible without their commitment and expertise. Particular thanks to Senator Greg Clausen (SD 57), who authored the legislation and served on the Steering Committee.

Below is a list of the Steering Committee members and their respective organizations.

Sue Abderholden	NAMI Minnesota
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Chris Bray	University of Minnesota, College of Education & Human Development
Greg Clausen	Senator, Minnesota Senate District 57
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Diane Forsyth	Winona State University, DNP Program
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Jeanne Nelson	Fond du Lac Reservation Human Services
Jody Nelson	Guadalupe Alternative Programs
Beth Nelson	Minnesota Association of Marriage & Family Therapists
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Sue Odegarden	Mayo Clinic
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Claire Wilson	Minnesota Association of Community Mental Health Programs
Nona Wilson	Minnesota Board of Behavioral Health & Therapy
Cory Yeager	Minnesota Association of Marriage & Family Therapists

EXECUTIVE SUMMARY

This report grew out of a concern for the ability of Minnesota's mental health workforce to adequately meet the needs of its citizens, now and in the coming years. With the implementation of the Affordable Care Act and mental health parity regulations, the demand for mental health care will increase and the system will become even more strained. The demand for mental health providers will also be exacerbated by the combined challenges of an aging mental health workforce, ongoing discrimination associated with mental illnesses, low wages, increasing regulations and the costs of education and training. These challenges are even more pronounced for diverse communities and for those living in rural parts of the state.

PURPOSE

In the spring of 2013 legislation (SF 1236) was enacted requiring Minnesota State Colleges and Universities (MnSCU) to hold a mental health summit and to write a state workforce plan.

The Minnesota State Colleges and Universities (MnSCU) will convene a summit involving 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 will be:

- 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.

The plan must be submitted to the legislature by January 15, 2015.

The demand for mental health providers will … be exacerbated by the combined challenges of an aging mental health workforce, ongoing discrimination associated with mental illnesses, low wages, increasing regulations and the costs of education and training.

Mental Health Workforce Steering Committee

Minnesota State Colleges and Universities (MnSCU) has eight Centers of Excellence with industry sector responsibilities. HealthForce Minnesota, the Center of Excellence in healthcare, was charged with leading the implementation of this legislation on behalf of the MnSCU system. Working with the primary sponsors of the legislation, HealthForce Minnesota established a Steering Committee of mental health workforce stakeholders.

The Steering Committee met monthly to advise and assist HealthForce Minnesota staff with the approach to, and implementation of, this legislation; the data analysis needed; and the determination of recommendations. The Steering Committee looked at efforts Minnesota had made over the previous decade to address mental health workforce challenges. It also reviewed other states' mental health workforce development plans to identify best practices.

Data

A data report that analyzes the supply of and demand for Minnesota's mental health professional workforce confirmed what providers and consumers had been noting for the previous decade. The shortage of psychiatrists and other professionals who

are able to prescribe medications is critical, especially in greater Minnesota. The shortage of child mental health professionals is worse than for adult populations. Diversity among all mental health professionals is not representative of the state's diverse population. While the supply of some professions appears adequate, there are concerns for all professions about geographic distribution. Available data on the mental health workforce is limited and the available data has many limitations.

Community Forums

Recognizing that the data analysis alone would not provide a clear understanding of the mental health workforce needs throughout the state, 20 community forums and outreach meetings were held throughout Minnesota to gather information and recommendations. Over and over again, Minnesotans indicated that workforce shortages were acute and that mental health resources were scarce and, as a result, the delivery of mental health care was compromised.

Survey

To broaden the opportunity for input even more, an online survey was developed. The survey was completed by more than 500 Minnesotans. Survey respondents described problems, such as filling psychiatrist and psychiatric nurse practitioner positions (e.g. it could take more than one year to fill a position) and access (e.g., wait times for appointments could stretch to three or more months). Many respondents proposed recommendations for the state plan.

Recommendations fall under the general categories of:

- *Recruitment*
- *Education and training*
- *Placement after program completion*
- *Retention*
- *Assessment*

The 2014 Mental Health Summit

As required by the legislation, a Mental Health Summit was held on May 28, 2014, at Hennepin Technical College. The Summit resulted in more than 100 recommendations aimed at increasing both the number and diversity of the mental health workforce as well as ensuring the availability, accessibility and quality of education and training of the mental health workforce.

For many of the attendees, the highlight was having educators and providers at the same table, crafting solutions to the challenges they face. Attendees also heard from individuals with mental illnesses and their family members, bringing home the very reason for the Summit.

Recommendations

Utilizing all the information gathered, Minnesota's Mental Health Workforce Development Plan of 2014 was drafted and forwarded to the Steering Committee for approval. The Steering Committee approved the report's recommendations on December 3, 2014, and the final report was submitted to MnSCU Chancellor Steven Rosenstone.

Recommendations fall under the general categories of:

- Recruitment
- Education and training
- Placement after program completion
- Retention
- Assessment

They are listed below and are described in greater detail in the body of the state plan.

RECRUITMENT

Recommendation 1: Expose middle and high school students to mental health careers, with a particular focus on those schools with diverse student populations.

a) Target funding to School Linked Mental Health grantees that plan to implement an activity or event (such as a career day) related to mental health careers.
b) Expand HealthForce Minnesota Scrubs Camps to reach all regions of the state and include mental health career exploration at each camp.
c) Investigate health career fairs/internships sponsored by other healthcare organizations to determine whether mental health career exploration is being or can be included.
d) Investigate feasibility of running a program like the INPSYDE (Indians in Psychology Doctoral Education) Program Summer Institute, a two-week enrichment program for Native American junior and senior high school students, who are interested in pursuing a degree in psychology related disciplines, run by the University of North Dakota.
e) Create a clearing house of culturally-specific mental health professionals willing to speak to various audiences about mental health careers, promote this resource, and make it available in a variety of formats.

Recommendation 2: Authorize funding to support Project Lead the Way's biomedical science curriculum.

Recommendation 3: Improve collection and dissemination of mental health workforce data at all levels.

EDUCATION AND TRAINING

Supervision

Recommendation 4: Ensure access to and affordability of supervisory hours. The Department of Human Services (DHS) will convene the relevant licensing boards and stakeholders to evaluate and develop recommendations in the following areas:

a) A process for cross-discipline certification of supervisors
b) Common supervision certificate in education programs
c) Internship hours counting towards licensure
d) Practicum hours counting toward supervisory experience
e) Creation of a supervision training institute that would provide free supervision training throughout Minnesota
f) Consideration of tax incentives for mental health professionals' preceptorships such as those set up in Georgia

Recommendation 5: 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.

Expansion

Recommendation 6: 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. Specific areas to be addressed include:

a. Expansion of psychiatric nurse practitioner programs
b. Expansion of social work and mental health programs to tribal colleges
c. Determination of the need for new programs and curriculum development
d. Expansion and/or better promotion of existing weekend cohort or online master's programs
e. Evaluate how grant funds for Minnesota higher education institutions could ensure access to mental health master's programs around the state, including rural areas.

Recommendation 7: Increase by four the number of psychiatric residency and fellowship slots in Minnesota over the next two years.

Recommendation 8: Expand/replicate the Diversity Social Work Advancement Program to additional mental health disciplines (e.g. marriage and family therapists, psychologists, etc.) and practice locations.

Recommendation 9: Expand capacity to train Certified Peer Specialists and Family Peer Specialists throughout the state with a particular emphasis on recruitment from communities of color.

Education and Training

Recommendation 10: Support efforts to expand and broaden mental health telemedicine, including using the technology in training programs, grants and funding to expand telemedicine capacity throughout the state. Require commercial health plans to cover services delivered via tele-health technology.

Recommendation 11: Improve and expand cultural competency (awareness) training. Establish cultural competence (awareness) as a core behavioral health education and training requirement for all licensure/certification disciplines.

Recommendation 12: Develop a faculty fellowship model to engage faculty in newest understanding and treatment of mental illness in both children, youth, adults and older adults.

Recommendation 13: Charge the Department of Human Services with establishing criteria and a payment mechanism to incentivize mental health settings committed to providing students with a practicum experience that features evidence-based treatment interventions.

Recommendation 14: Increase exposure to psychiatric/mental health experiences for nursing and medical school students and increase continuing education offerings for licensed nurses and physicians.

Recommendation 15: Utilize Accreditation Council for Graduate Medical Education (ACGME) and American Psychological Association (APA) standards for psychiatry residency and accredited psychology internship programs, thus expanding access and program funding.

Recommendation 16: Provide support so that all psychology internships at state institutions are accredited by the APA.

Recommendation 17: Minnesota Department of Health will evaluate Medical Education and Research Costs (MERC) funding to identify changes needed to support mental health workforce development and will add Licensed Marriage and Family Therapist and Licensed Professional Clinical Counselors professions to the program.

Recommendation 18: Promote a team-based healthcare delivery model for mental health treatment.

ENCOURAGE JOB SEEKING IN HIGH NEED AREAS

Recommendation 19: Add mental health professionals to the eligibility requirements for the Minnesota Health Professionals Loan Forgiveness program and increase funding by $750,000 a year; add requirement that 50% of this additional funding be made to mental health professionals from diverse ethnic and/or cultural backgrounds.

Recommendation 20: Continue funding of the Foreign Trained Health Care Professionals Grant Program.

RETENTION

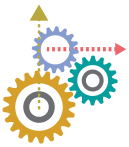
Recommendation 21: Identify gaps in the educational, certification, or licensing systems that impede career movement from entry-level, paraprofessional positions to terminal degrees and licensure as an independent professional. Identify the special challenges of and barriers to incorporating persons in recovery and persons of diverse cultural backgrounds into traditional career ladders. Develop strategies, curricula, certifications to support these pathways.

Recommendation 22: Examine ways technology can be used to streamline paperwork and ensure necessary data capture.

Recommendation 23: Increase reimbursement rates.

ASSESSMENT

Recommendation 24: Assess the recommendations made in the mental health workforce state plan by July 2017, to determine progress being made on implementation and evaluate outcomes of the above recommendations.



MINNESOTA MENTAL HEALTH WORKFORCE DEVELOPMENT PLAN REPORT

LEGISLATIVE CHARGE

Senate File 1236 called for:

The Minnesota State Colleges and Universities (MnSCU) will convene a summit involving the Department of Human Services, MnSCU, University of Minnesota, private colleges, mental health professionals, special education representatives, child and adult mental health advocates and providers, and community mental health centers. The purpose will be 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.

The following state plan and recommendations are in response to this legislation.

Of Minnesota's 11 geographic regions, 9 have been designated by the Health Resources and Services Administration (HRSA) as mental health professional shortage areas.

INTRODUCTION

Of Minnesota's 11 geographic regions, 9 have been designated by the Health Resources and Services Administration (HRSA) as mental health professional shortage areas. This designation is based on a psychiatrist to 30,000 population ratio calculation. Other workforce metrics can also be used to understand access to mental health services. Waiting time for an appointment, number of culturally diverse mental health professionals and practitioners, and time required to recruit providers are examples of other constructs by which the sufficiency of the mental health workforce could be measured. Concern about all of these factors – combined with concerns about geographic distribution, cultural diversity, and care across the lifespan – led to the legislative action responsible for this workforce development plan. This legislative action is built on a decade of previous state efforts which will be summarized later in this report.

This State Mental Health Workforce Development Action Plan will define the workforce issues relevant to working with persons with mental health conditions, and does not include workforce issues relevant to persons with autism or substance use disorders.[1] The mental health workforce is a broad range of provider types defined as:

- **Mental Health Professionals:** The core mental health providers: psychiatrists, psychologists, clinical social workers, advanced practice psychiatric nurses, marriage and family therapists, and clinical counselors who meet specified training and licensing criteria.

- **Mental Health Practitioners:** Individuals who have advanced degrees and are pursuing licensure in one of the core professions identified above and provide clinical services under the supervision of a Mental Health Professional.
  - > There are also Mental Health Practitioners who are not pursuing licensure in one of the core professions identified above. They have a Master's or Bachelor's Degree or extensive experience and meet the qualifications as defined in Minnesota statute and provide mental health services under the supervision of a Mental Health Professional.
- **Direct Service Workers:** Individuals who are in the work force in roles such as mental health case managers, residential treatment supervisors and counselors, child and youth workers, mental health behavioral aides, peer support specialists, rehabilitative workers and EBD (Emotional/Behavioral Disorders) teachers. Most work under the supervision of a Mental Health Practitioner or a Mental Health Professional.[2]

BACKGROUND AND PREVIOUS FEDERAL AND STATE WORKFORCE INITIATIVES

Mental health workforce development has been of deep concern at both the federal and state levels for the past decade and more. The themes remain alarmingly constant and similar over time.

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Federal

The Federal Action Agenda for the President's New Freedom Commission on Mental Health (2002) reported that "The Mental Health Delivery System can only be as good as the practitioners who staff it. Therefore the Commission recommended making strong efforts to train, educate, recruit, retain, enhance an ethnically, culturally, and linguistically competent mental health workforce throughout the country."[3] The Commission developed a National Strategic Workforce Development Plan with the overarching goal statement:

> *…to expand and improve the capacity of the mental health workforce to meet the needs of racial and ethnic minority consumers, children and families; to address the concerns of rural mental health, children and families; to make consistent and appropriate use of evidenced-based mental health prevention and treatment interventions; and to work at the interface of primary care and behavioral healthcare settings.*

The Annapolis Coalition, commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA), created a strategic plan for developing a mental and behavioral health force. Its 2007 *Action Plan for Behavioral Health Workforce Development* states:

> *There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population… The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported.* [4]

In 2013, SAMHSA's *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*[5] responded to the changes in access and care delivery as a result of the passage of the Affordable Care Act. Its recommendations highlighted continued need for:

- Minority fellowship programs
- Recovery to Practice Initiative
- National Child Traumatic Stress Network
- Creation of career pathways
- Recruit people earlier in the pipeline
- Diversity training
- Cross-training
- Greater use of clinical supervision
- Use of Peer Specialists

Minnesota

Minnesota has addressed workforce shortages over the past several years through various committees, workgroups and initiatives such as The Minnesota Mental Health Action Group (MMHAG)[6] and The Mental Health Acute Care Needs Workforce Subcommittee Report[7]. The reports from these initiatives contain many of the same themes such as the need for mentoring programs with child psychologists and other mental health professionals, working with third-party payers to redefine payment rules, expanding loan forgiveness programs to more agencies, offering classes for social work and chemical dependency counselors at tribal colleges, and requiring training programs to include rotations in community-based clinics, primary care clinics and community mental health centers.

The Steering Committee chose to focus this report on recommendations which were realistic, had widespread support, and were actionable in a relatively short time frame.

A few recommendations from these committees, workgroups, and initiatives have been implemented. Progress is being made in developing a curriculum for the Mental Health Behavioral Aide II to help build a career ladder for entry-level mental healthcare workers. An additional role of Family Peer Specialist has been created and will be added to the workforce category of Direct Service Workers. Minnesota's Medical Education and Research Costs (MERC) funding has been expanded to include psychologists and clinical social workers.

The Steering Committee chose to focus this report on recommendations which were realistic, had widespread support, and were actionable in a relatively short time frame. It acknowledges that more remains to be done than is recommended in this plan but believes the work described in these recommendations lays the foundation for future Mental Health Workforce Summits and further successes in providing quality mental health care to all Minnesotans.

DATA ANALYSIS

A data report on mental health professionals was commissioned and provided a starting point for discussion by the Steering Committee. The report is a compilation of well-defined, well-recognized data sets. Where data was available, it is presented regionally based on Minnesota's six economic planning regions. The data report contains more data than is summarized below including vacancy rates, wages, demographic, and education completion data, as well as more detailed analysis of the tables below. The report was completed in March 2014 and is included as Appendix A. Additional data on diversity was collected subsequent to the March report and is also included in Appendix A.

Scope and Limitations

Preliminary discussions with experts in this field regarding data on the mental health workforce identified significant data challenges and constraints. This discussion led to a data analysis focused solely on mental health professionals. (Information on workforce needs related to mental health practitioners and support services was gathered through different means.) Mental health professional data is available through a variety of sources including licensing boards (supply and basic demographic information), the Minnesota Department of Health, Office of Rural and Primary Care (race and practice information), the Minnesota Department of Employment and Economic Development (DEED) (demand and labor market information), and the Integrated Post-secondary Education Data System (IPEDS) (completer data).

While Minnesota is widely acknowledged as having some of the best workforce data in the country, the mental health professional data analysis identified … shortcomings.

While Minnesota is widely acknowledged as having some of the best workforce data in the country, the mental health professional data analysis identified the following shortcomings.

- Standard occupational classifications do not always correspond to the practitioner/professional designations in the mental health field. For example, licensed and unlicensed workers are often reported within the same classifications so that shortages of licensed professionals are difficult to identify.
- Similarly, education program codes cross major categories making identification of programs difficult resulting in the possibility of an overstatement of supply.
- DEED employment survey data does not include individuals who may be self-employed or in private practice, a particular limitation in the mental health professional arena where self-employment is significant.
- Current occupational codes do not identify the myriads of mental health workers, not designated as professionals, who play critical roles in caring for people with mental illnesses. Practitioners who are not pursuing licensure, mental health case managers, behavioral aides, Education/Behavioral Disorders (EBD) teachers and many other mental health workers are not included in the data analysis, not because their work is not extremely important, but because data collection methods are currently inadequate, an issue recommendations made in this report hope to rectify in the future.

Employment

The table below summarizes the current employment and projected growth for mental health professionals. Using the best standard data available, the table illustrates the data challenges identified above.

Total Projected Openings and Projected Growth Rate, Statewide

	Current Employment	Total Projected Openings,(e) 2010-2020	Projected Growth Rate, 2010-2020
Psychiatrists (a)	290	180	25.4%
Psychologists (a)	2,420	1,900	24.4%
Social Workers, Mental Health and Substance Abuse (b)	2180	1,200	28.7%
Social Workers, Child, Family, & School (b)	5,660	2,000	7.3%
Social Workers, Healthcare (b)	2,580	1,040	22.8%
Social Workers, Other (b)	390	120	6.2%
Marriage & Family Therapists (c)	820	640	50.3%
Mental Health Counselors (c)	2180	1,130	34.0%
Advanced Practice Psychiatric Nurses (d)	303	No data*	No data
Statewide, All Occupations		1,041,750	13.0%

SOURCE: Minnesota Department of Employment and Economic Development (DEED)
(a) Data does not reflect those who are self-employed.
(b) Data is collected according to federal standard occupation codes identifying type of work being done which may not correlate to employer terminology. Data does not distinguish between licensed and un-licensed. Data is reliant on employer nomenclature.
(c) Data does not distinguish between licensed and unlicensed.
(d) Data is not collected for this occupational category/distinct role.
(e) Includes new and replacement openings.

While Minnesota does have a larger number of psychologists, clinical social workers, psychiatric nurses, and marriage and family therapists per 100,000 population than the U.S. overall, it is below the U.S. number for both psychiatrists and child and adolescent psychiatrists. Given the extreme shortage of mental health professionals around the country, the comparison of Minnesota to the U.S. tells us relatively little about the adequacy of mental health care in the state. The Steering Committee cautions against complacency relative to this national data. The numbers are helpful, however, in providing a benchmark from which progress can be measured. *

* Substance Abuse and Mental Health Services Administration, *Behavioral Health, United States, 2012*, pp. 195-196.

Minnesota and U.S. Mental Health Treatment Providers, by Discipline Per 100,000 population, 2008, 2009 and 2011

	Child and adolescent psychiatrists, 2009	Psychiatrists, 2009	Psychologists, 2011	Clinical social workers, 2011	Psychiatric nurses, 2008	Counselors, 2011	Marriage & family therapists
U.S.	2.1	11	30.7	62	4.5	46.5	20
MN	1.8	9.2	60.8	80.1	8.8	22.5	26.4

Education and Training

Education and training of the mental health workforce takes place across Minnesota's public and private higher educational institutions. The table below identifies Minnesota colleges and universities that educate mental health professionals at the master's degree and above. Data on the number of graduates from these programs in 2012 can be found in Appendix A.

Mental Health Professional Educational Programs Offered Within Minnesota[8] (Master's and Doctoral)

	Psychiatric Residency	Psychologist/ doctoral	Psychiatric APRN	Marriage & Family Therapy	Social Worker	LPCC/MH Counselor
Adler Graduate School						●
Argosy University		●		●		
Augsburg College					●	
Bethel University						●
Capella University		●		●		●
College of St. Scholastica			●		●	
Mayo Clinic, Mayo School of Graduate Medical Education	●					
Minnesota State University, Mankato					●	●
Minnesota State University-Moorhead						●
Regions Hospital/ County Medical Center	●					
St. Catherine University					●	
St. Cloud State University				●	●	●
Saint Mary's University of Minnesota		●		●		●
University of Minnesota, Duluth					●	
University of Minnesota, Twin Cities	●	●	●	●	●	
University of St. Thomas		●			●	●
Walden University		●			●	●
Winona State University						●

SOURCE: IPEDS adjusted to include programs which were coded in a different CIP code.

It is worth noting that the table above, and the data analysis provided in Appendix A, does not include bachelors-prepared social workers, who may be licensed as an LSW (licensed social worker). These licensed professionals serve a critical role in the mental health workforce in the State of Minnesota. As of June 30, 2014, there were 5,814 LSWs. While not authorized to engage in "clinical social work practice", LSWs work in a variety of agencies such as schools, hospitals, nursing homes, private non-profit agencies, and county social service agencies. They provide assessment, intervention, case management, client education, counseling, crisis intervention, referral, advocacy, development and administration of social service programs and policies, and community organization. They work with some of the most vulnerable populations and serve a vital role in the social service delivery system and the mental health workforce.

Mental health practitioner and support roles are educated at institutions throughout Minnesota. Many Minnesota State Colleges and Universities, private colleges, and the University of Minnesota offer programs at the certificate, diploma, associate and bachelor degree levels that can lead to careers in mental health such as human services, psychology, registered nurse, mental health behavioral aide II, etc.

In addition, the Minnesota Department of Human Services offers an 80-hour training to become a certified peer specialist as well as the training to become a mental health behavioral aide I.

Special Education: Children and adolescents with mental health needs attend Minnesota's schools making schools important sites for mental health and school personnel to partner in treatment and delivery of services. The Minnesota Department of Education (MDE) has prioritized increasing educator awareness and skills in addressing student mental health needs. Mental health teacher standards are included in each of the special education teaching licenses and MDE has supported school-based initiatives to address student mental health (e.g., mental health grants, Positive Behavior Intervention and Support (PBIS), Children's Therapeutic Services and Support (CTSS)). Special education teachers and related services providers (e.g., social workers, school psychologists) are the school personnel who primarily support students with mental health needs within school settings.

Children and adolescents with mental health needs attend Minnesota's schools making schools important sites for mental health and school personnel to partner in treatment and delivery of services.

Minnesota special education teachers serve children and students from birth through age 21 with a variety of disabilities and abilities. MDE's Educator Licensing Division oversees the licensing of all educators, speech therapists, school psychologists, school social workers, and administrators working in Minnesota public schools.

Candidates most often meet special education teacher licensure standards in teacher education programs in colleges or universities. The Minnesota Board of Teaching (BOT) approves college and university programs to prepare Minnesota teachers. The University of Minnesota Twin Cities and Duluth campuses and the institutions in the Minnesota State Colleges and Universities (MnSCU) System all have BOT-approved special education teacher licensure programs. In addition, seven Minnesota private colleges and universities currently offer BOT-approved programs leading to special education licensure (Augsburg College, Bethel University, Concordia University St. Paul, Hamline University, St. Mary's University, University of St. Thomas, and Walden University). Institutions are continually submitting special education programs to the BOT for approval. Colleges and universities offer licensure programs as part of undergraduate and graduate programs.

Mental health concerns are present in all of the special education categorical areas, although they are most commonly identified in students in the emotional behavior disorders, early childhood special education, other health disabilities, and autism spectrum disorder categories. Many students with mental health needs are served by mental health providers from community and clinical providers in the school setting. There is an increased need for pre-service and ongoing professional development curricula and programs to increase clinician and educator competence, and enhance collaboration skills across mental health and school-based systems to meet complex student needs.

DIVERSITY

Minnesota, like most states, lacks a sufficiently diverse mental health workforce and too few child mental health professionals to meet the demand for services. It is especially important to develop and implement strategies that adequately address these challenges and to monitor progress over time as Minnesota's population becomes more diverse.

Workforce development is critically important to ensure comprehensive mental health services and supports to diverse communities. To be effective, mental health treatment must be sensitive to the culture of the people being served. The need for culturally and linguistically diverse mental healthcare professionals poses two distinct but related challenges: (1) increasing the number of racial and ethnic minority mental healthcare professionals, and (2) ensuring that the mental health workforce is culturally and linguistically competent.

It is critical to acknowledge the changing face of Minnesota and the importance of providing relevant and culturally appropriate services and treatments to the growing ethnic and culturally diverse population. African-Americans, Hmong, and Latinos represent the largest minority groups in the state of Minnesota. There are also growing numbers of other minority groups and immigrant and refugee groups living in Minnesota: Somali, Ethiopians, Karen, etc. The current workforce does not mirror the racial and ethnic diversity of the populations it serves.

The legislative charge includes a clear directive to expand cultural competency and diversity of the mental health workforce.

People experiencing mental health challenges often need treatment and support from mental health professionals who understand and are sensitive to their ethnic and cultural values, customs and practices. The 2007 Annapolis Coalition's report *An Action Plan for Behavioral Health* addressed this issue squarely:

> *The need to improve the cultural diversity of the behavioral health workforce and increase the number of bicultural and bilingual service providers is reflected in the increasing discrepancy between the growth in minority populations and the number of service providers from each of the major communities of color.* [9]

The legislative charge includes a clear directive to expand cultural competency and diversity of the mental health workforce. Data on the diversity of the mental health workforce is often limited. However, for some of the mental health professional categories, the Minnesota Health Department's Office of Rural Health and Primary Care conducts post-license renewal surveys which provides self-reported race and ethnicity data as well as information on work locations, hours, and retirement plans, among other items.

The table below summarizes data from the post-licensure survey showing race and ethnic diversity of the current mental health professional workforce in Minnesota. Unfortunately, no race/ethnicity data has been collected for Minnesota Licensed Psychologists, Licensed Professional Counselors, or Licensed Professional Clinical Counselor. A breakdown by region is available in the full data report in the addendum to Appendix A.

Race and Ethnicity, select professions

	Psychiatrist	Social Worker	Marriage/ Family Therapist	Psychiatric APRN	Percent diversity in MN
Licensees	670	12,125	1578	303	
Number responding to survey	406	6788	853	187	
American Indian	0.3%	0.0%	0.5%	0.5%	1.3%
Asian	6.0%	1.0%	2.0%	0.0%	4.5%
Black	2.3%	2.0%	2.2%	0.5%	5.7%
Other (a)	2.3%	3.0%	3.4%	1.1%	2.3%
Unknown-did not respond to race question	10.3%	4.0%	5.4%	3.7%	
Hispanic/Latino (b)	3.2%	1.0%	1.1%	0.0%	5.0%
Unknown—did not respond to ethnicity question	8.1%	5.0%	7.3%	3.7%	

(a) Includes Native Hawaiian, multiples races, and "Other"
(b) Ethnicity was a separate question from race on this survey

Psychiatrists Source: Minnesota Department of Health, Office of Rural Health and Primary Care Workforce Survey, 2011. The percentages above are based on responses survey respondents with a Minnesota mailing address who responded to the survey.
Social workers Source: Preliminary results from the Office of Rural Health and Primary Care, Minnesota Department of Health; 2012-2013 Workforce Survey.
MFT Source: Office of Rural Health and Primary Care, Minnesota Department of Health; 2012.
APRN Source: Minnesota Department of Health, Office of Rural Health and Primary Care Workforce Survey, 2011. The percentages are based on responses from the survey respondents with a Minnesota mailing address.
Percent diversity in MN is from the U.S. Census, 2013 estimates.

In its publication, *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*, the IOM (2004) reported that racial and ethnic minority healthcare professionals are significantly more likely than their white peers to serve minority and medically underserved communities, which would improve problems of limited minority access to care. This report also cites studies that found that minority patients who have a choice are more likely to select healthcare professionals of their own racial or ethnic background, and that they are generally more satisfied with the care that they receive from minority professionals.[10]

A 2013 *Health Affairs* article on the mental health workforce highlighted the importance of addressing diversity issues:

> *A strong consensus has emerged among federal and state policy makers and educators that there must be equitable access to culturally relevant care and that the entire mental health and addiction workforce must be competent to treat people from diverse cultures. Achieving these goals means that educators and supervisors must help providers develop sensitivity to cultural differences in perceptions about illness, treatment, and recovery, as well as the ability to adapt care to the personal goals, cultural beliefs, and primary language of each client.*[11]

The importance of a culturally competent mental health workforce was underscored in the survey (described further in this report) of more than 500 Minnesota mental health stakeholders. In response to a question about the areas in which mental health professionals and practitioners needed more education and training, 72% of the non-White respondents identified cultural competence as a critical area for education and training compared to 38% of White respondents[12] suggesting that this is an area that may be more apparent to underserved populations than to the current workforce and to the majority population.

CHILDREN

Just as the diversity of the mental health workforce needs focused attention, so does the workforce that provides mental health care and services to children. Shortages of child psychiatrists have plagued psychiatry for decades with relatively little progress toward solution. In 1990, the Council on Graduate Medical Education (COGME) estimated that the nation would need more than 30,000 child and adolescent psychiatrists by the year 2000.[13] A decade later, two reports by the Surgeon General on Mental Health and on Children's Mental Health[14] decried the inadequacies in the child and adolescent psychiatry workforce that limited access to care. Another layer of this problem is the severe mal-distribution of child and adolescent psychiatrists, especially in rural and poor, urban areas.

Shortages of child psychiatrists have plagued psychiatry for decades with relatively little progress toward solution.

The American Association of Child and Adolescent Psychiatry reports that the national average wait time to see a Child and Adolescent Psychiatrist is 7.5 weeks.[15] In Minnesota, the wait for an appointment with a child psychiatrist can be even longer, with some providers reporting a wait time of up to 14 weeks for an appointment with a child psychiatrist.[16] Nationally, Child and Adolescent Psychiatry Fellowship training programs are not being filled for reasons which include staggering medical student debt. [17] At the same time, the mean age of Child and Adolescent Psychiatrists is 53 years, indicating that the shortage may soon grow even worse.[18] Comparable problems of shortages of child and adolescent clinicians exist in the other mental health professions as well.

In the Children's Mental Health Services, Gaps Analysis Survey (2013), counties were asked about their highest priority for service development for the next two years.[19] The counties' primary goals center on workforce issues, noting the lack of child psychiatrists, clinical nurse specialists/advance practice nurses, and mental health professionals.

According to the Annapolis Coalition report, significant gaps exist in the core competencies of the children's mental health workforce. There often is a mismatch between educational preparation and actual service provision and a time lag between the development of evidence-supported interventions and their implementation in the field.[20]

The Georgetown Brief 1, *Transforming the Workforce in Children's Mental Health*, concluded that "the people who do this work need competencies in best community practices, child development, family and youth partnerships, cultural competencies and effective collaborative relationships with many agencies and disciplines."[21] The report highlights that the workforce issues for providers who work with children and adolescents are particularly challenging because:

1. Children and adolescents change constantly as they grow through largely predictable developmental stages;
2. Children and adolescents live in families and a "whole family" approach is needed for services and supports to be effective;
3. Mental health needs of children and adolescents are complex and linked to developmental stages; and
4. Children and adolescents with mental health needs often interact with multiple service systems (e.g., health, education, child welfare, juvenile justice).

Workforce issues in the delivery of services for children, adolescents and their families are particularly critical in Minnesota as provider agencies identify similar issues to those highlighted in the Georgetown Briefs. Some employers stated they would like new graduates coming out of master's level programs to have more early childhood experience or specific training in child development than they currently have. There is an increased focus on training in evidence-based practices but very few, if any, resources to pay for staff to attend these intensive trainings. Agencies need to invest in administrative infrastructures to meet the compliance expectations of many government entities which reduce their budgets in the areas of workforce recruitment, compensation, development and retention. Agencies noted that they are losing seasoned, well-trained providers to private practice, or to systems that pay higher wages.

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COMMUNITY FORUMS

In addition to the data analysis and the particular focus on diversity and children, it was important to gather input from stakeholders throughout Minnesota. To that end, 20 forums were held around the state to elicit input and recommendations from various mental health stakeholders. More than 290 educators, providers, advocates, family members of people with mental illnesses, students in mental health programs, mental health professional association members, licensing boards, special education teachers, state agencies, culturally-specific organizations, law enforcement representatives and others attended these forums.

Community forum meetings were held in the following communities: Bemidji, Brainerd, Duluth, Grand Rapids, Mankato, Northfield, Pine City, Rochester, St. Cloud, Willmar, and Worthington. Three community forums were held in the Twin Cities metro area. In addition, meetings were held with the Minnesota Chapter of the American Psychiatric Nurses Association, Minnesota Chapter of the American Psychiatric Association, Minnesota Coalition of Licensed Social Workers, Healthcare Education-Industry Partnership Council, Minnesota Association of Community Mental Health Programs, Native American Mental Health Advisory Council, and the Minnesota State

Operated Community Services. Each forum and meeting began with an overview of the legislation, the process and timeline being followed, and a brief history of mental health workforce initiatives in Minnesota and across the country. The majority of time, however, was devoted to stakeholder input, comments, and recommendations.

Below are illustrative comments raised at these meetings:

> *After hospitalization, his first psychiatric appointment was 3 months later because of booked schedule and too few psychiatrists in our area.* ~Family member, northwest MN

> *We could probably double the number of mental health case managers in some of our counties and still not have enough; same with psychiatrists, especially ones who work with children and adolescents.* ~Mental health professional, community mental health center, Twin Cities

> *We need more Mental Health Professionals who speak more than one language and who are more culturally competent.* ~Supervisor, corporate foster care, southeastern MN

> *Interns and recent graduates hold jobs working with the highest responsibility/risk, most vulnerable clients. These jobs are the lowest paid and the organizations operate with the least amount of support-supervision...when they need it the most. If they had more support they could provide better care, avoid burnout and give better services back to our communities.* ~Mental health practitioner, community mental health setting, Twin Cities

Concerns about wait times for appointments, the inability to access supervisory hours for licensure (particularly in social work), low reimbursement rates, low wages and the high cost of education, and the difficulty of recruiting professionals in greater Minnesota emerged as common themes in these discussions. Several community leaders acknowledged that there was no fallback plan if their clinic closed or their only psychiatrist left town. A more complete summary of the community forums is provided in the Appendix B.

SURVEY

While community forums and focused meetings allowed hundreds of mental health stakeholders to connect with this planning effort, not everyone who had valuable insights was able to participate. Therefore, an online survey was created and distributed by Steering Committee members to their distribution/contact lists. Via this mechanism, more than 500 Minnesotans completed the survey to make suggestions regarding the recruitment, education, and training and retaining mental health workers. A profile of the respondents finds:

- More than 50% identified themselves as mental health professionals.
- 20% either live with a mental illness or have a family member with a mental illness.
- 40% live in greater Minnesota.
- 10% identified their race/ethnicity as other than White.

This survey yielded valuable insights into the mental health workforce and confirmed many challenges identified by the Steering Committee. Survey results included:

- Throughout the state, psychiatrists were identified as the profession for which it was most difficult to fill job vacancies. In Northeastern and Southwestern Minnesota, all respondents felt it took at least a year to fill a psychiatrist position. In other parts of the state, the perception was slightly better, but still quite problematic.
- Among all respondents, integrated dual diagnosis treatment, trauma, and working in/on teams and across agencies were ranked as the top three areas where mental health professionals and practitioners needed more education and training.
- However, for respondents who identified as non-white, cultural competence was identified as the area of greatest education and training need.
- For respondents who identified as living with mental illness or living with a family member with mental illness, working across teams and family engagement were the two areas with greatest need for education and training.

Workforce recommendations provided by survey respondents ran the gamut—that peer support specialists be used for cultural competence with diverse populations, that medical schools offer more mental health education, that graduate programs are more accessible to people in rural areas, that wages be raised to reflect the responsibility, training and hard work of the mental health workforce. Survey results, including the survey tool, are provided in Appendix C.

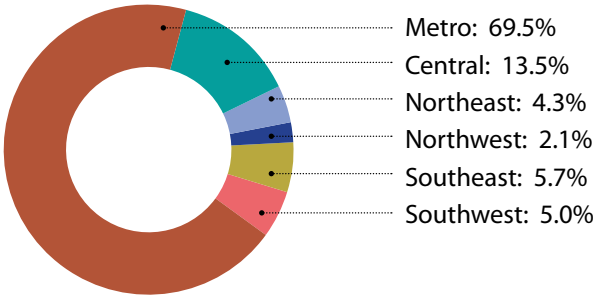
2014 MENTAL HEALTH WORKFORCE SUMMIT

As required by the legislation, a Mental Health Summit was held on May 28, 2014, at Hennepin Technical College. The Summit was attended by 150 stakeholders.

Attendees represented:

- State Agencies
- Governor's Workforce Development Council
- Hospitals
- Insurers/Health Plans
- State Elected Officials
- U.S. Senate staff
- Providers
- Foundations
- Advocacy groups
- People living with mental illness
- Family members of people living with a mental illness
- Private colleges and universities
- University of Minnesota
- Minnesota State Colleges and Universities
- School districts

All regions of Minnesota were represented with approximately 70% from the metro and 30% from greater Minnesota. A detailed breakdown is shown below:



While many of the stakeholders either knew each other or had heard of each other, they had never, collectively, come together to focus on the issue of workforce development. It was noted by many that the presence of the educational institutions was especially valuable.

The day-long summit included an overview of the work done over the course of this initiative, presentations from people who lived with mental illnesses or had a family member with a mental illness, and breakout workshops that focused on particular workforce development issues. The workshops were specifically aimed at generating recommendations for the Steering Committee in the areas of education, recruitment and retention in:

- rural areas,
- among culturally diverse communities,
- in special education,
- with older adults,
- in early childhood,
- with children,
- with adults in acute/residential settings, and
- adults in community settings.

Participants were asked to focus discussion and recommendations in areas other than rate increases, which were acknowledged as a necessity, so that other areas where change is needed could be explored. Facilitated by members of the Steering Committee, the workshops were designed to generate concrete recommendations and action steps required to implement the recommendation. Note takers and flip charts were used to record the workshop results.

More than 140 recommendations were generated at the Summit. Samples of recommendations include:

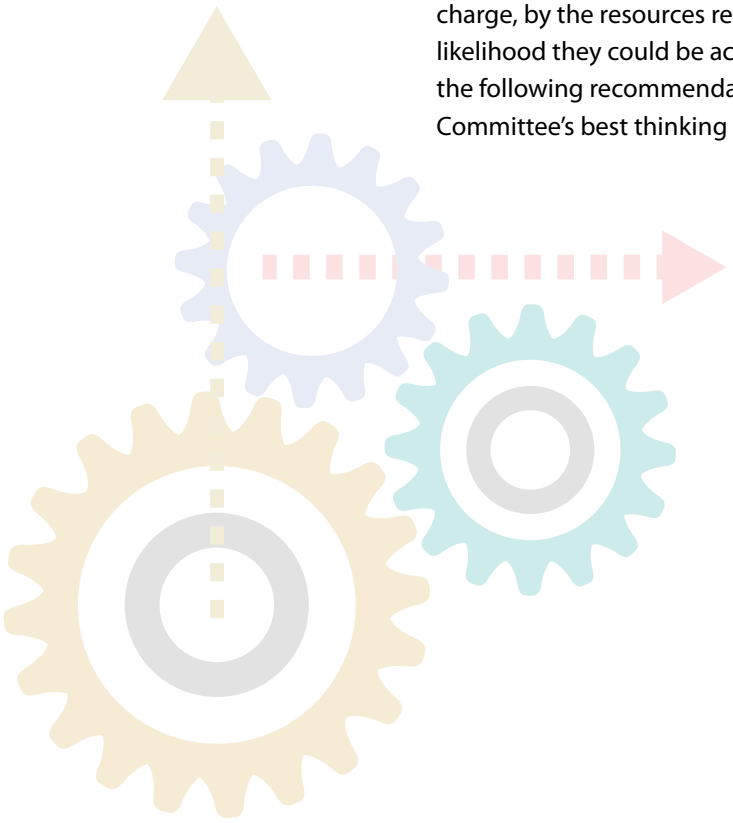
- Develop mental health career promotional campaign that exposes middle and high school students (especially from diverse communities) to mental health careers
- Determine ways that Certified Peer Specialist training can be offered so that it is accessible to the entire state
- Increase funding to Minnesota's Health Professionals Loan Forgiveness program
- Expand access to and affordability of supervisory hours
- Map a career ladder of progressive steps in education, certification and licensure for mental health workers
- Expand psychiatric residencies and psychiatric nurse practitioner programs in Minnesota

The summit agenda and a summary of recommendations are provided in Appendix D.

CALL TO ACTION

From the first meeting of the Steering Committee, the importance of actionable and measurable recommendations was clear. The Steering Committee acknowledged the critical need for increased reimbursement rates to attract and retain a high quality mental health workforce and then turned its attention to areas needing attention, such as recruitment, training and education innovations, and cultural competence.

Recommendations from community forums, survey responses, the Summit's breakout sessions, previous Minnesota mental health task forces, and other states' plans were considered, discussed, and developed. Recommendations were evaluated by the extent to which they addressed one or more of the goals outlined in the legislative charge, by the resources required, by the difference they would make, and by the likelihood they could be achieved. The Steering Committee achieved consensus on the following recommendations. Action steps that are included reflect the Steering Committee's best thinking on how to achieve the recommendation.



MINNESOTA MENTAL HEALTH WORKFORCE RECOMMENDATIONS

RECRUITMENT

RECOMMENDATION 1: Expose middle and high school students to mental health careers, with a particular focus on those schools with diverse student populations.

a. Target funding to School Linked Mental Health grantees that plan to implement an activity or event (such as a career day) related to mental health careers.

This builds on the current DHS School Linked Mental Health grants program that has been in existence since 2008. A total of 36 mental health organizations will be providing school-linked mental health services to approximately 35,000 students in more than 800 schools across 257 school districts and 82 counties by 2018. Adding a component of mental health career introduction in conjunction with providing services is an efficient approach to getting information to this population who might otherwise not know of these careers. Grantees wishing to add this feature will be eligible for an additional funding.

Administered by DHS.
Timeline: 2015-2017
Funding: In existing budget

b. Expand HealthForce Minnesota Scrubs Camps to reach all regions of the state and include mental health career exploration at each camp.

HealthForce Minnesota has co-sponsored Scrubs Camps for high school and middle school students for the past eight years in Winona, Minneapolis and Saint Paul. More than 1000 high school students (at least half of whom are students of color) have attended Scrubs Camps.

During camp, students are exposed to a wide variety of health careers—nurse, radiologist, health information technologist, etc. in a variety of settings—nursing home, hospital, pediatric ward. They visit a simulation lab and deliver a baby. They dissect a pig's heart. They type their own blood. In 2013, mental health professions (psychologist, social worker, peer specialist, etc.) were added to the menu of healthcare careers students discovered.

To date, camp have been offered in Winona (with Winona State University) , Minneapolis (through Augsburg College) and St. Paul (at Saint Paul College). It is recommended to expand the reach of Scrubs Camps to students in all regions of the state and include mental health career exploration as part of the curriculum.

Responsible party: HealthForce Minnesota
Timeline: 2015-16
Funding: $50,000

c. Investigate health career fairs/internships sponsored by other healthcare organizations to determine whether mental health career exploration is being or can be included.

Many organizations hold health career events including the Minnesota Hospital Association, which coordinates summer internships, Roosevelt High School's health magnet program, and others.

Responsible party: HealthForce Minnesota
Timeline: 2015-16

d. Investigate feasibility of running a program like the INPSYDE (Indians in Psychology Doctoral Education) Program Summer Institute, a two-week enrichment program for Native American junior and senior high school students, run by the University of North Dakota. The Summer Institute is designed to help students develop strong academic foundations in psychology and science which are vital to success in college behavioral science and psychology courses. The Summer Institute courses emphasize areas in psychology such as history, assessment, psychotherapy, cross-cultural psychology, research design, and statistics.

Responsible Party: University of Minnesota
Timeline: 2015

e. Create a clearing house of culturally-specific mental health professionals willing to speak to various audiences about mental health careers. Promote this resource and make it available in a variety of formats.

Responsible parties: Minnesota Department of Health, Cultural Providers Network, Mental Health Professionals' Associations (i.e. MN Psychology Assn, etc.)
Timeline: 2015

RECOMMENDATION 2: Authorize funding to support Project Lead the Way's biomedical science curriculum.

Project Lead the Way (PLTW) is the nation's leading provider of K-12 STEM (science, technology, engineering, and math) programs. PLTW's curriculum and teacher professional development model, combined with its network of educators and corporate and community partners, help students develop the skills necessary to succeed in our global economy. As a 501(c) (3) nonprofit organization, PLTW delivers programs to more than 6,500 elementary, middle, and high schools in all 50 states and the District of Columbia.

In 2013-14, more than 50,000 Minnesota students in middle and high schools took PLTW courses. Over 60 new schools expressed interest in PLTW implementation in the 2014-2015 academic year.

This recommendation is for the biomedical science curriculum with the expectation that mental health will be one of the career choices that students would learn about.

Action Steps:
Offer grants to schools that are interested in implementation of PLTW's biomedical science curriculum.

Responsible Party: Department of Education
Funding Request: Cost of $50,000 per school to implement PLTW to 10 schools for a total of $500,000
Timeline: 2015-16 school year.

RECOMMENDATION 3: Improve collection and dissemination of mental health workforce data at all levels.

This report outlined many of the data limitations faced in describing the mental health workforce. Data is critical for benchmarking and measuring progress. While Minnesota has better data than many states, the following steps could improve what is collected for the mental health workforce.

Action Steps:

1. Develop memoranda of understanding/interagency agreements to clearly operationalize the roles and responsibilities of Health Licensing Boards (HLB) and the Minnesota Department of Health Office of Rural Health and Primary Care (MDH ORHPC) as stated in statutes in collecting and analyzing data including data sharing agreements and processes.
2. Develop IT mechanisms to streamline data sharing between HLBs and MDH-ORHPC to increase data accuracy, and reduce inefficiencies.
3. With input from stakeholders (DEED, MDH, HLBs, professional associations, educators), design and launch a dissemination platform such as an online workforce dashboard/data portal to make mental health workforce data accessible and actionable.
4. Healthcare and social assistance organizations, which employ the vast majority of mental health practitioners and professions, shall provide data on employment and wages to the Minnesota Department of Employment and Economic Development for the purpose of developing employment and wage estimates by industry and occupation.

Funding: $75,000

EDUCATION AND TRAINING: Supervision

RECOMMENDATION 4: Ensure access to and affordability of supervisory hours.

DHS will convene the relevant licensing boards and stakeholders to evaluate and develop recommendations in the following areas:

a) A process for cross-discipline certification of supervisors
b) Common supervision certificate in education programs
c) Internship hours counting towards licensure
d) Practicum hours counting toward supervisory experience
e) Creation of a supervision training institute that would provide free supervision training throughout Minnesota
f) Consideration of tax incentives for mental health professionals' preceptorships such as those set up in Georgia.

In order to become a licensed professional, mental health practitioners need between 2,000-6,000 hours (depending on the profession) of supervision by a mental health professional. These hours come at a cost to the employer in terms of productivity loss, the student, in terms of additional cost to pay for the supervision, or both. The result is a bottleneck in the pipeline of mental health professionals.

Through a meeting of the above named stakeholders, it is hoped this bottleneck can be eased without compromising professional standards and care through consideration of the above listed recommendations proposed at the Mental Health Workforce Summit.

Responsible Party: DHS
Timeline: 2015
Funding: $50,000 (0.5 FTE)

RECOMMENDATION 5: 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.

Action steps: Draft legislation directing the above activity.

Responsible Party: Dept. of Commerce
Timeline: 2015

EDUCATION AND TRAINING: Expansion

RECOMMENDATION 6: 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. Specific areas to be addressed include:

a. Expansion of psychiatric nurse practitioner programs
b. Expansion of social work and mental health programs to tribal colleges
c. Determination of the need for new programs and curriculum development
d. Expansion and/or better promotion of existing weekend cohort or online master's programs
e. Evaluate how grant funds for Minnesota higher education institutions could ensure access to mental health master's programs around the state, including rural areas.

Responsible Parties: Private College Council, University of Minnesota, MnSCU, Office of Rural Health and Primary Care
Timeline: 2015

RECOMMENDATION 7: Increase by four the number of psychiatric residency and fellowship slots in Minnesota over the next two years.

There are three psychiatric residency programs in Minnesota: University of Minnesota, Regions Hospital/ Hennepin County Medical Center, and Mayo Clinic. In 2012/2013, the programs had 13, 7, and 9 residents, respectively, for a total of 29. As noted in the Supply and Demand Conditions for Select Mental Health Occupations (included in Appendix A), projected demand for this occupation is expected to grow at nearly twice the statewide average job growth rate in the next ten years. Existing shortages are likely to worsen in the future unless supply increases. The National Center for Health Workforce Analysis identifies psychiatry as one of three medical specialties in which per capita declines are anticipated by 2025. [22]

A physician residency is estimated to cost the organization $150,000/year. A psychiatric residency is approximately two thirds that cost or $100,000/year, which includes salary, fringe benefits, overhead, and administrative costs. Psychiatric residencies are four years. Thus, the cost to increase the number of psychiatric residencies by four would be $400,000 the first year, $800,000 the second year, $1,200,000 the third year, and $1,600,000 the fourth year. The cost would then remain $1,600,000.

Timeline: 2015-2016.
Budget: $400,000 for year 1, $800,000 for year 2, $1,200,000 for year 3, $1,600,000 for year 4. Total of $4 million over four years.
The cost for the additional four residencies would be $1,600,000/year for subsequent years.

RECOMMENDATION 8: Replicate and expand the Diversity Social Work Advancement Program to include additional mental health disciplines (e.g. marriage and family therapists, psychologists, etc.) and practice locations. Create training programs with stipends/ scholarships and pathways to licensure targeted at students from diverse communities.

The Diversity Social Work Advancement Program (DSWAP) has three primary goals: 1) To increase the number of licensed mental health professionals from immigrant, refugee and minority communities serving their own communities. 2) To expand the accessibility of culturally competent, trauma-informed mental health services to members of diverse communities. 3) To train and develop a cadre of supervisors with a deepened understanding of diverse cultures within the community and a greater understanding of the dynamics of cross-cultural supervision.

The pilot DSWAP is operated by The Family Partnership, in collaboration with several partner organizations and the MSW programs at Augsburg College, St. Catherine University and the University of St. Thomas, and the University of Minnesota – Twin Cities. It has been funded by a grant from the Minnesota Department of Human Services Adult Mental Health Division since 2010.

Recommended action steps based on the current DSWAP pilot include:

1. DHS initiate a Request for Proposals for agencies and collaborators to host mental health professional trainees in their capstone field placements, while replicating the essential DSWAP components.
   - Field placement/practicum dedicated to providing services to members of immigrant, refugee or minority communities. Students in placement receive a stipend.
   - Graduate level curriculum on trauma, immigrant, minority and refugee issues, and supervision (provided by the trainee's educational institution).
   - Additional training in trauma-informed care, from providers identified in goal #2.
2. DHS initiate a Request for Proposals for educators/trainers to provide training in trauma-informed models designed specifically for immigrant and refugee communities. The selected trainer(s) will partner with agencies/students selected for Action step 1.
3. DHS initiate a Request for Proposals to provide training in in cross-cultural supervision. The selected trainer(s) partner with agencies/students selected for Action step 1.
4. That DHS initiate a Request for Proposals for agencies and collaborators to provide the following professional development support, in collaboration with the agencies/students selected for:
   - Licensure exam training, specifically targeted to minority, immigrant and refugee trainees
   - Monthly post-graduate supervision groups at no charge to trainee, while on pathway to Mental Health Professional licensure

Goal: At the end of three years, up to 60 trainees from diverse races and ethnicities, immigrants and refugees, would have achieved or be on the pathway to Mental Health Professional licensure.

Administered by: Department of Human Services
Timeline: 2015-2018, with extension for successful programs
Funding: $500,000 year to fund 2-4 settings training 20 students total, with funding renewed for at least 3 years = $1.5 million. ($500,000/year x 3 years)

RECOMMENDATION 9: Expand capacity to train Certified Peer Specialists and Family Peer Specialists throughout the state with a particular emphasis on recruitment from communities of color.

Peer specialists are an emerging profession in mental health care. Minnesota has certified 295 individuals as peer specialists since its first class was held in 2009. As the important role that peer specialists can play in recovery is recognized by providers, it is estimated that as many as 1200 could be employed within the next 6 years. The challenge will be to make sure that all persons throughout the state can avail themselves of this training with a particular emphasis on diverse and underserved communities.

In 2007, the Minnesota Legislature directed DHS to establish the Medicaid-covered Certified Peer Specialist role. The Center for Medicare and Medicaid Services (CMS) recognizes peer support providers as a distinct provider type for the delivery of support services and considers it an evidence-based mental health model of care. The Certified Peer Specialist does not replace other mental health professionals, but rather is a complement to an array of mental health support services. Peer specialists have a lived experience with a mental illness and have taken the state's 80-hour certification program, which is offered over a two-week period. The training thus far has been paid for with State and Federal Block grant dollars. The program was developed by Recovery Innovations of Phoenix, AZ and used in a number of states.

The Certified Family Peer Specialist was established in 2013 and offers similar peer support to families with children with a mental illness. This program has not yet started.

MnSCU can be a valuable partner in the effort to train this workforce both by providing a venue for the training throughout the state as well as offering additional components to the training, such as motivational interviewing and documentation. By offering college credit for becoming a peer or family peer specialist, a career ladder is created to other types of mental health practitioner roles.

Just 2% of the current certified peer specialist workforce is non-White. Recruitment efforts to communities of color should be enhanced through development of relationships with providers and organizations such as the Community Health Worker Alliance. In Minnesota and around the US, the community health worker (CHW) role is gaining recognition for its contributions to the Triple Aim and health equity. As trusted and knowledgeable members of the communities they serve, CHWs apply their unique understanding and training to a variety of roles including outreach, patient education, care coordination, advocacy and information and referral. As reported by the National Council of Behavioral Health, there are opportunities for CHWs to address the mental health and related needs of underserved populations in culturally-responsive ways as members of teams in mental health, primary care and integrated health settings.

Action Steps:

1. Determine which classes currently offered through MnSCU could lead to certification for adult peer specialists and family peer specialists.
2. Determine what class(es) must be developed to meet this goal and how to integrate key components from Recovery Innovations.
3. Assess how ready mental health providers are to hire peers and what steps can be taken to increase the number of peers that are hired.

Responsible Parties: Department of Human Services, Department of Health, HealthForce Minnesota
Timeline: 2015-16
Funding: Not at this point

RECOMMENDATION 10: Support efforts to expand and broaden mental health telemedicine, including using the technology in training programs, grants and funding to expand telemedicine capacity throughout the state. Commercial health plans should be required to cover services delivered via tele-health technology.

Telemedicine has repeatedly been looked to as one part of the solution to making specialists available to a wider segment and to help close the workforce gap. This is particularly true in rural Minnesota where mental health professional shortages are most severe

Responsible Party: Minnesota Legislature, Office of Rural Health and Primary Care

RECOMMENDATION 11: Improve and expand cultural competency (awareness) training. Establish cultural competence (awareness) as a core behavioral health education and training requirement for all licensure/certification disciplines. All RFPs, accreditation requirements, supervision, education, and training must have evidence of components of cultural competence components.

Racial and cultural minorities are a growing demographic, and reside in every county in Minnesota. There are no generally agreed upon standards for culturally competent training or services. The primary cultural groups are Caucasian, Native American, GLBT, Southeast Asian, Latino, African and African American. Traditional behavioral health training has not adequately prepared practitioners for effective work with minorities. Achieving cultural competence is not inexpensive. Some estimates place costs at ten-percent of training, education and supervision funds to achieve levels of cultural competence needed by the mental health workforce.

Action Steps:

1. Integrate evidenced-based cultural competence curriculum into all education, training, and supervision.
2. Provide resources and incentivize training sites to incorporate cultural competency training in their curricula, to ensure all practitioners-in-training have knowledge, understanding, assessment, treatment planning, and counseling skills with minority cultural groups in the communities.

3. Establish a statewide behavioral health cultural competence taskforce and network of resources (American Psychological Assn. model).
4. Engage consumers of color and their families in workforce development, training, and advocacy.
5. Review nationally developed standards and best practices and use them to develop a training package for provider organizations to analyze their cultural competency and to develop a work plan to increase their cultural competence.
6. Assess all mental health education and training programs in the state as to their cultural competence training to develop benchmarks. Ensure that government and private providers of mental health services perform a cultural self-assessment, adopt cultural competence standards, embrace diversity, and adapt their services to address the needs of diverse populations.

Goal: Within three years all new mental health professionals will demonstrate proficiency in culturally-competent behavioral health services.

Responsible Parties: DHS, Public and private colleges and universities, mental health professional associations, mental health providers
Timeline: Starting in 2015 and on-going.
Budget: $100,000 to initiate action steps.

RECOMMENDATION 12: Develop a faculty fellowship model to engage faculty in the newest understanding and treatment of mental illness in children, youth, adults and older adults.

The purpose of this recommendation is to increase the quality of the mental health workforce by introducing students early to the latest research influencing advancements in the diagnosis and treatment of mental illnesses.

The mental health workforce is as good as the training students receive during their graduate education and their ongoing field training and experience. In order to impact the workforce in a profound, long lasting way that truly creates reform in the field, it is imperative that student education and training is comprehensively targeted and given high priority on the state's workforce development agenda.

Fellowship models exist within universities and colleges around the country, particularly in Schools of Social Work. The focus might be on pairing a faculty with a student or pairing an early career faculty with a credible research focused faculty. Features of either model include: a small stipend to early career faculty selected through an application process; a time limited commitment requiring early career faculty to dedicate a portion of their time to attend monthly topical seminars, forums, brown bags etc. where new developments in the field are discussed, a mentoring or matching requirement. A variation of the above occurred in North Carolina where a consensus panel on disruptive behavior models was established to encourage thinking in mental health about (i) enhancing skills in the workforce needed to be in place to do the work and (ii) addressing the overlap with parent training/behavior modification and treatment issues.

Action Steps: Convene table of stakeholders including DHS, MnSCU, public and private colleges and universities, and providers to: (i) identify successful models, (ii) select a model for MN, (iii) identify associated costs, (iv) recommend a funding mechanism.

Responsible Party: HealthForce Minnesota
Budget: $150,000
Timeline: 2015

RECOMMENDATION 13: Charge the Department of Human Services with establishing criteria and a payment mechanism to incentivize mental health settings committed to providing students with a practicum experience that features evidence-based treatment interventions.

The Importance of Using Evidence-Based Practices and Interventions

Evidence-based practices (EBP) describe core intervention components that have been shown through rigorous research in the form of randomized control trials to produce desirable outcomes. EBPs have common elements including: a clear philosophy, specific treatment components, treatment decision making, structured service delivery components, and continuous improvement components.[23] *According to the MN Department of Human Services (DHS) website, DHS is committed to the use of "comprehensive diagnostic assessments and evidence-based treatments that consider children's characteristics, circumstances and culture" with the goal of creating consistent quality in services, and reducing healthcare disparities among children.*

The Importance of Training on Evidence-Based Practices Early in a Clinician's Career

Over the past three decades, effective psychosocial programs (EBPs) have been developed, and with them, the field of prevention and intervention research in children's mental health. However, the adoption rate of EBPs and prevention programs into community settings serving families is very low – about 1%. That is, the vast majority of practice in children's mental health (in settings including clinics, child welfare, education, and juvenile justice) is still not evidence-based. Through a survey conducted by the University of MN's Ambit Network, it was discovered that fewer than 3% of the over 20,000 licensed clinicians in Minnesota are trained in delivering EBPs (DHS and Ambit Network Data, 2014). Clinicians are using methods learned in their academic training and have not been updated on the most effective, research based, treatment methods.

Benefits:

- *Children, youth, and their families are given the tools, and receive the support they need, to remain and succeed in school and acquire the social-emotional development that leads to healthy, well-adjusted children, adolescents, and young adults and resulting in reduced costs.*
- *Outstanding, leading-edge training and education opportunities are available for students early in their career.*

Responsible Party: Department of Human Services
Timeline: 2015-16
Funding: $500,000 to fund grants of up to $10,000 per agency plus $100,000 for staff. Maximum of four trainees/therapist with amount of grant pro-rated if under four. Trainees on site for practicums of at least six continuous months and agreement in place with trainees' educational program that this placement satisfies program requirements.

RECOMMENDATION 14: Increase exposure to psychiatric/mental health experiences for nursing and medical school students and through increased continuing education offerings for licensed nurses and physicians.

Because people with mental illnesses present in all healthcare settings, not just psychiatric units or offices, nursing and medical students as well as already licensed nurses and physicians should have additional opportunities for exposure to treating patients with mental illnesses.

Action steps:

1. Consider an incentive similar to the Georgia preceptor tax credit to retain and attract primary care preceptors for medical, advanced or practice nursing and physician assistant students.
2. Convene group of nursing and medical training programs, continuing education, mental health providers, and consumers to review current mental health training and continuing education requirements.
3. Provide incentives to nursing and medical training programs to increase mental health educational opportunities if a shortage is identified.
4. Increase the number of continuing education programs in mental health if a shortage is identified.
5. Create continuing education programs in mental health and promote them.
6. Offer incentives for providers to arrange mental health clinical educational opportunities for students and licensed providers.

Timeline: 2015-16
Responsible Party: Minnesota Department of Health, Private College Council

RECOMMENDATION 15: Utilize Accreditation Council for Graduate Medical Education (ACGME) and American Psychological Association (APA) standards for psychiatry residency and accredited psychology internship programs, thus expanding access and program funding.

Responsible Party: DHS
Timeline: Include in review of rule 47.

RECOMMENDATION 16: Provide support so that all psychology internships at state institutions are accredited by the APA.

The standard for doctoral training of psychologists is completion of a doctoral program and internship accredited by the American Psychological Association (APA) Commission on Accreditation (CoA). Currently there are 12 APA-accredited internship programs in Minnesota. There is one accredited internship sponsored by the State of Minnesota at the State Operated Forensic Services in St. Peter and there are two at the University of Minnesota, though only the one at the University Counseling and Consultation Services receive state funding (the one at the Medical School does not). Currently there are two other internships in State of Minnesota facilities that are not accredited: (1) The Department of Corrections (DOC) in Stillwater and (2) the Minnesota Sex Offender Program in Moose Lake. Those programs should become and continue to be accredited. All internships sponsored by the federal government (e.g., Veterans Affairs Medical Centers) are required to be accredited.

Goal: APA Accreditation of the Department of Corrections/Stillwater and Moose Lake internships by 2018.

Action steps:

1. Commissioners of DHS and DOC to direct site administrators and internship staff to pursue accreditation for psychology doctoral internships.
2. Provide appropriation to provide administrative support, staffing, and consultation to these two programs to prepare them for accreditation.
3. Direct programs to develop plan for sustaining accreditation once it is achieved, including budgeting for annual accreditation fees.

Responsible Parties: Minnesota Legislature, Department of Human Services, Department of Corrections
Administered by: Department of Human Services, Department of Corrections (DOC)
Timeline: 2015-2017
Funding: Unknown at this time, up to $50,000.

RECOMMENDATION 17: Minnesota Department of Health will evaluate Medical Education and Research Costs (MERC) funding to identify changes needed to support mental health workforce development and will add Licensed Marriage and Family Therapist and Licensed Professional Clinical Counselors professions to the program.

RECOMMENDATION 18: Promote a team-based healthcare delivery model for mental health treatment.

ENCOURAGE JOB SEEKING IN HIGH NEED AREAS

RECOMMENDATION 19: Add mental health professionals to the eligibility requirements for the Minnesota Health Professionals Loan Forgiveness program and increase funding by $750,000 a year; add requirement that 50% of this additional funding be made to mental health professionals from diverse ethnic and/or cultural backgrounds.

Currently the only mental health professionals eligible for this program, which provides loan repayment in exchange for service in a rural or underserved urban area, are psychiatrists who agree to work in rural and underserved urban areas and advanced practice nurses who agree to work in rural areas. This recommendation would open eligibility to other mental health professionals, to include psychologists, marriage and family therapists, licensed social workers and licensed professional clinical counselors. Expanding eligibility must be tied to the expansion of funding as outlined below. Without additional funding, the recommendation's goal will not be met.

This proposal also recommends that an additional $750,000 per year over the next two years (for a total of $1.5 million) be added to the program, to fund an additional 25 mental health professionals. One-half of those additionally funded, should represent diverse populations.

Goal: Additional 25 mental health professionals working in areas underserved for mental health services areas in Minnesota, one-half from diverse communities.

Action steps:

1. Funding Appropriation
2. Language change of statute (M.S. 144.1501) to include mental health professionals as eligible
3. Define diverse communities and define areas underserved for mental health services.

Administered by: Office of Rural Health & Primary Care
Timeline: 2015-2017
Responsible Parties: Minnesota Legislature
Funding: $750,000/year x 2 years =$ 1.5 Million

RECOMMENDATION 20: Continue funding of the Foreign Trained Health Care Professionals Grant Program.

This program, administered by DEED, helps foreign-trained healthcare professionals obtain their licensure in Minnesota. In addition to covering physicians, nurses, dentists, and pharmacists, it also covers mental health professionals and is a critical component to addressing the need for diversity among the mental health workforce. When awarding grants, the commissioner must consider the following factors:

(1) whether the recipient's training involves a specialty that is in high demand in one or more communities in the state;

(2) whether the recipient commits to practicing in a designated rural area or an underserved urban community, as defined in Minnesota Statutes, section 144.1501;

(3) whether the recipient's language skills provide an opportunity for needed health care access for underserved Minnesotans.

RETENTION

RECOMMENDATION 21: Identify gaps in the educational, certification, or licensing systems that impede career movement from entry-level, paraprofessional positions to terminal degrees and licensure as an independent professional. Identify the special challenges of and barriers to incorporating persons in recovery and persons of diverse cultural backgrounds into traditional career ladders. Develop strategies, curricula, certifications to support these pathways.

Goal: Creation of clear ladders in mental health from certificates to associate, baccalaureate, and masters' degree programs in the state.

Action steps:

1. Convene table of stakeholders including DHS, MnSCU, public and private colleges and universities, and providers to identify needed competencies of entry level and paraprofessional mental health workers.
2. Identify gaps that impede career movement and develop strategies to bridge those gaps, with particular focus on persons in recovery and persons from diverse backgrounds.
3. Create additional certifications to ensure that each major educational advancement is accompanied by an associated reward or recognition of that advancement.
4. Develop curricula and other mechanisms specifically designed to support people in recovery and people of diverse cultural backgrounds in achieving success.

Responsible Party: HealthForce Minnesota
Timeline: 2015-2016
Funding: $50,000

RECOMMENDATION 22: Examine ways technology can be used to streamline paperwork and ensure necessary data capture.

Mental health workers raised concerns at community forums about the amount of time spent on paperwork, how much of the paperwork seemed duplicative, and how that work meant they did not as much time with their clients as they felt would benefit their recovery. This is a concern found among healthcare workers at all levels and in all venues where health care is currently delivered and likely has multiple causes.

Documentation of care is critical, in part to implement evidence-based practices, and education and training programs should ensure their students understand this as part of their job and the rationale behind it. However, duplication of paperwork is a frustration for both patients as well as the workforce and should be eliminated at all levels. Technology has advanced enough to eliminate this.

Action Steps: DHS will offer small incentives to providers to pilot "best practices" in reduction of duplicative paperwork. These practices will then be promoted throughout the state.

Timeline: 2015-2017
Administered by: DHS
Funding: Appropriation from general fund.

RECOMMENDATION 23: Increase reimbursement rates.

The stigma and discrimination facing people with mental illness is reflected in the value placed on the work of the mental health workforce. Their wages and salaries do not adequately compensate for the responsibility of their jobs or the education and training required. ***Recruitment and retention will continue to be an issue, especially in greater Minnesota, until adequate resources are made available to fund needed services.*** *The following suggestions begin to address the need to increase funding to the system.*

1. *Extend 23.7% increase to mental health providers beyond Community Mental Health Centers.*
2. *Implement a disproportionate-share type payment to mental health providers who serve high percentages of people on Medicaid.*
3. *Reduce Master's level automatic cutback in pay of 20%.*
4. *Ensure reimbursement rates are no lower than Medicare reimbursement rates.*
5. *Make Prepaid Medical Assistance Program (PMAP) reimbursement data publicly available; audit PMAP payments to ensure rates are correctly paid, and ensure current fee schedules are implemented immediately.*

ASSESSMENT

RECOMMENDATION 24: Assess the recommendations made in the mental health workforce state plan by July 2017, to determine progress being made on implementation and evaluate outcomes of the above recommendations.

Responsible Party: Healthforce Minnesota
Timeline: 2017

ENDNOTES

1 The Steering Committee recognizes that there are significant workforce needs within these areas and that there are overlaps and co-occurring conditions. Adding the workforce issues from those communities would require the involvement of many additional individuals and would greatly broaden the scope of an already large task. It is hoped that those communities can use this report to inform their respective workforce development plans.

2 See MN Dept. Human Services webpage for statute definition of mental health workers: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058037

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8 Some programs listed are online only. Not all enrolled students are in Minnesota or plan to work in Minnesota upon program completion.

9 Annapolis Coalition, *op. cit.*

10 Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, 2004.

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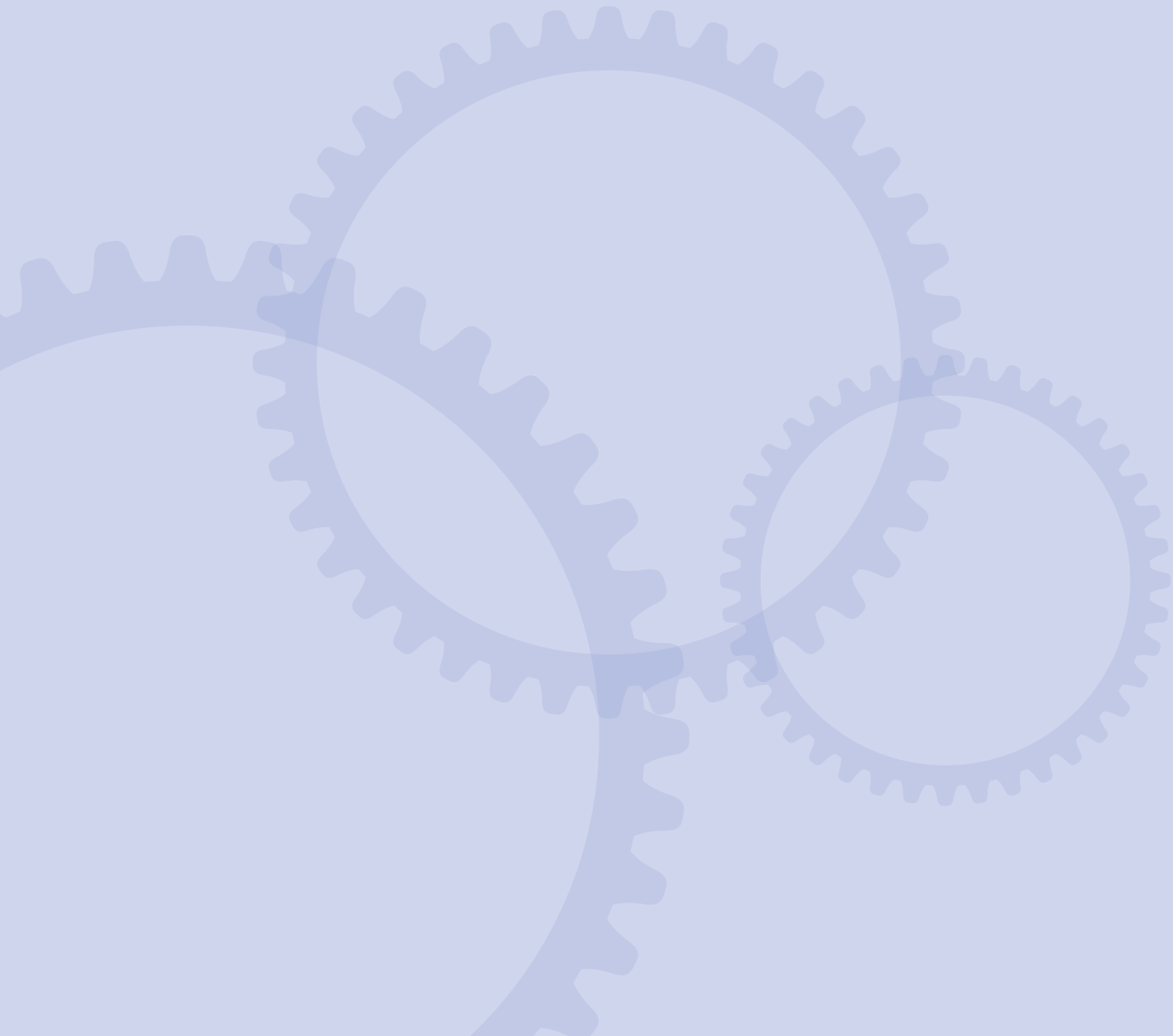
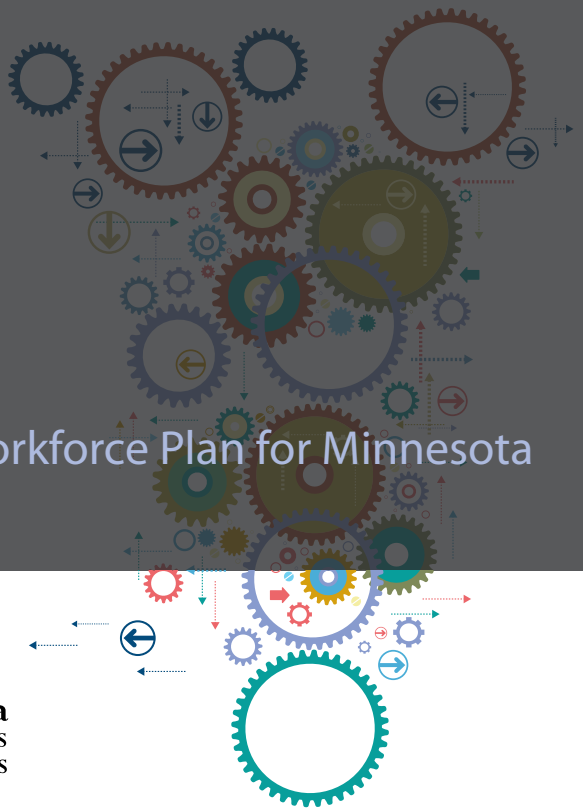


Gearing Up for Action: Mental Health Workforce Plan for Minnesota



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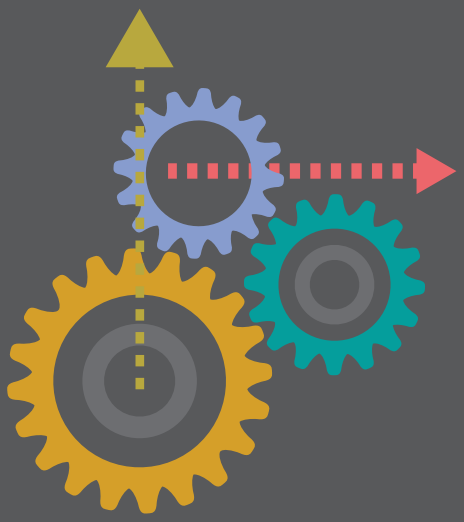

APPENDICES

Appendix A: Supply and Demand Conditions for Select Mental Health Occupations Addendum

Appendix B: Mental Health Workforce Community Forums

Appendix C: 2014 Mental Health Workforce Survey Results

Appendix D: Mental Health Workforce Summit Agenda
Mental Health Workforce Summit Recommendations

APPENDICES CAN ALSO BE FOUND AT www.healthforceminnesota.org

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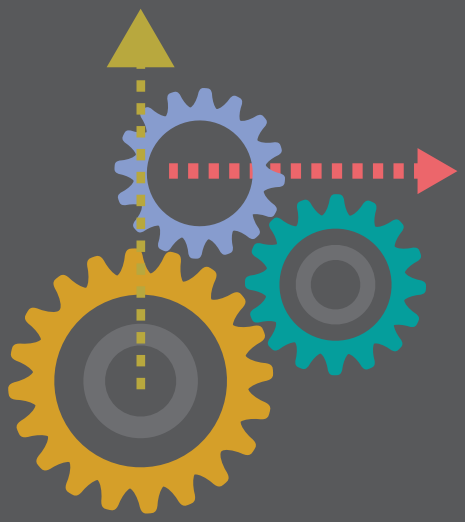
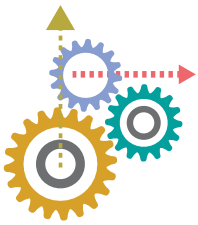


Appendix A:
Supply and Demand Conditions for Select Mental Health Occupations

Data Addendums



Appendix A:
Supply and Demand Conditions for Select Mental Health Occupations

in Minnesota's Economic Planning Areas

March 2014

Prepared by:

Minnesota State Colleges and Universities
Systems Office

Minnesota
STATE COLLEGES
& UNIVERSITIES

In collaboration with:

HealthForce Minnesota
Minnesota Department of Health
Minnesota Department of Employment and Economic Development

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Background & Purpose

During the last 15 years, there have been important ongoing policy discussions and initiatives focused on improving Minnesota's mental health care system. Though the discussions have been nuanced, focusing on different aspects of the system, there is broad agreement that the system is not adequately equipped to meet the growing need for mental health services in Minnesota. An important factor is the shortage of workers. In 2013, the Minnesota legislature passed legislation (SF 1236) to improve the mental health workforce. The legislation mandates that:

> *The Minnesota State Colleges and Universities (MNSCU) will convene a summit involving 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 will be:*
>
> - *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.*

As the result of this legislation, in November 2013, MNSCU and HealthForce Minnesota convened a steering committee to organize the mental health workforce summit and prepare the workforce plan.

This report supports the work of the steering committee. Its purpose is twofold:

(1) Document the current levels of supply and demand for core mental health occupations.

(2) Propose specific, further areas of inquiry for the mental health workforce steering committee.

This report encourages the steering committee to consider not just the shortages of mental health *services* in Minnesota, but whether and how those are related to *shortages of workers*.

In very general terms, there are two possible reasons for the lack of adequate numbers of mental health workers. The first involves *workforce supply* and factors affecting it. Supply-side factors include: (a) not enough people interested in entering the mental health fields; (b) not enough training available; (c) training that is inadequate to meet the needs of employers and/or communities; and (d) training not being offered in locations where there is a need for more mental health workers.

The second consideration for an inadequate workforce involves *demand-side issues* and the factors that affect it. For example, inadequate public or third party funding for mental health services may constrain hiring in those fields, or aspects of the jobs are unattractive to prospective candidates (e.g., wages or benefits are not competitive in some sectors or regions). Inadequate geographic concentration of consumers such that there is not an adequate number to financially support professionals is a related demand-side consideration. Supply and demand factors are not necessarily independent of one another in practice.

This report can only provide partial insight into supply- and demand-side factors. Its goal is to document, in broad terms, what the quantitative data show about the balance of supply of, and demand for, mental health workers in Minnesota. Where possible, it also highlights critical questions that are left *unanswered* by existing data. This can help guide further inquiry or data collection efforts that can occur during the spring 2014 community forums and beyond.

This report includes occupations that have been identified by the Health Resources and Services Administration (HRSA) as "core" mental health occupations. In some cases, the occupations for which data are collected do not match one-to-one with HRSA occupational classifications. In those cases, the steering committee selected the nearest match:

- Psychiatrists
- Clinical, Counseling, & School Psychologists
- Social Workers
    - Mental Health & Substance Abuse Social Workers
    - Child, Family, & School Social Workers
    - Healthcare Social Workers
    - Social Workers, All Other
- Marriage & Family Therapists
- Mental Health Counselors
- Advanced Practice Psychiatric Nurse Practitioners

Data Sources and Limitations

The data in this report come from several reliable sources. Data on the supply of mental health workers comes from three main sources. First, the licensing boards for various professions have provided counts of licensees and basic demographic information. Second, the Minnesota Department of Health, Office of Rural and Primary Care, conducts workforce surveys on a number of these professions, affording richer insights on the employment patterns of some licensed mental health workers. Finally, the Integrated Postsecondary Education Data System (IPEDS) includes counts of completers of educational programs based on a standard set of program categories.

Data on the demand for mental health workers come from the Minnesota Department of Employment and Economic Development (DEED), which relies on standard occupational categories to quantify and measure labor market conditions.

Together, these data sets provide the most comprehensive and statistically reliable sources of supply and demand information currently available for Minnesota. However, the data sources also present some challenges for our purposes.

Challenge #1: Standard occupational classifications do not always correspond to the practitioner/professional divide in the mental health field.

One key constraint is that the standard occupational classifications for which data are available include both licensed and non-licensed workers. For example, there is no standard occupational classification for Licensed Professional Clinical Counselor, an occupation the steering committee identified as important. Rather, this job title is subsumed in the broader classification "Mental Health Counselor." Not all Mental Health Counselors are LPCCs, although all LPCCs are coded as Mental Health Counselors. Similarly, there are some workers who provide social work services in Minnesota who are coded as "Social Workers" but do not have a license. The result is that, while these data give us important insights into the supply and demand for workers who are providing mental health services generally, they cannot identify shortages among licensed professionals as precisely as might be desired.

Challenge #2: No residency data available

A second limitation is that IPEDS does not collect data on residency programs—the only clear source of information on the supply of new psychiatrists. Data from the three psychiatric residency programs in Minnesota were obtained to overcome this limitation.

Challenge #3: Small sample sizes

Although we are interested in studying supply and demand patterns by region in Minnesota, the small sample sizes in some regions preclude analysis. When occupations employ a relatively small number of workers, the data become too "thin" and/or identifiable and are, therefore, not released. These cases are indicated by an "N/A" in the data tables.

Small sample sizes also limit our ability to gauge changes in demand over time. Because small sample sizes result in greater sampling error and greater variability in estimates, it is difficult to discern true changes from "noise" in the estimates. The estimates of wage offers, for example, vary widely across time points. These estimates may not be terribly useful in providing support for the evidence of shortages, but even though they fail to confirm clear trends, they can generate hypotheses regarding actual trends.

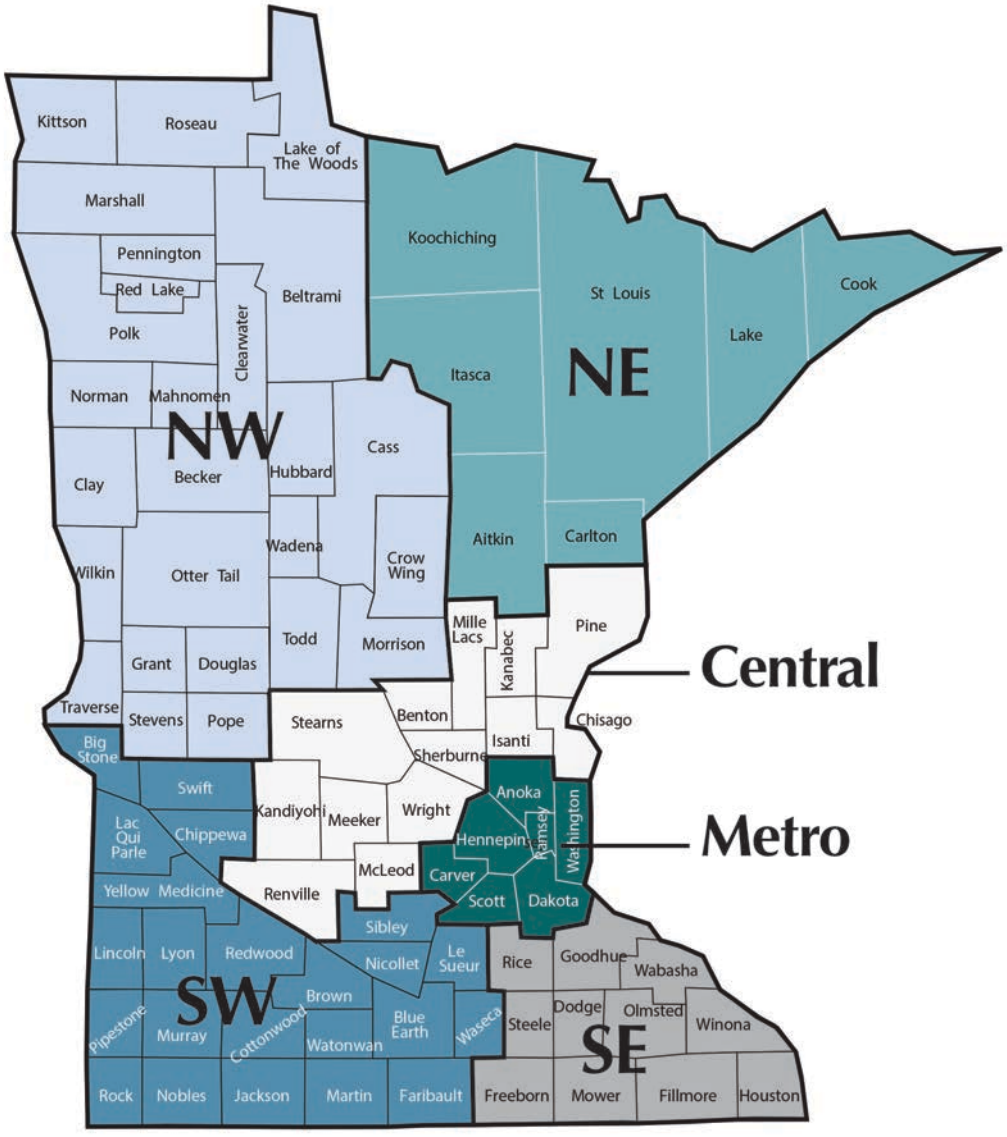
Challenge #4: Education program codes cross major categories making identification of programs difficult

This challenge is most evident in identifying psychology and mental health counseling programs. Classification of Instruction Programs (CIP) codes for applicable programs have been coded into 13-Education, 42-Psychology, and 51-Health Professions and Related Programs. As noted in Challenge #1, completers in any individual education program may not be entering the mental health workforce which can result in an overstatement of supply.

Minnesota Regions

This report provides data about mental health care labor market conditions in six regions: northeast, northwest, central, Twin Cities, southeast and southwest Minnesota. These are the economic planning regions defined by the Minnesota Department of Employment and Economic Development (DEED). For reference, the regions are presented below.

Minnesota's Economic Planning Regions



Summary of Findings

Psychiatrists

Demographics

- Minnesota psychiatrists are generally older than the workforce at large: nearly half are 55 years of age or older, compared to 21 percent of the whole workforce nationally. More than half, 55 percent, of psychiatrists plan to continue practicing for more than ten years.

- The majority of psychiatrists are male (65 percent), and white (89 percent).

Workforce Supply

- Licensing: There are 497 licensed psychiatrists with Minnesota mailing addresses, and another 161 Minnesota licensees with non-Minnesota mailing addresses.

- Education: There are three psychiatric residency programs in Minnesota: University of Minnesota, Regions Hospital/Hennepin County Medical Center, and Mayo Clinic. In 2012/2013, the programs had 13, 7, and 9 residents, respectively, for a total of 29.

Workforce Demand

- Employment. Psychiatry has a limited workforce in Minnesota. Licensing and employment estimates differ somewhat, but considering both sets of estimates, it is likely that 500 or fewer psychiatrists are practicing statewide. Across regions, employment estimates vary from 20 in Southwest Minnesota to 160 in the Twin Cities metro. (The number of practicing psychiatrists is too small to even be published in Northeast Minnesota.) Just over half of all psychiatrists are employed in physicians' offices and hospitals, and another 17.6 percent are employed in general medical and surgical hospitals.

- Current Demand. Because it has a relatively small workforce, the indicators of current demand (job vacancy rates and occupations-in-demand [OID] indicator) are unpublishable in many sub-state regions within Minnesota. However, at the statewide level, the data suggests that current hiring demand for psychiatrists is very high. The job vacancy rate for psychiatrists is 18.2 percent, compared to 2.8 percent across all occupations. The OID indicator is 4 out of 5, also indicating high current demand. On the other hand, wage estimates over time are not consistent with a picture of worker shortages. Economists argue that shortages often result in upward pressure on wages, but there is no evidence that psychiatrists' wages have risen over the last ten years.[1]

- Future Demand. Overall, Minnesota's economy is projected to increase by 13 percent between 2010 and 2020. The growth rate for psychiatrists is nearly twice that at 25.4 percent. There is

[1] Wage offers for psychiatrists have fluctuated widely over the last ten years, likely due to a high level of sampling error in the Job Vacancy Survey estimates. However, if there was pressure to increase wages to attract psychiatrists to openings, we would likely see some evidence of this in the findings.

also very high projected employment growth in Central, Northeast, Northwest, and the Twin Cities metro regions (growth rates are not publishable for the two southern regions in the state).

Avenues for Further Inquiry

- The high job vacancy rate for psychiatrists in Minnesota suggests that employers may struggle to find and hire psychiatrists, supporting the view of inadequate training levels. Additional work could be done to pinpoint and document the extent to which unfilled vacancies are a function of supply- and demand-side conditions. For example, additional survey research or conversations with employers could explore: how long do psychiatry vacancies remain open? To what extent are unfilled vacancies a reflection of inadequate recruitment efforts, or lack of qualified candidates? If there is a lack of qualified candidates, are shortages more severe across regions or specialties? Are salaries and remuneration rates for psychiatrists in Minnesota commensurate with rates across the country? Finally, what options do employers have to meet the demand for psychiatric services if psychiatrists with accredited training are not available in their area?

- Since projected demand for this occupation is projected to grow at nearly twice the statewide average job growth rate in the next ten years, any existing shortages are likely to worsen in the future unless supply increases. Therefore, the mental health steering committee would do well to consider how best to grapple with these potential shortages in the longer-term.

- The nature of psychiatrists' work patterns also affects the ability of the workforce to meet patient needs. A comprehensive analysis of psychiatrists' work in terms of the number of patients they see per day, the types of patients they see, the percent of their time devoted to clinical care, and related factors would provide additional insights by which to gauge the capability of the existing workforce to meet the demand for their services.

Clinical, Counseling, and School Psychologists

Demographics

- There is no comprehensive data available delineating the demographics of licensed psychologists in the state of Minnesota.

Workforce Supply

- Licensing: According to the Minnesota Board of Psychology, there are 2,145 doctoral level licensed psychologists and 1,626 licensed master's psychologists[2] in Minnesota, for a total of 3,771 licensed psychologists. In addition, there are currently 1,123 school psychologists and 63 with limited licenses regulated through the Minnesota Department of Education.

- Education: In the 2012 school year, Minnesota schools produced 555 master's and 156 doctoral-level psychology graduates in a range of specialties. There are doctoral psychology

[2] Minnesota no longer licenses psychologists at the master's level other than those grand-parented under earlier versions of the Psychology Practice Act.

programs at the Minneapolis School of Professional Psychology-Argosy, the University of Minnesota, the University of St. Thomas, as well as non-traditional doctoral programs at Capella University and Walden University. Border states may also add to Minnesota's supply of psychologists: Iowa produced 250, North Dakota 40, and South Dakota 62. Considering that the total projected openings for psychologists from 2010 through 2020 is 1,900 statewide (or 190 annually, assuming even growth over the decade), these data indicate that Minnesota has the capacity to meet that demand.

Workforce Demand

- Employment. This occupational category includes clinical, counseling, and school psychologists. This is a medium-sized occupation in the state of Minnesota, with an estimated 3,518 licensees and 2,240 professionals employed statewide.[3] Regionally, employment of psychologists ranges from an estimated 130 in Northwest Minnesota to 1,500 in the Twin Cities metro. Approximately one half of all psychologists are employed in three industries: offices of physicians, elementary and secondary schools, and offices of other healthcare practitioners.

- Current Demand. Some current demand indicators are unpublishable at regional levels due to small sample sizes. However, the available economic indicators suggest that psychologists are currently in high demand around the state. The current job vacancy rate is 5.5 percent, compared to a vacancy rate of 2.8 percent across all occupations statewide. The occupations-in-demand indicator generally ranges from 4 to 5 (out of 5) across all regions, with the exception of Southwest Minnesota where the OID indicator is 3. On the other hand, economists argue that high hiring demand and worker shortages often result in upward pressure on wages, and there is no evidence that wage offers for psychologists have risen significantly over the last ten years.[4]

- Future Demand. Future demand appears to be extremely high for clinical, counseling, and school psychologists in Minnesota. This is a fast-growing occupation, expected to expand by 24.4 percent in Minnesota between 2010 and 2020, compared to an overall projected growth rate of 13.0 percent. There is a projected need for 1,900 new psychologists to fill new and replacement openings statewide.

Avenues for Further Inquiry

- Although current and future demand levels for psychologists appear very high, with the large numbers of psychology graduate program completers, there is no clear quantitative evidence that the field is being undersupplied overall. In fact, there has been concern raised about oversupplies nationally[5]. If there are anecdotal reports of shortages in this occupation, further qualitative study may be helpful to pinpoint the reasons and geographic locations of shortages.

[3] Differences between the number of licensees and the number of employees could be due to a variety of factors: (1) some licensees might not be working as psychologists; (2) some may be self-employed, which the employment estimate does not include; or (3) the true employment estimate may be subject to some sampling error.

[4] Wage offers for psychologists have fluctuated widely over the last ten years, likely due to a high level of sampling error in the survey estimates. However, if there was pressure to increase wages to attract psychiatrists to openings, we would likely see some evidence of this in the findings.

[5] Robiner, W. N., & Crew, D. P. (2000). Rightsizing the workforce of psychologists in healthcare: Trends from licensing boards, training programs, and managed care. *Professional Psychology: Research and Practice, 31*(3)*,* 245-263.

Additionally, it may be worth quantifying shortages in specific specialties (e.g., child psychology, geropsychology) within psychology.

Social Workers

Demographics

- Minnesota social workers' ages vary widely, with substantial shares of at all ages. About half are under 45 years old, 19 percent are 45-54 years old, 22 percent are 55-64 years old, and 9 percent are 65 years and older. They are just slightly older than the national workforce as a whole. Sixty-five percent of licensed Minnesota social workers plan to continue practicing for more than ten years.

- More than 80 percent of Minnesota's licensed social workers are female.

- The vast majority—93 percent statewide—are white. The remaining seven percent are evenly divided between Asian, Black, multiple races, and American Indian.

Workforce Supply

- Licensing: The Minnesota Board of Social Work regulates 6,395 licensees. This comprises licensed clinical social workers, licensed social workers, and licensed graduate social workers.

- Education: Minnesota higher educational institutions (Augsburg College, Saint Cloud State University, St. Catherine University, St. Mary's University, University of Minnesota- Duluth, University of Minnesota- Twin Cities, University of St. Thomas) as well as non-traditional programs (Capella University, Walden University) have master's and/or doctoral level programs. Together, all produced 487 social work master's and Ph.D. graduates in the 2011-2012 school year. Neighboring states produced another 506 (155 in Iowa; 68 in North Dakota; and 283 in Wisconsin). There are 18 bachelor's level programs.

- Employment. Many people who perform social work activities in their jobs, and are therefore counted as "social workers" in the Bureau of Labor Statistics categories, are not licensed social workers. In total, across the four specialties of social work, there were 6,395 licensees, but an estimated 10,810 people employed in these occupations. More than half—5,660—were employed as Child, Family, and School Social Workers. Another 2,580 were working as Healthcare Social Workers, 2,180 were employed as Mental Health and Substance Abuse Social Workers, and 390 in the Social Workers, All Other occupational category. Social workers are employed in a wide variety of industries, including clinic/outpatient settings, schools, hospitals and medical centers, government, and social service agencies.

Workforce Demand

- A note on occupational classifications. The Bureau of Labor Statistics has four separate classifications for social workers: (1) Mental Health and Substance Abuse; (2) Child, Family, and School; (3) Healthcare and (4) Social Workers, All Other. The Mental Health Steering Committee

did not express particular interest in these breakouts, but since this is the way statewide demand indicators are published, this is how these occupations are presented in this report.

- Current Demand. Current demand indicators suggest that hiring demand in social work occupations ranges from modest to high. Job vacancy rates are lower than average for three out of the four social work specialties. Only the "Social Workers, All Other" category had a statewide vacancy rate that exceeded the statewide average, 3.7 percent versus 2.8 percent, respectively. Taken on its face, this statistic would not support a claim that employers are having difficulty recruiting workers to fill social work positions. The occupations-in-demand indicator is another measure of current demand, taking into account job vacancies, employment size, and unemployment insurance claims. This indicator ranges from 3 to 5 (out of a possible 5) across regions, suggesting moderate to very high demand. Finally, there is no evidence that wage offers have increased over time, which, were it present, would be indicative of workforce shortages. Considering all three sets of indicators, there is mixed, and overall, probably weak evidence of a shortage of social workers to fill positions.

- Future Demand. There is a projected need for 4,360 new social workers across all four social work specialty areas to fill growth and replacement openings in Minnesota between 2010-2020. Assuming that growth is even across all ten years, that translates into an annual need for approximately 436 new social workers. In Minnesota alone there were 487 social work Master's and Ph.D. level graduates in 2011-2012. While there may be regional shortages—or shortages across different specialties—the overall picture suggests relative parity between supply and demand for social work occupations.

Avenues for Further Inquiry

- One question that this data leaves unanswered concerns the supply and demand of *licensed* social workers. As noted above, the estimates suggest that just under a half of all people who provide social work services are not licensed. Additional inquiry could delve into and/or document the extent to which non-licensed practitioners or paraprofessionals are able to provide at least some of the services necessary to meet clients' or patients' needs. Additionally, this report has not documented whether there are regional and/or specialty area shortages, which also would be a fruitful line of inquiry.

Marriage and Family Therapists

Demographics

- Licensed Marriage and Family Therapists span the age distribution. As a workforce, they are slightly older than the workforce overall, with over one-third being over the age of 55 (compared to one-fifth of the overall workforce).

- Three-fourths of all licensed Marriage and Family Therapists are female.

- The vast majority—91 percent—are white, with the remainder spread evenly between Asian, Black, and multiple races.

Workforce Supply

- Licensing: There are 1,489 licensed Marriage and Family Therapists with a Minnesota mailing address. The statewide employment estimate is 820.[6]

- Education: In the 2011-2012 academic year, there were 238 Master's and Ph.D. level completers of Marriage and Family Therapy programs in Minnesota with programs at Argosy University-Twin Cities, Saint Mary's University of Minnesota, and St. Cloud State University. There is also an online program at Capella University. Neighboring states had additional graduates: 43 in South Dakota and two in Wisconsin.

Demand

- Employment. Statewide, this occupation employs an estimated 820 people, the vast majority of whom (680) are employed in the Twin Cities metro area, and the remaining distributed fairly evenly across other regions. Statewide, about three-quarters of these professionals work in three industry sectors: outpatient care centers, individual and family services, and offices of other healthcare practitioners.

- Current Demand. Current demand indicators suggest that overall, statewide demand for Marriage and Family Therapists is moderate. The vacancy rate in this occupation is 0.9 percent. Compared to the statewide average of 2.8 percent, this suggests that employers are not encountering difficulties filling these positions. The statewide occupations-in-demand indicator is 4 out of 5, indicating healthy—but not overwhelming—demand. Like the other mental health occupations included in this report, there is no evidence that wage offers for Marriage and Family Therapists have increased over the last ten years, indicating that any shortages that might exist have not been reflected in upward pressure on wages.

- Future Demand. Between 2010 and 2020, the demand for Marriage and Family Therapists is projected to grow much faster than average occupations. The occupation is expected to expand by 50 percent (compared to an overall growth rate of 13 percent). This will translate into 640 growth and replacement openings during this period. Assuming an even growth across the ten-year period, this translates into the need for about 64 new workers each year. In the 2011-2012 school year (the most recent year for which data are available) there were 238 Master's and Ph.D. level Marriage and Family Therapy program completers. Given these basic indicators, there is no evidence that this is a shortage occupation, and indeed may be an area of surplus.

Avenues for Further Inquiry

- For this particular occupational specialty, it does not appear that there is a shortage of *workers*. There may be a shortage of *services* available to families, but that is another matter that would fall outside the scope of labor market processes. If the mental health steering committee wishes to focus effort on increasing the number of Marriage and Family Therapists, it may need to

[6] Differences between the number of licensees and the number of employees could be due to a variety of factors: (1) some might be licensed as psychologists; rather than MFTs (2) some may be self-employed, which the employment estimate does not include; or (3) the true employment estimate may be subject to some sampling error.

consider whether, or where, there are enough viable employment opportunities to absorb an increased supply. Analysis of reimbursement and other operational factors could identify employment challenges/opportunities.

Mental Health Counselors

Demographics

- Licensed mental health counselors in Minnesota are just slightly younger than the U.S. workforce at large. An estimated 60 percent are under the age of 45.
- The vast majority—82 percent—of licensed mental health counselors are female.
- Race data is not available for mental health counselors.

Workforce Supply

- Licensing: There are 1,066 licensed mental health counselors (Licensed Professional Counselors [LPCs] and Licensed Professional Clinical Counselors [LPCCs]) in Minnesota.
- Education: In the 2011-2012 academic year, there were 262 master's level completers of mental health counseling programs from the only program in Minnesota, the online program at Capella University. There were another 170 completers of substance abuse/addiction counseling from a variety of programs. There were also small numbers of completers from these two programs in neighboring states.

Workforce Demand

- Employment. The BLS occupational group "Mental Health Counselor" includes both licensed and non-licensed workers who provide mental health counseling-related services. As noted above, there were 1,066 LPC and LPCC licensees in Minnesota, but this occupation employs about twice that (2,180) statewide. Employment ranges from a low of 80 in Southwest Minnesota to a high of 1,390 in the Twin Cities metro region.
- Current Demand. As indicated by job vacancy rates and the occupations-in-demand indicator, there is relatively high hiring demand for mental health counselors in Minnesota. Job vacancy rates are not publishable for most regions due to small numbers, but statewide, there were 6.9 vacancies for every 100 mental health counselor jobs. This is more than twice the job vacancy rate across all occupations (2.8 percent). In addition, the OID indicator is 5 out of 5, indicating very high hiring demand. Finally, there is some evidence that wage offers have been increasing over the last ten years (the median wage offer in 2002 was $10.10, but had risen to $17.55 by 2012). This is not conclusive evidence, but is consistent with the upward pressure on wages that can result from worker shortages.

- Future Demand. This profession is projected to grow quickly over the 2010-2020 period, increasing by 34 percent statewide, compared to an overall growth rate of 13 percent. This growth will result in a need for an estimated 1,130 new workers to fill openings resulting from both growth and replacement. Assuming that growth is steady over the ten year period, this translates into approximately 113 openings annually. Keeping in mind that there were 262 master's level completers of mental health counseling and 170 completers of substance abuse/addiction counseling programs, these data suggest that Minnesota has the capacity to produce the needed supply in this occupation.

Avenues for Further Inquiry

- Based on the data presented, it appears that supply and demand are relatively balanced for Mental Health Counselors. However, as noted above, this occupational category includes both licensed and non-licensed personnel. Therefore, one question that this analysis cannot answer is whether there are enough *licensed* counselors to meet employment demand in Minnesota. This is a very important question, given the wider latitude of licensed professionals to provide mental health services. What is the hiring demand for the subset of mental health counselors who are licensed? The Mental Health Workforce Steering Committee may wish to undertake a more nuanced study or employer survey focusing only on this question.

Advanced Practice Psychiatric Nurses

Demographics

- Advanced practice psychiatric nurses, as a group, are older than the workforce at large. In Minnesota an estimated 57 percent of advanced practice psychiatric nurses are age 55 and over.

- This is an overwhelmingly female, overwhelmingly white occupation. The vast majority—94 percent—are female, and 98 percent are white (1 percent are black and another 1 percent are American Indian).

Workforce Supply

- Licensing: There are 303 licensed advanced practice nurses with specializations in psychiatry or mental health in Minnesota.

- Education: There are two Psychiatric Nurse Practitioner programs in Minnesota – the University of Minnesota and the College of St. Scholastica. According to IPEDS, in 2011-2012, there were only eight psychiatric-mental health nurse practitioner graduates – all of these from the College of St. Scholastica. The University of Minnesota had four graduates in that year which must have been coded in a different classification.

Workforce Demand

- Because advanced practice psychiatric nursing is not an occupational category for which data are collected, no current or future demand information is available statewide or regionally for this specialty. As a frame of reference, the category of 'Nurse Practitioner" is identified as an

occupation in high demand (5 on a scale of 1-5). The job vacancy rates for Nurse Practitioner range from 4.6 percent in the SE region to a high of 8.5 percent in the SW region. The overall state vacancy rate is 6.5percent.

Avenues for Further Inquiry

As a subset of a larger occupation, an analysis of Psychiatric/Mental Health Nurse Practitioners is limited. A special survey of program graduates or additional surveys by the Board of Nursing might provide useful information as to location of employment, utilization, and overall demand.

Mental Health Workforce Supply and Demand Analyses

Psychiatrists

Summary Information about Psychiatrists*

Occupational Description

Physicians who diagnose, treat, and help prevent disorders of the mind.

Sample of Reported Job Titles

Staff Psychiatrist, Child Psychiatrist, Consulting Psychiatrist, Prison Psychiatrist

Top Job Duties

- Prescribe, direct, or administer psychotherapeutic treatments or medications to treat mental, emotional, or behavioral disorders.
- Analyze and evaluate patient data or test findings to diagnose nature or extent of mental disorder.
- Collaborate with physicians, psychologists, social workers, psychiatric nurses, or other professionals to discuss treatment plans and progress.
- Design individualized care plans, using a variety of treatments.
- Gather and maintain patient information and records, including social or medical history obtained from patients, relatives, or other professionals.

Education, Licenses, and Certifications

- 100% of psychiatrists have a doctoral, professional degree (i.e, M.D. or D. O.).
- This occupation requires a medical license.
- Psychiatrists may be certified in a variety of different specialties.

*Source: Adapted from Occupational Information Network, U.S. Department of Labor, Employment and Training Administration

Demographic Information on Psychiatrists

Table 1a: Age Distribution of Licensed Psychiatrists, by Minnesota Region

Region	Less than 35 years	35-44 years	45-54 years	55-64 years	65 years +
Central	0%	43%	30%	20%	7%
Northeast	6%	6%	50%	25%	13%
Northwest	0%	12%	35%	47%	6%
Twin Cities	3%	18%	32%	28%	20%
Southeast	4%	21%	28%	33%	13%
Southwest	9%	23%	32%	18%	18%
Statewide	**3%**	**19%**	**32%**	**29%**	**17%**
U.S., All Occupations	**34%**	**22%**	**23%**	**16%**	**5%**

Sources: Minnesota Board of Medical Practice, March 2012. Percentages above include only physicians board certified in psychiatry. There were a total of 658 licensed psychiatrists in Minnesota, but the data in the table above include only the 497 licensees with Minnesota mailing addresses.

Data on the age distribution for all occupations in the U.S. come from the Current Population Survey, Employed Persons by Detailed Occupation and Age, 2011 (http://www.bls.gov/cps/occupation_age.htm).

Table 1b: Gender of Licensed Psychiatrists, by Minnesota Region

Region	Female	Male
Central	33%	67%
Northeast	19%	81%
Northwest	12%	88%
Twin Cities	37%	63%
Southeast	31%	69%
Southwest	41%	59%
Statewide	**35%**	**65%**

Source: Minnesota Board of Medical Practice, March 2012. Percentages above include only physicians board certified in psychiatry. There were a total of 658 licensed psychiatrists in Minnesota, but the data in the table above include only the 497 licensees with Minnesota mailing addresses.

Table 1c: Race of Licensed Psychiatrists, by Minnesota Region

Region	American Indian	Asian	Black	White	Other
Central	0%	13%	7%	80%	0%
Northeast	0%	0%	0%	100%	0%
Northwest	0%	10%	0%	80%	10%
Twin Cities	0%	7%	1%	90%	2%
Southeast	3%	8%	3%	87%	0%
Southwest	0%	15%	0%	85%	0%
Statewide	**0%**	**7%**	**2%**	**89%**	**2%**

Source: Minnesota Department of Health, Office of Rural Health and Primary Care Workforce Survey, 2011. The percentages above are based on responses from the 296 survey respondents with a Minnesota mailing address who answered this question on the survey.

Supply of Psychiatrists

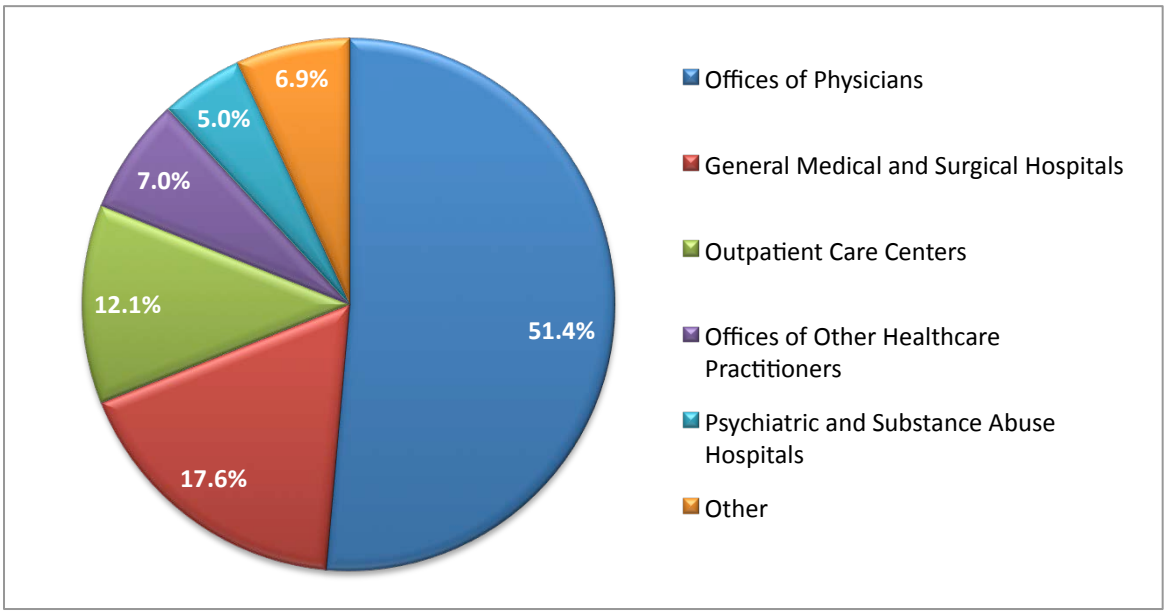
Table 1d: Number of Psychiatrists who are Licensed and Employed, by Region and Statewide

Minnesota Region	Number of Minnesota Licenses*	Number Employed**
Central	30	30
Northeast	16	N/A
Northwest	17	30
Minneapolis/St. Paul	337	160
Southeast	75	30
Southwest	22	20
Statewide	**497**	**290**

*Source: Minnesota Board of Medical Practice, March 2012. Percentages above include only physicians board certified in psychiatry. There were a total of 658 licensed psychiatrists in Minnesota, but the data in the table above include only the 497 licensees with Minnesota mailing addresses.
Note: A less conservative estimate from the Minnesota Board of Medical Practice lists 962 physicians licensed in Minnesota as psychiatrists, however, this includes 465 physicians listed as psychiatrists who may have out-of-state mailing practices, so it is presumed they are not practicing full-time in Minnesota. The extent of their clinical practice within Minnesota is not known.
.
**Source: Minnesota Department of Employment and Economic Development, Labor Market Information Office, Occupational Employment Statistics, Second Quarter 2013.

Demand for Psychiatrists

Figure 1a: Psychiatrist Employment, by Industry Setting in Minnesota



Source: Minnesota Department of Employment and Economic Development, Occupation-Industry Matrix, 2010

Table 1e: Employment Status of Psychiatrists

	Central	Northeast	Northwest	Twin Cities	Southeast	Southwest	Statewide
Employed in a paid position as a Psychiatrist	14	6	11	205	38	12	286
Employed in another field; seeking work as a Psychiatrist	1	0	0	0	1	0	2
Unemployed, but seeking work as a Psychiatrist	0	0	0	1	1	1	3
Unemployed, but not seeking work as a Psychiatrist	0	0	0	1	1	0	2
Not currently working due to family/medical reasons	0	0	0	0	1	0	1
Retired	0	2	0	11	0	1	14
Total	**15**	**8**	**11**	**216**	**42**	**13**	**308**

Source: Minnesota Department of Health, Office of Rural Health and Primary Care Workforce Survey, 2011. The data above come from 308 survey respondents with a Minnesota mailing address who answered this question on the survey.

Table 1f: Length of Time Psychiatrists in Minnesota Plan to Continue Working

Region	0-5 years	6-10 years	> 10 years
Central	14%	21%	64%
Northeast	75%	13%	13%
Northwest	11%	44%	44%
Twin Cities	23%	22%	55%
Southeast	15%	23%	62%
Southwest	27%	18%	55%
Total, Statewide	**23%**	**22%**	**55%**

Source: Minnesota Department of Health, Office of Rural Health and Primary Care Workforce Survey, 2011. The data above come from 285 survey respondents with a Minnesota mailing address who answered this question on the survey.

Table 1g: Current Occupational Demand Indicators for Psychiatrists, by Region

Area	Current Employment*	Number of Job Vacancies**	Job Vacancy Rate**	Occupations in Demand Indicator (1=Low; 5=High)†
Central	30	N/A	N/A	0-3
Northeast	N/A	N/A	N/A	3
Northwest	30	N/A	N/A	0-3
Twin Cities	160	29	18.0%	4
Southeast	30	N/A	N/A	2-4
Southwest	20	9	44.3%	N/A
Statewide, Psychiatrists	**290**	**41**	**18.2%**	**4**
Statewide, All Occupations	**2,641,110**	**72,569**	**2.8%**	**Not computed**

*Source: Minnesota Department of Employment and Economic Development, Occupational Employment Statistics; Second Quarter 2013. It should be noted that this is a survey of employers, and therefore does not include information about psychiatrists in independent practice.

**Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey; Second Quarter 2013

†Source: Minnesota Department of Employment and Economic Development, Occupations In Demand; data updated in June, 2013. Data are produced by economic development region (13 regions); therefore, the table above presents the range of OID scores within the region.

Figure 1b: Wage Offers on an Hourly Basis for Psychiatrists, 2002-2012, Statewide

Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey. Wages are adjusted with the Consumer Price Index to reflect 2012 dollars. Note that wages were unpublishable in 2005.

Table 1h: Total Projected Openings and Projected Growth Rate for Psychiatrists, by Region and Statewide

Area	Total Projected Openings, 2010-2020	Projected Growth Rate, 2010-2020
Central	20	28.6%
Northeast	N/A	23.1%
Northwest	10	33.3%
Twin Cities	90	23.2%
Southeast	N/A	N/A
Southwest	N/A	N/A
Statewide, Psychiatrists	**180**	**25.4%**
Statewide, All Occupations	**1,041,750**	**13.0%**

Source: Minnesota Department of Employment and Economic Development, Occupational Employment Projections. The N/A responses indicate data is not available to provide a basis for estimating future growth.

Clinical, Counseling, and School Psychologists

Summary Information about Clinical, Counseling, and School Psychologists*

Occupational Description

Diagnose and treat mental disorders; learning disabilities; and cognitive, behavioral, and emotional problems, using individual, child, family, and group therapies. May design and implement behavior modification programs.

Sample of Reported Job Titles

Clinical Psychologist, Counseling Psychologist, Forensic Psychologist, Counseling Services Director

Selected Job Duties

- Interact with clients to assist them in gaining insight, defining goals, and planning action to achieve effective personal, social, educational, and vocational development and adjustment.
- Identify psychological, emotional, or behavioral issues and diagnose disorders, using information obtained from interviews, tests, records, and reference materials.
- Use a variety of treatment methods, such as psychotherapy, hypnosis, behavior modification, stress reduction therapy, and possibly psychodrama and play therapy

Education, Licenses, and Certifications

- Nationally, the vast majority of licensed clinical and counseling psychologists (> 75%) have a doctoral degree, which is the entry level degree for the profession according to the American Psychological Association. By contrast, the majority of school psychologists (78%) have a master's degree, with another 19 percent having a doctoral degree.
- This occupation requires a license to practice either regulated by the Minnesota Board of Psychology or the Department of Education (for school psychologists.
- Psychologists may be certified in a variety of different specialties.

Source: Adapted from Occupational Information Network, U.S. Department of Labor, Employment and Training Administration

Demographic Information on Clinical, Counseling, and School Psychologists

****Note: there is no demographic data available for licensed Psychologists in the state of Minnesota.****

Supply of Clinical, Counseling, and School Psychologists

Table 2a: Number of Clinical, Counseling, and School Psychologists who are Licensed and Employed, by Region and Statewide

Minnesota Region	Number of Minnesota Licenses*	Number Employed**
Central	265	200
Northeast	182	240
Northwest	182	130
Minneapolis/St. Paul	2,495	1,500
Southeast	250	240
Southwest	144	160
Statewide	**3,518**	**2,420**

*Source: Minnesota Board of Psychology, 2014. This includes both master's and doctoral level psychologists. In 1991 legislation was enacted limiting licensure as "psychologists" to individuals with doctoral degrees. There was a lengthy grandparenting process. Others thereafter had different licensure and titles (i.e., are not licensed as "psychologists"; most new graduates of master's programs are now being licensed under a different board). Currently, approximately 57% of Minnesota psychologists are doctoral level (i.e., have Ph.D. Psy.D., or Ed.D.). That percentage is anticipated to keep rising.

**Source: Minnesota Department of Employment and Economic Development, Labor Market Information Office, second quarter 2013. This group excludes psychologists in independent practice, which constitute a large proportion of psychologists.

Table 2b: Minnesota Psychology Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Masters Completers	Number of Doctoral Completers
Clinical Psychology		**59**	**56**
Argosy University-Twin Cities	Doctoral degree—professional practice		48
Capella University	Doctoral degree—professional practice		8
Capella University	Master's degree	49	
Minnesota State University-Mankato	Master's degree	10	
Counseling Psychology		**255**	**11**
University of St. Thomas	Doctoral degree—research/scholarship		11
Capella University	Master's degree	110	
University of St. Thomas	Master's degree	60	
Saint Mary's University of Minnesota	Master's degree	54	
Bethel University	Master's degree	28	
Bemidji State University	Master's degree	3	
Developmental and Child Psychology		**109**	**9**
University of Minnesota-Twin Cities	Doctoral degree—research/scholarship		8
Capella University	Doctoral degree—research/scholarship		1
Capella University	Master's degree	99	
University of Minnesota-Twin Cities	Master's degree	10	
Psychology, General		**115**	**80**
Capella University	Doctoral degree—research/scholarship		56
University of Minnesota-Twin Cities	Doctoral degree—research scholarship		24
Capella University	Master's degree	107	
University of Minnesota-Twin Cities	Master's degree	7	
Metropolitan State University	Master's degree	1	
School Psychology		**17**	
Minnesota State University Moorhead	Master's degree	4	
Minnesota State University Moorhead	Post-Mater's certificate	13	
Statewide, All Psychology Programs		**555**	**156**

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note that there were no Master's or Ph.D. level completers in additional Psychology-related programs, including: Applied Behavior Analysis, Clinical Child Psychology, Geropsychology, Health/Medical Psychology, or Psychoanalysis and Psychotherapy programs. It is now known many Minnesota graduates, especially of online schools, seek to practice in Minnesota. Many of the master's graduates get licensed as mental health counselors (i.e., LPC, LPCC).

Table 2c: Iowa Psychology Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Masters Completers	Number of Doctoral Completers
Applied Behavior Analysis		**2**	
Kaplan University-Davenport Campus	Post-master's certificate	2	
Clinical Psychology		**12**	
University of Northern Iowa	Master's degree	10	
Loras College	Master's degree	2	
Counseling Psychology		**15**	
University of Northern Iowa	Master's degree	15	
Psychology, General		**183**	**28**
University of Iowa	Doctoral degree—research /scholarship		14
Iowa State University	Doctoral degree—research /scholarship		14
Iowa State University	Post-master's certificate	4	
Kaplan University-Davenport Campus	Master's degree	160	
Iowa State University	Master's degree	8	
University of Northern Iowa	Master's degree	5	
University of Iowa	Master's degree	5	
Loras College	Master's degree	1	
School Psychology		**10**	**28**
University of Northern Iowa	Master's degree	10	
Statewide, All Psychology Programs		**250**	

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Master's degree or less. Note that there were no Master's or Ph.D. level completers in additional Psychology-related programs, including: Clinical Child Psychology, Developmental and Child Psychology, Geropsychology, Health/Medical Psychology, or Psychoanalysis and Psychotherapy programs

Table 2d: North Dakota Psychology Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Masters Completers	Number of Doctoral Completers
Clinical Psychology			**9**
University of North Dakota	Doctoral degree—research /scholarship		9
Counseling Psychology			**8**
University of North Dakota	Doctoral degree—research /scholarship		8
Psychology, General		**16**	**4**
North Dakota State University	Doctoral degree—research /scholarship		4
Minot State University	Post-master's certificate	3	
University of North Dakota	Master's degree	11	
North Dakota State University	Master's degree	2	
School Psychology		**3**	
Minot State University	Post-master's certificate	3	
Statewide, All Psychology Programs		**19**	**21**

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note that there were no Master's or Ph.D. level completers in additional Psychology-related programs, including: Applied Behavior Analysis, Clinical Child Psychology, Developmental and Child Psychology, Geropsychology, Health/Medical Psychology, or Psychoanalysis and Psychotherapy programs

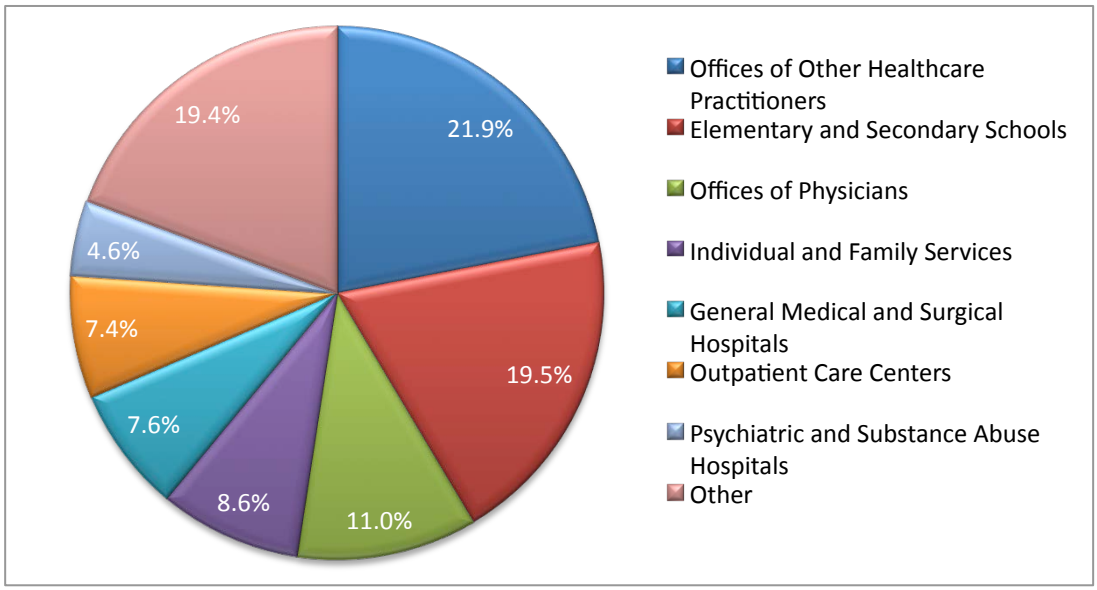
Table 2e: South Dakota Psychology Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Master's Completers	Number of Doctoral Completers
Counseling Psychology		**50**	
South Dakota State University	Master's degree	50	
Psychology, General		**10**	**2**
South Dakota State University	Doctoral degree—research/scholarship	2	2
South Dakota State University	Master's degree	10	
Statewide, All Psychology Programs		**60**	**2**

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note that there were no Master's or Ph.D. level completers in additional Psychology-related programs, including: Applied Behavior Analysis, Clinical Psychology, Clinical Child Psychology, Developmental and Child Psychology, Geropsychology, Health/Medical Psychology, Psychoanalysis and Psychotherapy, or School Psychology programs.

Demand for Clinical, Counseling, and School Psychologists

Figure 2a: Clinical, Counseling, & School Psychologist Employment, by Industry Setting in Minnesota



Source: Minnesota Department of Employment and Economic Development, Occupation-Industry Matrix, 2010

Table 2f: Current Occupational Demand Indicators for Clinical, Counseling, & School Psychologists, by Region

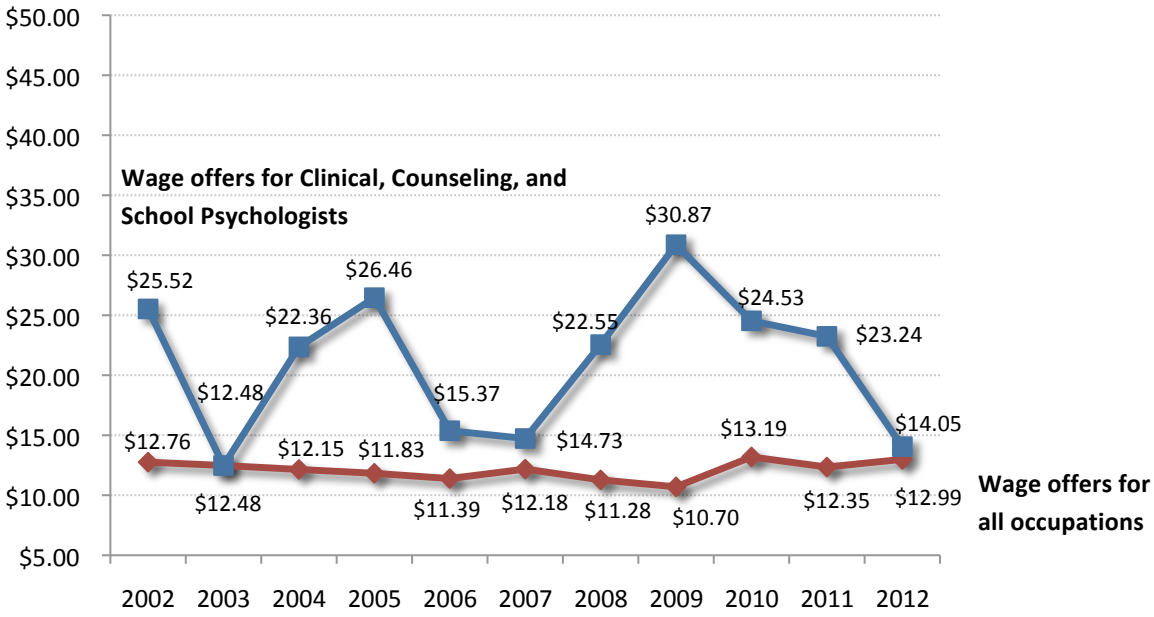
Area	Current Employment*	Number of Job Vacancies**	Job Vacancy Rate**	Occupations in Demand Indicator (1=Low; 5=High)†
Central	200	N/A	N/A	4-5
Northeast	240	22	9.2%	5
Northwest	130	N/A	N/A	4
Twin Cities	1,500	57	3.8%	4
Southeast	240	9	3.5%	5
Southwest	160	37	23.2%	3
Statewide, Clinical, Counseling, and School Psychologists	2,420	**132**	**5.5%**	**5**
Statewide, All Occupations	**2,641,110**	**72,569**	**2.8%**	**Not computed**

*Source: Minnesota Department of Employment and Economic Development, Occupational Employment Statistics; Second Quarter 2013. These statistics focus on employers and therefore do not include opportunities in independent practice.

**Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey; Second Quarter 2013

†Source: Minnesota Department of Employment and Economic Development, Occupations In Demand; data updated in June, 2013. Data are produced by economic development region (13 regions); therefore, the table above presents the range of OID scores within the region.

Figure 2b: Wage Offers on an Hourly Basis for Clinical, Counseling, and School Psychologists, 2002-2012, Statewide



Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey. Wages are adjusted with the Consumer Price Index to reflect 2012 dollars.

Table 2g: Total Projected Openings and Projected Growth Rate for Clinical, Counseling, and School Psychologists, by Region and Statewide

Area	Total Projected Openings, 2010-2020	Projected Growth Rate, 2010-2020
Central	160	24.1%
Northeast	110	19.9%
Northwest	180	31.3%
Twin Cities	1,070	23.0%
Southeast	180	25.4%
Southwest	160	19.8%
Statewide, Psychiatrists	**1,900**	**24.4%**
Statewide, All Occupations	**1,041,750**	**13.0%**

Source: Minnesota Department of Employment and Economic Development, Occupational Employment Projections.

Social Workers

Mental Health & Substance Abuse Social Workers
Child, Family, & School Social Workers
Healthcare Social Workers

Summary Information about Social Workers*

Occupational Descriptions

Mental Health & Substance Abuse Social Workers: Assess and treat individuals with mental, emotional, or substance abuse problems, including the abuse of alcohol, tobacco, and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention, and education.

Child, Family, & School Social Workers: Provide social services and assistance to improve the social and psychological functioning and children and their families to maximize the family well-being and academic functioning of children. May assist parents, arrange adoptions, and find foster homes for abandoned or abused children. In schools, they address such problems as teenage pregnancy, misbehavior, and truancy. May also advise teachers.

Healthcare Social Workers: Provide individuals, families, and groups with the psychosocial support needed to cope with chronic, acute, or terminal illnesses. Services include advising family caregivers, providing patient education and counseling, and making referrals for other services. May also provide care and case management or interventions designed to promote health, prevent disease, and address barriers to access to healthcare.

Sample of Reported Job Titles
Clinical Social Worker, Social Work Case Manager, Medical Social Worker, School Social Worker, Child Protective Social Worker, Mental Health Therapist, Substance Abuse Counselor, Therapist

Education, Licenses, and Certifications

- The vast majority of social worker positions require master's degrees, though some are at the bachelor's level and others are at the doctoral level (D.S.W.).
- Many social work positions require a license to practice.

Source: Adapted from Occupational Information Network, U.S. Department of Labor, Employment and Training Administration

Demographic Information on Licensed Social Workers

Table 3a: Age Distribution of Licensed Social Workers, by Minnesota Region (includes LICSW, LISW, and LGSW)

Region	Less than 35 years	35-44 years	45-54 years	55-64 years	65 years +
Central	22%	28%	19%	22%	9%
Northeast	21%	24%	20%	26%	9%
Northwest	21%	25%	18%	26%	9%
Twin Cities	25%	24%	19%	22%	9%
Southeast	22%	26%	18%	24%	11%
Southwest	32%	22%	20%	20%	6%
Statewide	25%	24%	19%	22%	9%
U.S., All Occupations	**34%**	**22%**	**23%**	**16%**	**5%**

Sources: Minnesota Board of Social Work, 2012-2013. These results are based on 6,395 active social workers with state of Minnesota mailing addresses.

The age distribution of all occupation sin the U.S. is from the Current Population Survey, Employed Persons by Detailed Occupation and Age, 2011 (http://www.bls.gov/cps/occupation_age.htm)

Table 3b: Gender of Licensed Social Workers (includes LICSW, LISW, and LGSW), by Minnesota Region

Region	Male	Female
Central	20%	80%
Northeast	21%	79%
Northwest	14%	86%
Twin Cities	16%	84%
Southeast	19%	81%
Southwest	12%	88%
Statewide	**16%**	**84%**

Source: Minnesota Board of Social Work, 2012-2013. These results are based on 6,395 active social workers with state of Minnesota mailing addresses.

Table 3c: Race/Ethnicity of Licensed Social Workers (includes LICSW, LISW, and LGSW), by Minnesota Region

Region	White	American Indian	Asian	Black	Multiple races	Native Hawaiian
Central	96%	0%	2%	1%	2%	0%
Northeast	91%	3%	2%	0%	4%	0%
Northwest	93%	2%	1%	1%	1%	1%
Twin Cities	92%	0%	3%	3%	2%	0%
Southeast	97%	0%	1%	0%	2%	0%
Southwest	98%	1%	1%	1%	0%	0%
Statewide	**93%**	**1%**	**2%**	**2%**	**2%**	**0%**

Source: **Preliminary results** from the Office of Rural Health and Primary Care, Minnesota Department of Health; 2012-2013 Workforce Survey. The percentages above are based on a sample of 3,106 (out of 6,348 license renewals). 148 survey respondents did not answer this question on the survey.

Supply of Social Workers

Table 3d: Number of Social Workers who are Licensed and Employed, by Region and Statewide

Minnesota Region	Total Number of Minnesota Licenses*	Child, Family, & School Social Workers**	Mental Health & Substance Abuse Social Workers**	Healthcare Social Workers**	Other Social Workers**
Central	451	520	130	230	60
Northeast	349	320	190	170	N/A
Northwest	306	480	170	300	N/A
Minneapolis/St. Paul	4,563	3,480	1,310	1,560	310
Southeast	471	660	170	260	N/A
Southwest	255	460	190	110	N/A
Statewide	**6,395**	**5,660**	**2,180**	**2,580**	**390**

*Source: Minnesota Board of Licensing. Includes only social work licensees (renewals and applicants) with a Minnesota mailing address. Includes LICSW, LISW, and LGSW.

**Source: Minnesota Department of Employment and Economic Development, Labor Market Information Office, Second Quarter 2013.

Table 3e: Minnesota Social Work Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Completers
Social Work		**475**
University of Minnesota-Twin Cities	Doctoral degree—research/scholarship	4
Capella University	Doctoral degree—research/scholarship	2
St. Catherine University	Master's degree	141
University of Minnesota-Twin Cities	Master's degree	118
Minnesota State University-Mankato	Master's degree	27
University of Minnesota-Duluth	Master's degree	27
Saint Cloud State University	Master's degree	15
Social Work, Other		**12**
Augsburg College	Master's degree	12
Statewide, All Social Work Programs		**487**

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note that there were no Master's or Ph.D. level completers of related social work programs, including: Clinical/Medical Social Work, Juvenile Corrections, or Youth Services/Administration.

Table 3f: Iowa Social Work Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Completers
Social Work		**155**
University of Iowa	Master's degree	77
University of Northern Iowa	Master's degree	40
Saint Ambrose University	Master's degree	38
Statewide, All Social Work Programs		**155**

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note that there were no Master's or Ph.D. level completers of related social work programs, including: Clinical/Medical Social Work, Juvenile Corrections, Youth Services/Administration, or Social Work, Other programs.

Table 3g: North Dakota Social Work Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Completers
Social Work		**68**
University of North Dakota	Master's degree	68
Statewide, All Social Work Programs		**68**

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note that there were no Master's or Ph.D. level completers of related social work programs, including: Clinical/Medical Social Work, Juvenile Corrections, Youth Services/Administration, or Social Work, Other.

Note: South Dakota had no social work program completers who earned a Master's degree or higher in 2012.

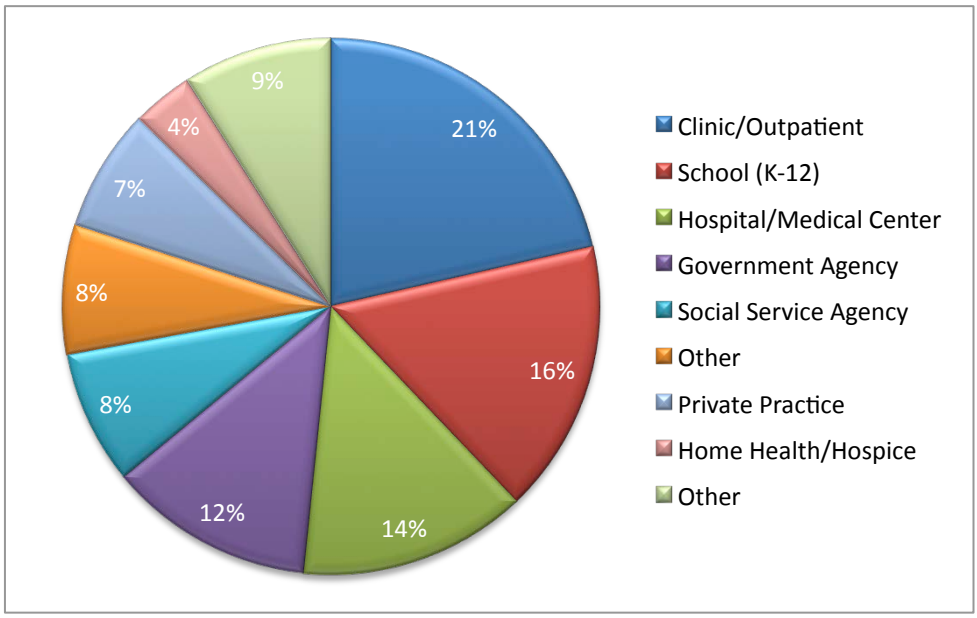
Table 3h: Wisconsin Social Work Program Completers 2012, Master's Degree and Higher

Program/Institution	Award Level	Number of Completers
Social Work		**283**
University of Wisconsin-Madison	Doctoral degree—research/scholarship	4
University of Wisconsin-Milwaukee	Doctoral degree—research/scholarship	1
University of Wisconsin-Madison	Master's degree	131
University of Wisconsin-Milwaukee	Master's degree	117
University of Wisconsin-Green Bay	Master's degree	16
University of Wisconsin-Oshkosh	Master's degree	14
Statewide, All Social Work Programs		**283**

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note that there were no Master's or Ph.D. level completers of Clinical/Medical Social Work, Juvenile Corrections, Youth Services/Administration, or Social Work, Other programs.

Demand for Social Workers

Figure 3a: Social Worker Employment, by Industry Setting in Minnesota



Source: Minnesota Department of Health Workforce Survey, 2012-2013. Based on 3,516 out of 6,348 license renewals.

Table 3i: Employment Status of Licensed Social Workers (includes LICSW, LISW, and LGSW)

	Central	Northeast	Northwest	Twin Cities	Southeast	Southwest	Statewide
Employed/Self-employed in a paid position engaged as a social worker	89%	89%	87%	89%	85%	90%	89%
Employed in another field, but seeking work as a social worker	1%	1%	1%	1%	0%	2%	1%
Employed in another field and not seeking work as a social worker	3%	3%	5%	3%	5%	2%	4%
Unemployed, but seeking work as a social worker	0%	1%	1%	1%	2%	1%	1%
Unemployed and not seeking work as a social worker	3%	5%	1%	2%	5%	3%	3%
Not currently working due to family or medical reasons	1%	0%	2%	2%	2%	2%	2%
Retired	1%	2%	3%	1%	1%	0%	1%
Student	0%	1%	0%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Minnesota Department of Health, Office of Rural Health and Primary Care, March, 2013. Note that 254 licensed social workers did not supply an answer to this question.

Table 3j: Length of Time Licensed Social Workers in Minnesota Plan to Continue Working (includes (LICSW, LISW, and LGSW)

Region	0-5 years	6-10 years	More than 10 years
Central	18%	18%	64%
Northeast	21%	13%	66%
Northwest	21%	22%	57%
Twin Cities	17%	18%	65%
Southeast	19%	15%	66%
Southwest	14%	20%	67%
Total, Statewide	**18%**	**18%**	**65%**

Source: Minnesota Department of Health, Office of Rural Health and Primary Care, March, 2013. Note that of the 3,156 licensed social workers in this survey, 66 did not supply an answer to this question, and another 231 were not practicing in Minnesota and are not counted in the table above.

Table 3k: Current Occupational Demand Indicators for Social Workers, by Region

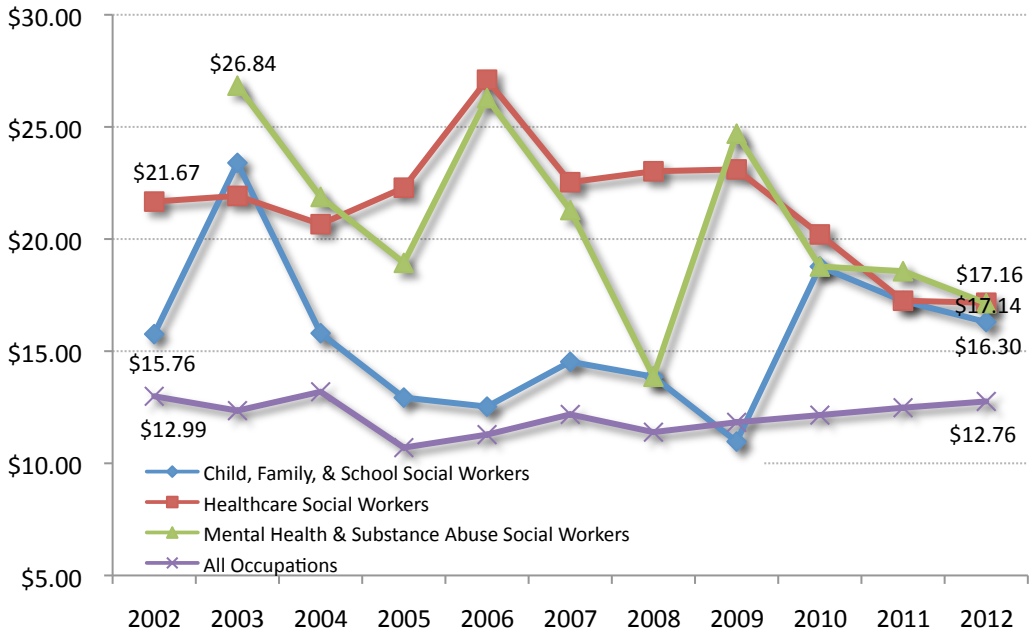
Area	Current Employment*	Number of Job Vacancies**	Job Vacancy Rate**	Occupations in Demand Indicator†
Mental Health and Substance Abuse Social Workers				
Central	160	N/A	N/A	3-5
Northeast	190	N/A	N/A	5
Northwest	170	N/A	N/A	3-5
Twin Cities	1,310	20	1.5%	5
Southeast	170	N/A	N/A	5
Southwest	190	5	2.4%	3-5
Statewide	**2,180**	**34**	**1.6%**	**5**
Child, Family, & School Social Workers				
Central	520	N/A	N/A	5
Northeast	320	N/A	N/A	4
Northwest	480	5	1.0%	3-5
Twin Cities	3,480	60	1.7%	5
Southeast	660	N/A	N/A	5
Southwest	460	N/A	N/A	5
Statewide	**5,660**	**79**	**1.4%**	**5**
Healthcare Social Workers				
Central	230	N/A	N/A	3-5
Northeast	170	N/A	N/A	3
Northwest	300	N/A	N/A	3-4
Twin Cities	1,560	30	1.9%	4
Southeast	260	N/A	N/A	3
Southwest	110	N/A	N/A	3-5
Statewide	**2,580**	**40**	**1.5%**	**4**
Social Workers, All Other				
Central	60	N/A	N/A	N/A
Northeast	N/A	N/A	N/A	N/A
Northwest	N/A	7	N/A	N/A
Twin Cities	310	N/A	N/A	N/A
Southeast	N/A	N/A	N/A	N/A
Southwest	N/A	N/A	N/A	N/A
Statewide	**390**	**14**	**3.7%**	**N/A**
Statewide, All Occupations	**2,641,110**	**72,569**	**2.8%**	**Not computed**

*Source: Minnesota Department of Employment and Economic Development, Occupational Employment Statistics; Second Quarter 2013. Combines licensed and non-licensed social workers.

**Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey; Second Quarter 2013. Combines licensed and non-licensed social workers. This does not include positions for independent practitioners who are self-employed.

†Source: Minnesota Department of Employment and Economic Development, Occupations In Demand; data updated in June, 2013. Data are produced by economic development region (13 regions); therefore, the table above presents the range of OID scores within the region. Combines licensed and non-licensed social workers.

Figure 3b: Wage Offers on an Hourly Basis for Social Workers, 2002-2012, Statewide*



Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey. Wages are adjusted with the Consumer Price Index to reflect 2012 dollars. Combines licensed and non-licensed social workers. This does not include social workers in independent practice.

Table 3l: Total Projected Openings and Projected Growth Rate, By Region and Statewide

Area	Total Projected Openings, 2010-2020	Projected Growth Rate, 2010-2020
Mental Health and Substance Abuse Social Workers		
Central	110	32.1%
Northeast	70	16.7%
Northwest	110	42.7%
Twin Cities	720	29.5%
Southeast	120	34.3%
Southwest	60	9.2%
Statewide	**1,200**	**28.7%**
Child, Family, & School Social Workers		
Central	340	16.4%
Northeast	110	6.1%
Northwest	190	6.5%
Twin Cities	1,150	7.2%
Southeast	150	5.8%
Southwest	110	2.5%
Statewide	**2,000**	**7.3%**
Healthcare Social Workers		
Central	120	33.2%
Northeast	80	22.0%
Northwest	90	30.0%
Twin Cities	600	20.9%
Southeast	90	26.7%
Southwest	50	14.6%
Statewide	**1,040**	**22.8%**
Social Workers, Other		
Central	10	-5.8%
Northeast	N/A	N/A
Northwest	N/A	N/A
Twin Cities	80	6.3%
Southeast	N/A	N/A
Southwest	N/A	N/A
Statewide	**120**	**6.2%**
Statewide, All Occupations	**1,041,750**	**13.0%**

Source: Minnesota Department of Employment and Economic Development, Occupational Employment Projections. Combines licensed and non-licensed social workers. Does not include self-employed.

Marriage & Family Therapists

Summary Information about Marriage and Family Therapists*

Occupational Description

Diagnose and treat mental and emotional disorders, whether cognitive, affective, or emotional, within the context of marriage and family systems. Apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.

Sample of Reported Job Titles

Licensed Marriage and Family Therapist (LMFT); Clinician; Counselor; Marriage and Family Therapist (MFT)

Top Job Duties

- Counsel clients on concerns, such as unsatisfactory relationships, divorce and separation; child rearing; home management; and financial difficulties.
- Encourage individuals and family members to develop and use skills and strategies for confronting their problems in a constructive manner.
- Maintain case files that include activities, progress notes, evaluations, and recommendations.
- Ask questions that will help clients identify their feelings and behaviors.

Education, Licenses, and Certifications

- Nationally, the vast majority (98 percent) of marriage and family therapists have a master's degree. The remainders have a doctoral or professional degree.
- This occupation requires a license to practice.
- Marriage and family therapists may be certified in a variety of different specialties.

*Source: Adapted from Occupational Information Network, U.S. Department of Labor, Employment and Training Administration.

Demographic Information on Marriage & Family Therapists

Table 4a: Age Distribution of Marriage and Family Therapists, by Minnesota Region

Region	Less than 35 years	35-44 years	45-54 years	55-64 years	65 years +
Central	22%	33%	18%	21%	6%
Northeast	26%	16%	14%	28%	16%
Northwest	30%	16%	23%	26%	5%
Twin Cities	21%	22%	20%	26%	11%
Southeast	14%	19%	24%	25%	19%
Southwest	28%	28%	18%	15%	9%
Statewide	**21%**	**23%**	**20%**	**25%**	**11%**
U.S., All Occupations	**34%**	**22%**	**23%**	**16%**	**5%**

Sources: Minnesota Board of Licensed Marriage and Family Therapists, June 2013. Percentages above are based on 1,489 license applicants/renewals with a Minnesota mailing address. (An additional 89 licensees had an out-of-state mailing address.)

Age distribution in all occupations in the U.S. comes from the Current Population Survey, Employed Persons by Detailed Occupation and Age, 2011 (http://www.bls.gov/cps/occupation_age.htm)

Table 4b: Gender of Marriage and Family Therapists, by Minnesota Region

Region	Male	Female
Central	21%	79%
Northeast	26%	74%
Northwest	23%	77%
Twin Cities	24%	76%
Southeast	32%	68%
Southwest	23%	77%
Statewide	**24%**	**76%**

Source: Minnesota Board of Licensed Marriage and Family Therapists, June 2013, based on 1,489 license applicants/renewals with a Minnesota mailing address. (An additional 89 licensees had an out-of-state mailing address.)

Table 4c: Race/Ethnicity of Marriage and Family Therapists, by Minnesota Region

Region	White	American Indian	Asian	Black	Multiple races with white	Other
Central	98%	0%	1%	0%	0%	1%
Northeast	83%	0%	0%	0%	13%	4%
Northwest	97%	0%	3%	0%	0%	0%
Twin Cities	90%	1%	3%	3%	2%	2%
Southeast	97%	3%	0%	0%	0%	0%
Southwest	97%	0%	0%	0%	3%	0%
Statewide	**91%**	**0%**	**2%**	**2%**	**2%**	**2%**

Source: Office of Rural Health and Primary Care, Minnesota Department of Health; 2012. The data above are based on 807 license applicants/renewals with a Minnesota mailing address. An additional 89 licensees had an out-of-state mailing address and 722 had no survey response for this question.

Supply of Marriage and Family Therapists

Table 4d: Number of Marriage and Family Therapists who are Licensed and Employed, by Region and Statewide

Minnesota Region	Number of Minnesota Licenses*	Number Employed**
Central	146	N/A
Northeast	50	30
Northwest	57	10
Minneapolis/St. Paul	1,112	680
Southeast	59	20
Southwest	65	20
Statewide	**1,489**	**820**

*Source: Minnesota Board of Licensed Marriage and Family Therapists, June 2013. Percentages above are based on 1,489 license applicants/renewals with a Minnesota mailing address. (An additional 89 licensees had an out-of-state mailing address.)

**Source: Minnesota Department of Employment and Economic Development, Labor Market Information Office, second quarter 2013.

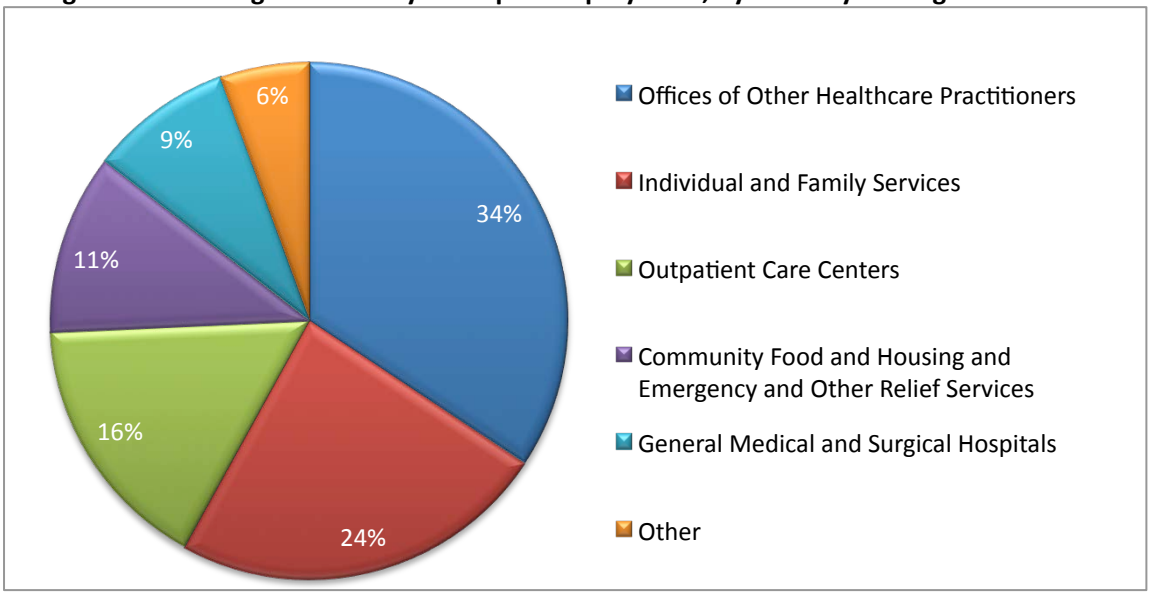
Table 4e: Marriage and Family Therapy Program Completers 2012
Master's Degree and Higher, Minnesota, Iowa, North Dakota, South Dakota, Wisconsin

Program/Institution	Award Level	Number of Completers
Minnesota, All Marriage and Family Therapy Program Completers		**238**
Argosy University-Twin Cities	Doctoral degree—professional practice	1
Saint Mary's University of Minnesota	Post-master's certificate	4
Capella University	Master's degree	70
Saint Mary's University of Minnesota	Master's degree	65
Argosy University-Twin Cities	Master's degree	47
Saint Cloud State University	Master's degree	14
Capella University	Post-baccalaureate certificate	34
Saint Cloud State University	Post-baccalaureate certificate	3
South Dakota, All Marriage and Family Therapy Program Completers		**2**
Sioux Falls Seminary	Master's degree	2
Wisconsin, All Marriage and Family Therapy Program Completers		**43**
Edgewood College	Master's degree	24
University of Wisconsin-Stout	Master's degree	9

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note: there were no Marriage and Family Therapy program completers from Iowa or North Dakota.

Demand for Marriage and Family Therapists

Figure 4a: Marriage and Family Therapist Employment, by Industry Setting in Minnesota



Source: Minnesota Department of Employment and Economic Development, Occupation-Industry Matrix, 2010

Table 4f: Employment Status of Licensed Marriage and Family Therapists

	Central	Northeast	Northwest	Twin Cities	Southeast	Southwest	Statewide
Employed in a paid position as an LMFT	93%	85%	81%	89%	88%	85%	89%
Employed in another field; seeking work as an LMFT	0%	4%	5%	2%	0%	5%	2%
Employed in another field; not seeking work as an LMFT	2%	0%	3%	4%	0%	3%	4%
Unemployed; seeking work as an LMFT	1%	0%	0%	1%	0%	3%	1%
Unemployed; not seeking work as an LMFT	0%	4%	3%	0%	0%	0%	0%
Not currently working due to family/medical reasons	1%	0%	3%	1%	3%	0%	1%
Retired	1%	4%	0%	1%	6%	3%	1%
Student	0%	0%	0%	0%	0%	0%	0%
None of the above	1%	4%	5%	2%	3%	3%	2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Minnesota Department of Health, Office of Rural Health and Primary Care, 2012 Workforce Survey. The above are based on 853 LMFT survey respondents.

Table 4g: Current Occupational Demand Indicators for Marriage and Family Therapists, by Region

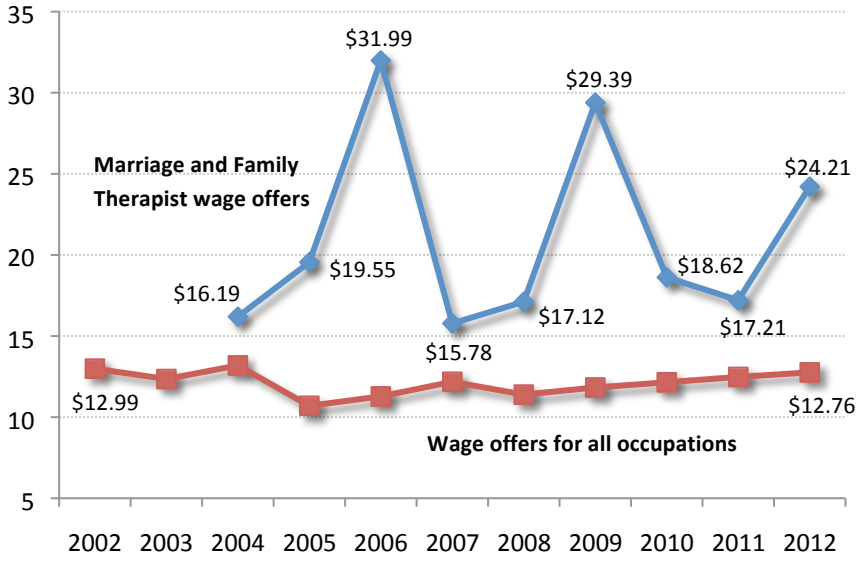
Area	Current Employment*	Number of Job Vacancies**	Job Vacancy Rate**	Occupations in Demand Indicator (1=Low; 5=High)†
Central	N/A	N/A	N/A	N/A
Northeast	30	N/A	N/A	5
Northwest	10	N/A	N/A	N/A
Twin Cities	680	N/A	N/A	4
Southeast	20	N/A	N/A	4
Southwest	20	N/A	N/A	4
Statewide, Marriage and Family Therapists	**820**	**7**	**0.9%**	**4**
Statewide, All Occupations	**2,641,110**	**72,569**	**2.8%**	**Not calculated**

*Source: Minnesota Department of Employment and Economic Development, Occupational Employment Statistics; Second Quarter 2013. Combines licensed and non-licensed workers.

**Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey; Second Quarter 2013. Combines licensed and non-licensed workers.

†Source: Minnesota Department of Employment and Economic Development, Occupations In Demand; data updated in June, 2013. Data are produced by economic development region (13 regions); therefore, the table above presents the range of OID scores within the region. Combines licensed and non-licensed workers.

Figure 4b: Wage Offers on an Hourly Basis for Marriage and Family Therapists, 2002-2012, Statewide



Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey. Wages are adjusted with the Consumer Price Index to reflect 2012 dollars. Combines licensed and non-licensed workers.

Table 4h: Total Projected Openings and Projected Growth Rate for Marriage and Family Therapists, by Region and Statewide

Area	Total Projected Openings, 2010-2020	Projected Growth Rate, 2010-2020
Central	30	66.7%
Northeast	N/A	N/A
Northwest	40	103.6%
Twin Cities	510	43.1%
Southeast	N/A	N/A
Southwest	N/A	25.0%
Statewide, Marriage and Family Therapists	**640**	**50.3%**
Statewide, All Occupations	**1,041,750**	**13.0%**

Source: Minnesota Department of Employment and Economic Development, Occupational Employment Projections. Combines licensed and non-licensed workers.

Mental Health Counselors

Summary Information about Mental Health Counselors*

Occupational Description

Counsel with an emphasis on prevention. Work with individuals or groups to promote optimum mental and emotional health. May help individuals deal with issues associated with addictions and substance abuse; family, parenting, and marital problems, stress management, self-esteem, and aging.

Sample of Reported Job Titles

Behavior Analyst; Behavior Support Specialist; Case Manager; Clinician; Counselor; Mental Health Specialist; Therapist

Selected Job Duties

- Maintain confidentiality of clients' records pertaining to treatment.
- Encourage clients to discuss their feelings and discuss what is happening in their lives; helping them to develop insight into themselves or their relationships.
- Collect information about clients through interviews, observations, and tests.
- Perform crisis intervention with clients.
- Assess patients for risk of suicide attempts.

Education, Licenses, and Certifications

- Nationally, 64 percent of Mental Health Counselors have a master's degree. Another 34 percent have a bachelor's degree, and about one percent have an associate degree.
- This occupation requires a license to practice at the professional level.
- Mental Health Counselors may be certified in a variety of different specialties.

*Source: Adapted from Occupational Information Network, U.S. Department of Labor, Employment and Training Administration.

*Source: Adapted from Occupational Information Network, U.S. Department of Labor, Employment and Training Administration.

*Source: Adapted from Occupational Information Network, U.S. Department of Labor, Employment and Training Administration.

Demographic Information on Mental Health Counselors

Table 5a: Age Distribution of Licensed Professional Counselors and Licensed Professional Clinical Counselors, by Minnesota Region

Region	Less than 35 years	35-44 years	45-54 years	55-64 years	65 years +
Central	34%	29%	22%	8%	6%
Northeast	28%	35%	18%	17%	2%
Northwest	24%	35%	23%	15%	3%
Twin Cities	30%	31%	20%	16%	4%
Southeast	31%	22%	21%	21%	5%
Southwest	29%	30%	21%	14%	6%
Statewide	**30%**	**30%**	**21%**	**15%**	**4%**
U.S., All Occupations	**34%**	**22%**	**23%**	**16%**	**5%**

Sources: Minnesota Board of Behavioral Health Therapy, 2014. Percentages above are based on 1,095 licensees.

Age distribution in all occupations in the U.S. comes from the Current Population Survey, Employed Persons by Detailed Occupation and Age, 2011 (http://www.bls.gov/cps/occupation_age.htm)

Table 5b: Gender of Licensed Professional Counselors and Licensed Professional Clinical Counselors, by Minnesota Region

Region	Male	Female
Central	16%	84%
Northeast	15%	85%
Northwest	12%	88%
Twin Cities	20%	80%
Southeast	17%	83%
Southwest	16%	84%
Statewide	**18%**	**82%**

Source: Minnesota Board of Behavioral Health Therapy, 2014.
Percentages above are based on 1,095 licensees.

Note: no data on race are available for Minnesota Licensed Professional Counselors or Licensed Professional Clinical Counselors.

Supply of Mental Health Counselors

Table 5c: Number of Mental Health Counselors who are Licensed and Employed, by Region and Statewide

Minnesota Region	Number of Minnesota Licenses (LPCs and LPCCs)*	Number Employed**
Central	120	110
Northeast	59	170
Northwest	60	290
Minneapolis/St. Paul	666	1,390
Southeast	99	110
Southwest	62	80
Statewide	**1,066**	**2,180**

*Source: Source: Minnesota Board of Behavioral Health and Therapy, 2014. Percentages above are based on 1,095 licensees.

**Source: Minnesota Department of Employment and Economic Development, Labor Market Information Office, second quarter 2013. Includes both licensed and non-licensed counselors.

Table 5d: Counseling-Related Program Completers 2012,
Master's Degree and Higher, Minnesota, Iowa, North Dakota, South Dakota, and Wisconsin

Program/Institution	Award Level	Number of Completers
Minnesota, Mental Health Counseling/Counselor		**262**
Capella University	Master's degree	262
North Dakota, Mental Health Counseling/Counselor		**5**
University of Mary	Master's degree	5
Wisconsin, Mental Health Counselor/Counselor		**26**
University of Wisconsin-Stout	Master's degree	16
Marquette University		10
Minnesota, Substance Abuse/Addiction Counseling		**170**
Hazelden Graduate School of Addiction Studies	Master's degree	78
Capella University	Master's degree	3
Capella University	Post-baccalaureate certificate	75
University of Minnesota-Twin Cities	Post-baccalaureate certificate	7
Saint Cloud State University	Post-baccalaureate certificate	6
Winona State University	Post-baccalaureate certificate	1
North Dakota, Substance Abuse/Addiction Counseling		**1**
University of Mary	Master's degree	1
South Dakota, Substance Abuse/Addition Counseling		**6**
University of South Dakota	Master's degree	2
University of South Dakota	Post-baccalaureate certificate	4
Minnesota, Counseling Psychology		**28**
Saint Cloud State University	Master's degree	28
Minnesota, Counselor Education/School Counseling and Guidance Services		**228**
Minnesota State University Mankato	Doctor's degree	1
Capella University	Doctor's degree	2
Capella University	Master's degree	122
Minnesota State University Moorhead	Master's degree	15
Minnesota State University-Mankato	Master's degree	36
Saint Cloud State University	Master's degree	17
Winona State University	Master's degree	35

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less. Note: there were no Counseling-related program completers from Iowa. There were no completers of Clinical Pastoral Counseling/Patient Counseling programs.
Note: It is not known how many Capella completers reside in and/or intend to practice in Minnesota.
Note: Programs with completers who are eligible to become LPCCs are included in this table. It is not known how many completers choose that area of practice.

Demand for Mental Health Counselors

Table 5e: Current Occupational Demand Indicators for Mental Health Counselors, by Region

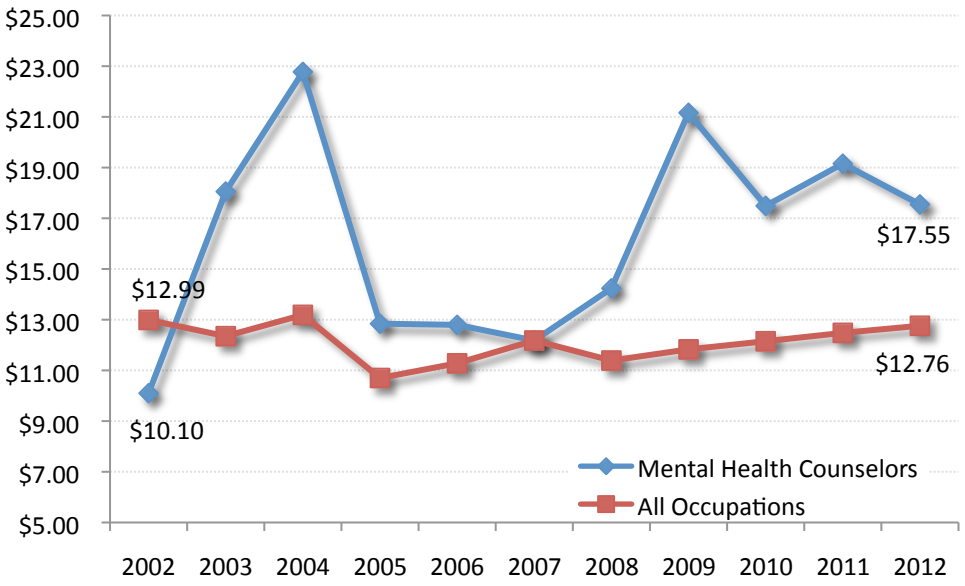
Area	Current Employment*	Number of Job Vacancies**	Job Vacancy Rate**	Occupations in Demand Indicator (1=Low; 5=High)†
Central	110	N/A	N/A	3-5
Northeast	170	N/A	N/A	5
Northwest	290	N/A	N/A	4-5
Twin Cities	1,390	96	6.9%	5
Southeast	110	N/A	N/A	5
Southwest	80	N/A	N/A	N/A
Statewide, Mental Health Counselors	**2,180**	**150**	**6.9%**	**5**
Statewide, All Occupations	**2,641,110**	**72,569**	**2.8%**	**Not calculated**

*Source: Minnesota Department of Employment and Economic Development, Occupational Employment Statistics; Second Quarter 2013

**Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey; Second Quarter 2013

†Source: Minnesota Department of Employment and Economic Development, Occupations In Demand; data updated in June, 2013. Data are produced by economic development region (13 regions); therefore, the table above presents the range of OID scores within the region.

Figure 5b: Wage Offers on an Hourly Basis for Mental Health Counselors, 2002-2012, Statewide



Source: Minnesota Department of Employment and Economic Development, Job Vacancy Survey. Wages are adjusted with the Consumer Price Index to reflect 2012 dollars.

Table 5f: Total Projected Openings and Projected Growth Rate for Mental Health Counselors, by Region and Statewide

Area	Total Projected Openings, 2010-2020	Projected Growth Rate, 2010-2020
Central	130	43.4%
Northeast	40	25.3%
Northwest	110	63.8%
Twin Cities	710	29.3%
Southeast	30	41.7%
Southwest	90	30.3%
Statewide, Mental Health Counselors	**1,130**	**34.0%**
Statewide, All Occupations	**1,041,750**	**13.0%**

Source: Minnesota Department of Employment and Economic Development, Occupational Employment Projections.

Advanced Practice Psychiatric Nurses

Summary Information about Advanced Practice Psychiatric Nurses*

Occupational Description
Provide advanced nursing care for patients with psychiatric disorders. May provide psychotherapy under the direction of a psychiatrist.

Sample of Reported Job Titles
Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Psychiatric Clinical Nurse Specialist

Selected Job Duties

- Diagnose psychiatric disorders and mental health conditions.
- Distinguish between physiologically and psychologically based disorders and diagnose appropriately.
- Assess patients' medical and physical status based on presenting symptoms and complaints.
- Conduct individual, group, or family psychotherapy for those with chronic or acute mental disorders.

Monitor patient's medication usage and results; may prescribe medication consistent with state scope of practice regulations.

Education, Licenses, and Certifications

- Nationally, 96 percent of workers in this occupation have a master's degree, and the remaining 4 percent have a doctorate or professional degree.

*Source: Occupational Information Network, U.S. Department of Labor, Employment and Training Administration.
Note: Entry to practice will be at the doctoral level as of 2015.

Demographic Information on Advanced Practice Psychiatric Nurses

Table 6a: Age Distribution of Advanced Practice Psychiatric Nurses, by Minnesota Region

Region	Less than 35 years	35-44 years	45-54 years	55-64 years	65 years +
Central	13%	6%	25%	38%	19%
Northeast	12%	24%	18%	27%	18%
Northwest	9%	18%	26%	35%	12%
Twin Cities	8%	10%	20%	44%	18%
Southeast	14%	3%	26%	40%	17%
Southwest	13%	25%	13%	44%	6%
Statewide	**10%**	**12%**	**21%**	**40%**	**17%**
U.S., All Occupations	**34%**	**22%**	**23%**	**16%**	**5%**

Sources: Minnesota Board of Nursing, 2011-2012. Percentages above are based on 303 licensees.

Age distribution in all occupations in the U.S. comes from the Current Population Survey, Employed Persons by Detailed Occupation and Age, 2011 (http://www.bls.gov/cps/occupation_age.htm)

Table 6b: Gender of Advanced Practice Psychiatric Nurses, by Minnesota Region

Region	Male	Female
Central	6%	94%
Northeast	9%	91%
Northwest	0%	100%
Twin Cities	8%	92%
Southeast	0%	100%
Southwest	6%	94%
Statewide	**6%**	**94%**

Source: Minnesota Board of Nursing, 2011-2012. Percentages above are based on 303 licensees.

Table 6c: Race of Advanced Practice Psychiatric Nurses, by Minnesota Region

Region	American Indian	Asian	Black	White	Other
Central	0%	0%	0%	100%	0%
Northeast	0%	0%	0%	100%	0%
Northwest	5%	0%	0%	91%	5%
Twin Cities	0%	0%	1%	98%	1%
Southeast	0%	0%	0%	100%	0%
Southwest	0%	0%	0%	100%	0%
Statewide	1%	0%	1%	98%	1%

Source: Minnesota Department of Health, Office of Rural Health and Primary Care Workforce Survey, 2011. The percentages above are based on responses from the 180 survey respondents with a Minnesota mailing address who answered this question on the survey.

Supply of Advanced Practice Psychiatric Nurses

Table 6d: Number of Licensed Advanced Practice Psychiatric Nurses

Minnesota Region	Number of Minnesota APRNs
Central	32
Northeast	33
Northwest	34
Minneapolis/St. Paul	153
Southeast	35
Southwest	16
Statewide	**303**

Table 6e: Psychiatric/Mental Health Nursing Program Completers, 2012
Master's Degree and Higher, Minnesota, Iowa, North Dakota, South Dakota, and Wisconsin

Program/Institution	Award Level	Number of Completers
Minnesota, Psychiatric/Mental Health Nursing		**12**
The College of Saint Scholastica	Master's degree	6
The College of Saint Scholastica	Post-baccalaureate certificate	2
University of Minnesota	Doctorate of Nursing Practice	4
Iowa, Psychiatric/Mental Health Nursing		**11**
Allen College	Post-master's certificate	2
Allen College	Master's degree	9
North Dakota, Psychiatric/Mental Health Nursing		**1**
University of North Dakota	Post-baccalaureate certificate	1

Source: National Center for Education Statistics, Integrated Postsecondary Data System (IPEDS). Excludes completers who complete award levels of Bachelor's degree or less.

Demand for Advanced Practice Psychiatric Nurses

****There is no demand data for APRNs because this is not a Bureau of Labor Statistics SOC category.****

Appendix A: Data Addendum

This data report was prepared by the Minnesota State Colleges and University Systems Office in collaboration with HealthForce Minnesota, the Minnesota Department of Health and the Minnesota Department of Employment and Economic Development and presented to the Mental Health Workforce Steering Committee in March 2014. The Steering Committee used the report as a basis to develop a definition of the mental health workforce as well as to define benchmarks against which recommendations could be measured.

This report was sent out to the 2014 Mental Health Summit participants. As a result, recommendations were made to amend the report. Those updates and amendments have been incorporated into the state plan. Budget constraints made it impossible to rewrite the data report, however. Changes are listed below.

1. Demographic data on race AND ethnicity has been updated and includes Hispanic/Latino.

Advanced Practice Psychiatric Nurses—Race

RACE	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
American Indian	0.0%	0.0%	4.5%	0%	0%	0%	0.5%
Black	0.0%	0.0%	0.0%	1.1%	0%	0%	0.5%
White	100.0%	90.0%	90.9%	93.5%	100%	90%	94.1%
Other	0.0%	0.0%	4.5%	1.1%	0%	0%	1.1%
Unknown— No Survey Response	0.0%	10.0%	0.0%	4.3%	0%	10%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Minnesota Department of Health, Nursing Workforce Survey, 2011-2012. Note that there were 303 Psychiatric APRN license renewals during this time period. The data above come from 187 survey respondents with Minnesota mailing addresses.

Advanced Practice Psychiatric Nurses—Ethnicity

Ethnicity	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
Hispanic/Latino/ Spanish Origin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not Hispanic	100.0%	90.0%	100.0%	95.7%	100.0%	90.0%	96.3%
Unknown— No Survey Response	0.0%	10.0%	0.0%	4.3%	0.0%	10.0%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Minnesota Department of Health, Nursing Workforce Survey, 2011-2012. Note that there were 303 Psychiatric APRN license renewals during this time period. The data above come from 187 survey respondents with Minnesota mailing addresses.

Psychiatrists—Race

RACE	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
American Indian	0.0%	0.0%	0.0%	0%	2.2%	0.0%	0.3%
Asian	4.0%	0.0%	8.3%	6.9%	2.2%	14.3%	6.0%
Black	0.0%	0.0%	0.0%	2.9%	2.2%	0.0%	2.3%
White	80.0%	88.9%	75.0%	77.9%	82.2%	71.4%	78.8%
Other	4.0%	0.0%	0.0%	2.0%	2.2%	0.0%	2.0%
Multi-racial	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.3%
Unknown— No Survey Response	12.0%	11.1%	16.7%	9.8%	9%	14.3%	10.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%%	100.0%

Psychiatrists—Ethnicity

Ethnicity	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
Hispanic/Latino/ Spanish Origin	4.0%	11.1%	0.0%	3.4%	2.2%	0.0%	3.2%
Not Hispanic	84.0%	77.8%	83.3%	88.2%	91.1%	85.7%	88.7%
Unknown— No Survey Response	12.0%	11.1%	16.7%	8.3%	6.7%	14.3%	8.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Minnesota Department of Health Physician Workforce Survey, 2013. Note that there were 670 licensed physicians with a psychiatric specialty or subspecialty. The data above come from 406 survey respondents with Minnesota business addresses.

Licensed Marriage and Family Therapists—Race

RACE	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
American Indian	0.0%	0.0%	0.0%	.5%	3.1%	0.0%	0.5%
Asian	1.1%	0.0%	2.7%	2.4%	0.0%	0.0%	2.0%
Black	0.0%	0.0%	0.0%	3.0%	0.0%	0.0%	2.2%
White	92.0%	76.9%	94.6%	85.2%	87.5%	92.5%	86.5%
Other	1.1%	3.8%	0.0%	1.9%	0.0%	0.0%	1.8%
Multi-racial	0.0%	11.5%	0.0%	1.7%	0.0%	2.5%	1.6%
Unknown— No Survey Response	5.7%	7.7%	2.7%	5.2%	9.4%	5.0%	5.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%%	100.0%

Source: Minnesota Department of Health LMFT Survey, 2012. Note that there were 1,578 licensed physicians with a psychiatric specialty or subspecialty. The data above come from 853 survey respondents with Minnesota mailing addresses.

Licensed Marriage and Family Therapists—Ethnicity

Ethnicity	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
Hispanic/Latino/ Spanish Origin	1.1%	3.8%	0.0%	1.1%	0.0%	0.0%	1.1%
Not Hispanic	92.0%	84.6%	97.3%	91.4%	87.5%	97.5%	92.0%
Unknown— No Survey Response	6.8%	11.5%	2.7%	7.5%	12.5%	2.5%	7.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Minnesota Department of Health LMFT Survey, 2012. Note that there were 1,578 licensed physicians with a psychiatric specialty or subspecialty. The data above come from 905 survey respondents with Minnesota mailing addresses.

Social Workers—Race

RACE	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
American Indian	0%	2%	1%	0%	0%	0%	0%
Asian	1%	1%	1%	2%	1%	0%	1%
Black	0%	0%	0%	3%	0%	1%	2%
White	94%	89%	93%	88%	94%	97%	90%
Other	1%	0%	0%	1%	1%	0%	1%
Multi-racial	1%	3%	2%	2%	1%	0%	2%
Unknown— No Survey Response	3%	5%	3%	5%	3%	1%	4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%%	100.0%

Social Workers—Ethnicity

Ethnicity	Central	Northeast	Northwest	Minneapolis/ St. Paul Metro	Southeast	Southwest	Total (Statewide)
Hispanic/Latino/ Spanish Origin	0%	0%	1%	1%	2%	1%	1%
Not Hispanic	95%	95%	96%	92%	93%	96%	94%
Unknown— No Survey Response	5%	4%	3%	6%	5%	3%	5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Minnesota Department of Health Social Worker Survey, 2012-2013. There were a total of 12,125 social workers licensed in Minnesota (including all four social work license types LICSWs, LGSWs, LISWs, and LSWs). The data above come from 6,788 social workers who responded to the MDH survey (for an overall survey response rate of 56 percent).

2. Page, 54. Graduate counseling programs are also offered at:

Additions to Table 5d: Counseling-Related Program Completers 2012

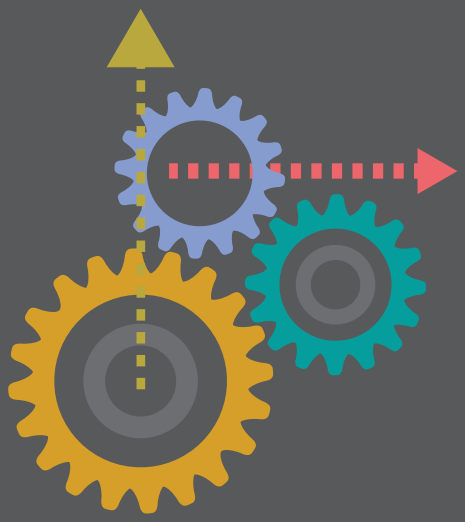
Program/Institution	Award Level	Number of Completers
Minnesota, Counseling Psychology		
Bethel University	Master's degree	27
Saint Thomas University	Master's degree	60
Minnesota, Counseling and Psychological Services		
Saint Mary's University	Master's degree	66
Minnesota, Adler Graduate School		
Clinical Mental Health Counseling	Master's degree	71

3. Report revised and item deleted.

4. Social Workers: The Minnesota Board of Social Work is authorized by law to issue four licenses: 1) Licensed Social Workers (LSW), Licensed Graduate Social Worker (LGSW), Licensed Independent Social Worker (LISW), and Licensed Independent Clinical Social Worker (LICSW). The Board currently regulates 13,347 licensees, as of June 30, 2014. For the purpose of this report the data is focused on three of the four social work licenses authorized by the Board to engage in "clinical" scope of social work practice, including differential diagnosis and treatment. These include the LGSW, LISW, and LICSW, which comprise a total of 6,395 licensees for the purpose of this report data (which is 7,533 licensees of June 30, 2014).

5. Social Workers: While the data in this report do not include the LSW bachelors social work license, these licensed professionals serve a critical role in the "mental health workforce" in the State of Minnesota. The Board licenses 5,814 LSWs as of June 30, 2014. While not authorized to engage in "clinical social work practice", LSWs work in a variety of agencies such as schools, hospitals, nursing homes, private non-profit agencies, and county social service agencies. They provide assessment, intervention, case management, client education, counseling, crisis intervention, referral, advocacy, development and administration of social service programs and policies, and community organization. They work with some of the most vulnerable populations and serve a vital role in the social service delivery system and the "mental health workforce".

6. To be licensed as a social worker in Minnesota applicants must obtain a bachelors or graduate degree in social work from an academic institution accredited by the Council on Social Work Education (CSWE).



Appendix B:
Mental Health Workforce Community Forums

Appendix B:
Mental Health Workforce Community Forums

Held Between February and May 2014

FORUM LOCATIONS

Bemidji
Brainerd
Duluth
Grand Rapids
Mankato
Metro Twin Cities (3)
Northfield
Pine City
Rochester
St. Cloud
Willmar
Worthington

PRESENTATIONS

State Operated Community Services
MN Chapter of American Psychiatric Assn.
MN Assn. of Community Mental Health Programs
MN Coalition of Licensed Social Workers
Native American Mental Health Advisory Council
Healthcare Education Industry Partnership

FORUM ATTENDEES

Providers	**146**
Educators	**68**
Family Members/Consumers	**19**
School Districts	**24**
State Agency or Board	**11**
Students	**18**
Elected official	**1**
Law enforcement	**2**
Licensing Board	**2**
Foundation	**1**
Media	**1**
TOTAL	**293**

	Bemidji	Brainerd	Duluth	Grand Rapids	Mankato	Metro-Bloomington	Metro-N. Mpls.	Metro-St. Paul
Providers	18	12	7	10	10		16	18
Educators	5	3	3	4	2	1	2	4
Family	2	1	1	3			1	1
School Districts	0	1	3	4	5			2
State Agency	1	1	2	1	0			2
Student in MH Program	7		2		1		3	
Law Enformcement	1							
Licensing Board					1	1		
Media								
Foundation								
Elected Official				1				
TOTAL	34	18	18	23	19	18	6	27

	Northfield	Pine City	Rochester	St. Cloud	Willmar	Worthington
Providers	5	9	13	10	9	9
Educators	2	11	10	17	2	2
Family	2	4	2	1		1
School Districts	1	5	2	1		
State Agency				3	1	
Student in MH Program			5			
Law Enforcement		1				
Licensing Board						
Media		1				
Foundation					1	
Elected Official						
TOTAL	10	31	32	32	13	12

CONCERNS/OBSERVATIONS

Finances
- Low wages
- Low reimbursement rates, especially in rural areas
- Cost of education
- Because travel time to see clients is not reimbursable, rural areas find the economics of providing care quite challenging.
- Need paid reimbursable time for supervision to create a learning culture in agencies.
- Raise reimbursement rates so wages can rise.
- Need more loan forgiveness programs.
- Wages for mental health workers on the reservation aren't competitive so good people leave for the county positions.
- Difficulty of developing long term strategies (which is needed) when dependent on a biennial budget to make decisions.
- Supervisory hours for licensure are too expensive for employers and licensees.

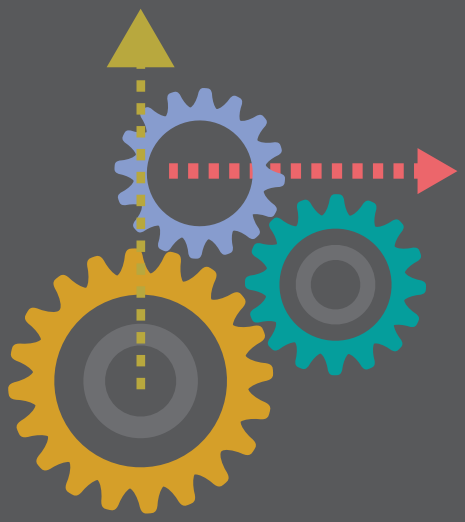
Recruitment
- Hard to find mental health care workers even in non-designated "shortage" areas
- Education needs to be brought to the students in rural areas if we want them to stay and work in rural areas.
- Develop job shadowing opportunities in community mental health clinics.
- Look at housing incentives as a way to recruit workforce to rural areas

Working conditions
- Paperwork

Implementation
- Recommendations have to be followed up with money and resources and a timeline for implementation.

Education and Training
- Explain and popularize role of Certified Peer Specialist.
- More MH training is needed for law enforcement, along with a budget to pay for it.
- Develop a certificate for direct care mental health workers.
- Develop a certificate for adult foster care workers.
- All group home workers should have more mental health education/training.
- Need more specialists in the schools.
- More interpreters and bi-lingual professionals and practitioners.
- Incorporate cultural diversity training into all curricula.
- More and better education and training on substance abuse/mental health (dual diagnosis) for all.
- All primary care providers should have a mental health educational base to recognize and deal appropriately with symptoms.
- Explore credit for prior learning for DHS and NAMI classes and certifications.
- More internships as part of bachelor's and master's social work training.
- Create equivalencies for supervision among disciplines for masters licensed professionals.
- Need for better de-escalation training.

Access to care
- Acute bed shortage
- Need for same day/next day appointments
- Stigma
- Housing and transportation needs of clients
- Extreme difficulty in finding services for children and young children
- Integrate behavioral health with primary health care—it works on the Bemidji State University campus



Appendix C:

2014 Mental Health Workforce Survey Results

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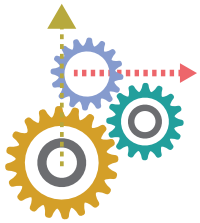
2014 Mental Health Workforce Survey Results



Survey Instrument
Survey Questions: Charts
Survey Open-ended Questions

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Survey Description

The Minnesota Legislature has asked for a state mental health workforce development plan to be created that increases the number of mental health workers at all levels, ensures appropriate education and training and creates a more culturally diverse mental health workforce.

We would like your input. This survey is intended for people who live with a mental illness, family members and parents, providers, educators, advocates, professionals and others who have a stake in the mental health system.

We have chosen to use one survey rather than break it into multiple surveys for different groups...so if a question does not apply to you, just skip over it. That's perfectly OK!

We want and need your ideas and experience to help develop this state plan.

Thank you for your time!

1. Based on your experience, which three of the following mental health professionals are the most difficult to access? (You may choose 3 from the list below.)

- [ ] Psychiatrists
- [ ] Advanced Practice Psychiatric Nurse Practitioners/Clinical Nurse Specialists
- [ ] Psychologists
- [ ] Licensed Independent Clinical Social Workers
- [ ] Licensed Professional Clinical Counselors
- [ ] Marriage and Family Therapists
- [ ] Not Applicable

2. If you are an employer of mental health professionals, what successful strategies have you used to recruit and retain mental health professionals?

3. What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

4. How long does it typically take your organization to fill an open position for a mental health professional (from the time the position becomes open to the time it is filled and the professional is working)?

	1-3 months	3-6 months	6-9 months	9-12 months	1 year or more
Psychiatrist	☐	☐	☐	☐	☐
Advanced Practice Psychiatric Nurse Practitioner/Clinical Nurse Specialist	☐	☐	☐	☐	☐
Psychologist	☐	☐	☐	☐	☐
Licensed Independent Clinical Social Worker	☐	☐	☐	☐	☐
Licensed Professional Clinical Counselor	☐	☐	☐	☐	☐
Marriage and Family Therapist	☐	☐	☐	☐	☐
Not Applicable	☐	☐	☐	☐	☐

Other occupation

5. In what areas do you think mental health professionals and practitioners need more education and preparation?

- ☐ Evidence-based practices
- ☐ Recovery
- ☐ Family engagement
- ☐ Integrated Dual Diagnosis Treatment
- ☐ Cultural Competence
- ☐ Integrated behavioral health
- ☐ Trauma
- ☐ De-escalation techniques
- ☐ Supervisory skills
- ☐ Diagnostic skills
- ☐ Working on teams and across agencies
- ☐ Administrative "paperwork" requirements

Other (please specify)

6. What steps do you think could be taken to ensure they receive this education and preparation?

7. What ideas do you have to make education and training more accessible and effective?

8. In what settings might peer and family specialists be used?

9. What suggestions do you have to create a more culturally competent workforce?

10. What ideas do you have to create a more culturally diverse workforce?

11. Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

12. What is your role? Check all that apply.

- [ ] Mental Health Professional
- [ ] Mental Health Practitioner
- [ ] Mental Health Support Staff
- [ ] Educator, including special education
- [ ] Peer Specialist
- [ ] Executive Director/CEO
- [ ] Superintendent
- [ ] Principal
- [ ] Special Education Director
- [ ] Community Health Worker
- [ ] Advocate
- [ ] Live with a mental illness
- [ ] Family member
- [ ] County social worker/case manager
- [ ] Health care provider

Other (please specify)

13. In what setting do you work?

- [ ] State operated facility
- [ ] Hospital
- [ ] IRTS (Intensive Residential Treatment Services)
- [ ] Adult day treatment
- [ ] Adult partial hospitalization
- [ ] Community mental health center
- [ ] Community mental health provider
- [ ] Corporate foster care
- [ ] Children's residential
- [ ] Children's day treatment
- [ ] Children's partial hospitalization
- [ ] School
- [ ] County
- [ ] Health care clinic
- [ ] Health plan

Other (please specify)

14. Where in the state are you located?

- ◯ Twin Cities
- ◯ Central
- ◯ Northeastern
- ◯ Northwestern
- ◯ Southeastern
- ◯ Southwestern

15. Please specify your ethnicity.

- ◯ White
- ◯ Hispanic or Latino
- ◯ Black or African American
- ◯ Native American or American Indian
- ◯ Asian / Pacific Islander
- ◯ Other

Other (please specify)

16. If you work in the mental health field, how many years have you been working there?

- ◯ less than one year
- ◯ 1-3 years
- ◯ 3-5 years
- ◯ 5-10 years
- ◯ 10-20 years
- ◯ more than 20 years

17. What is the highest degree you have attained?

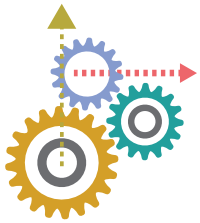
- ◯ High School
- ◯ B.A./B.S.
- ◯ B.S.N.
- ◯ M.S.N.
- ◯ APRN
- ◯ M.S.W.
- ◯ M.A./M.S.
- ◯ PsyD.
- ◯ Ed.D.
- ◯ Ph.D.
- ◯ M.D.

Other (please specify)

18. If you are a mental health professional, what is the principle type of setting in which you work?

- ◯ Solo or group independent practice
- ◯ Outpatient clinic
- ◯ School
- ◯ University
- ◯ Hospital
- ◯ Federally qualified health center
- ◯ Residential treatment facility
- ◯ Social service agency
- ◯ Nursing home
- ◯ Corrections setting
- ◯ Community-based program

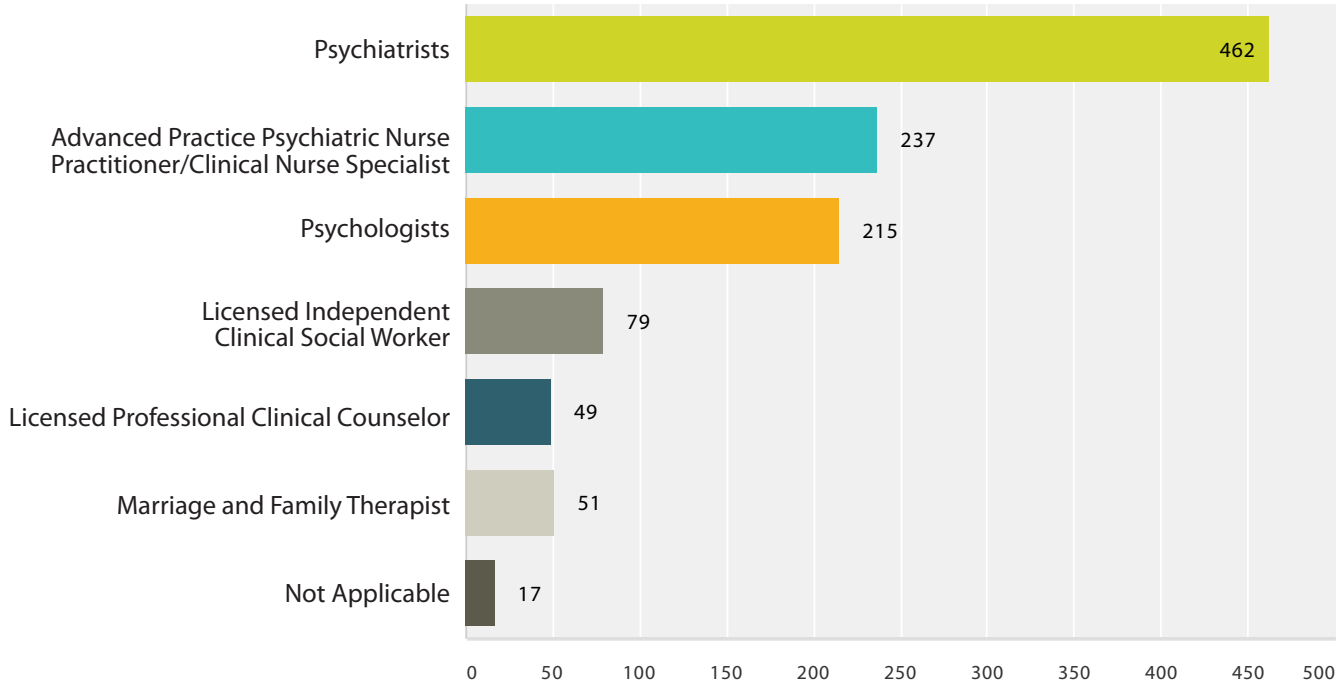
Appendix C:
Survey Results - Charts



CONTENTS

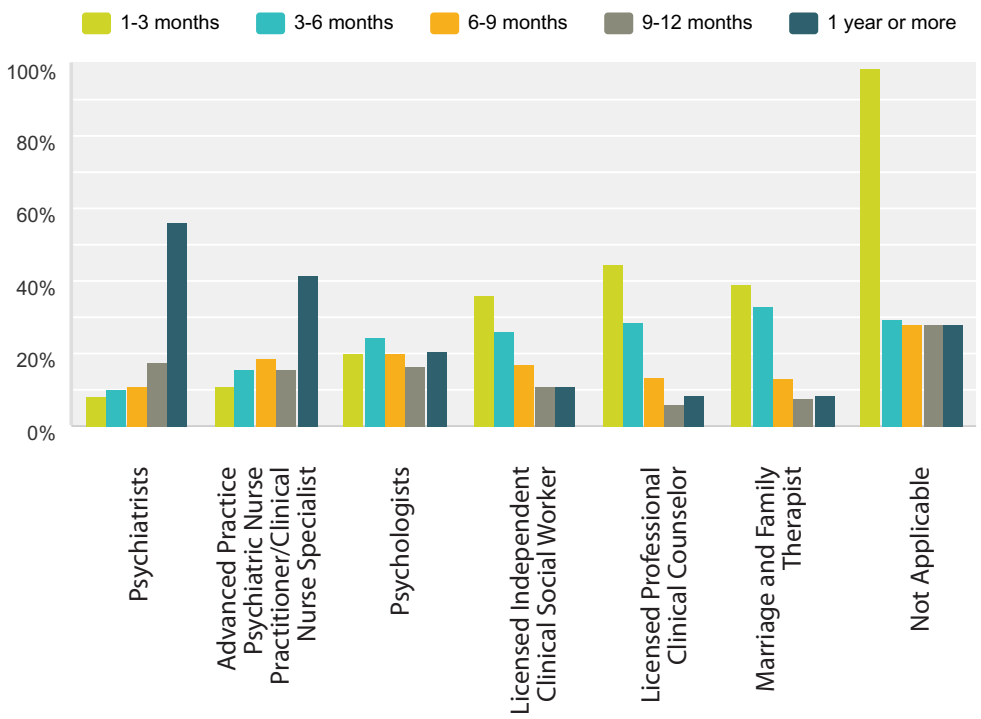
SURVEY QUESTION 1: Based on your experience, which three of the following mental health professionals are the most difficult to access? (You may choose 3 from the list below.)

Answered: 498 Skipped: 15



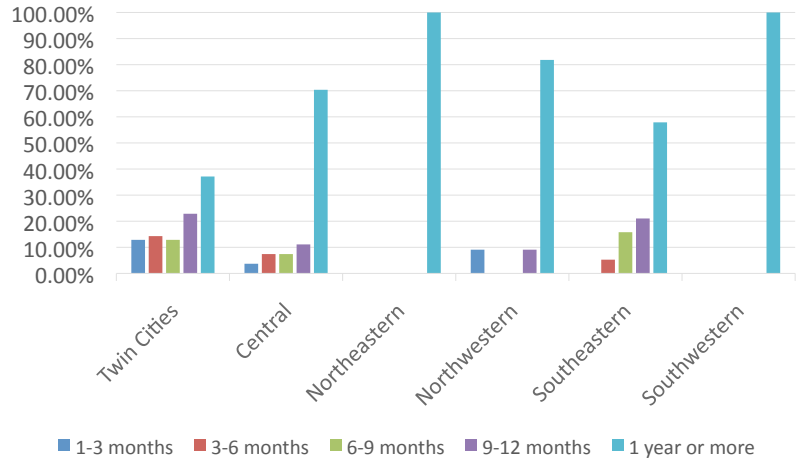
SURVEY QUESTION 4: How long does it typically take your organization to fill an open position for a mental health professional (from the time the position becomes open to the time it is filled and the professional is working)?

Answered: 261
Skipped: 252

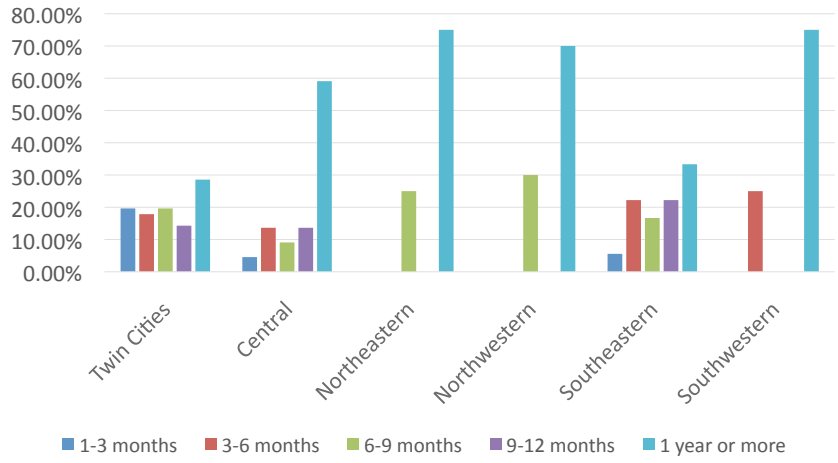


SURVEY QUESTION 4: Continued

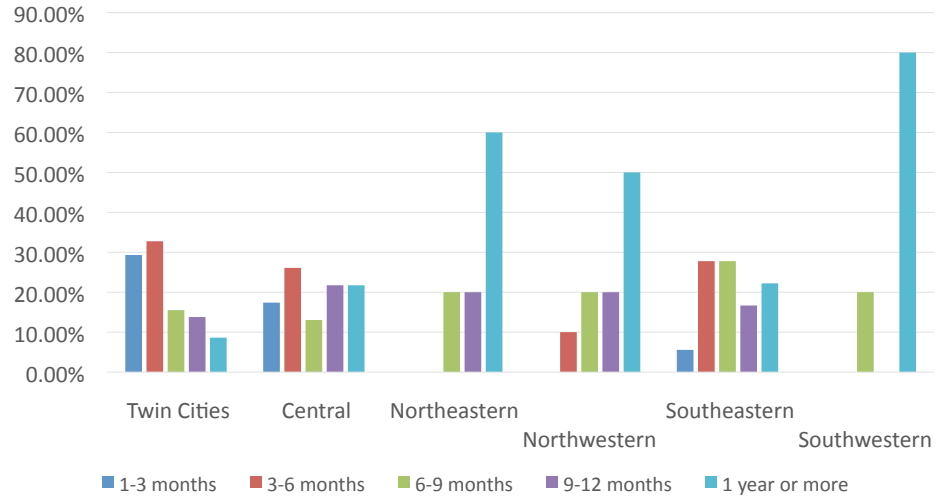
Perception of how long it takes to fill psychiatrist position



Perception of how long it takes to fill Psychiatric APRN position

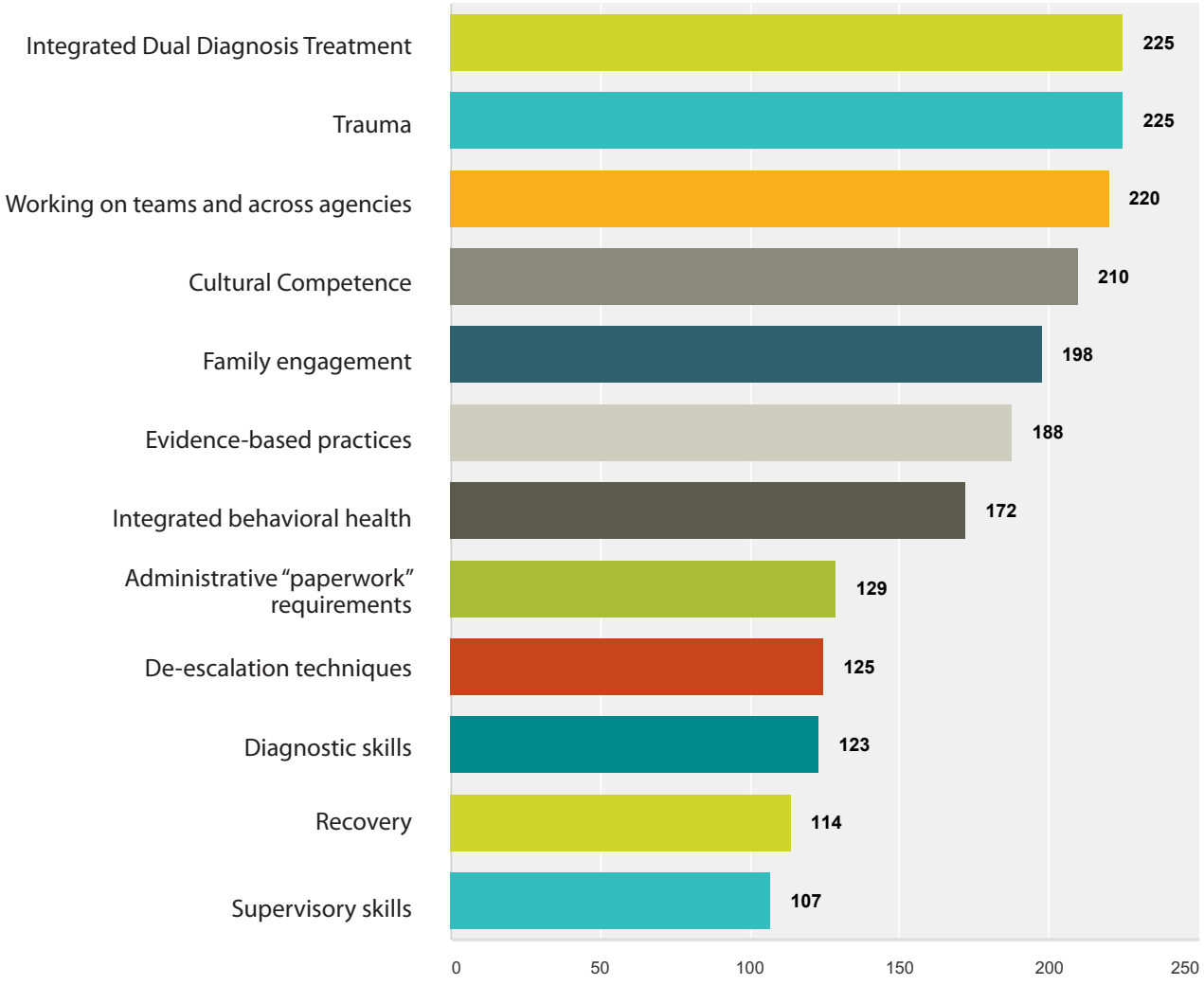


Perception of how long it takes to fill Psychologist position



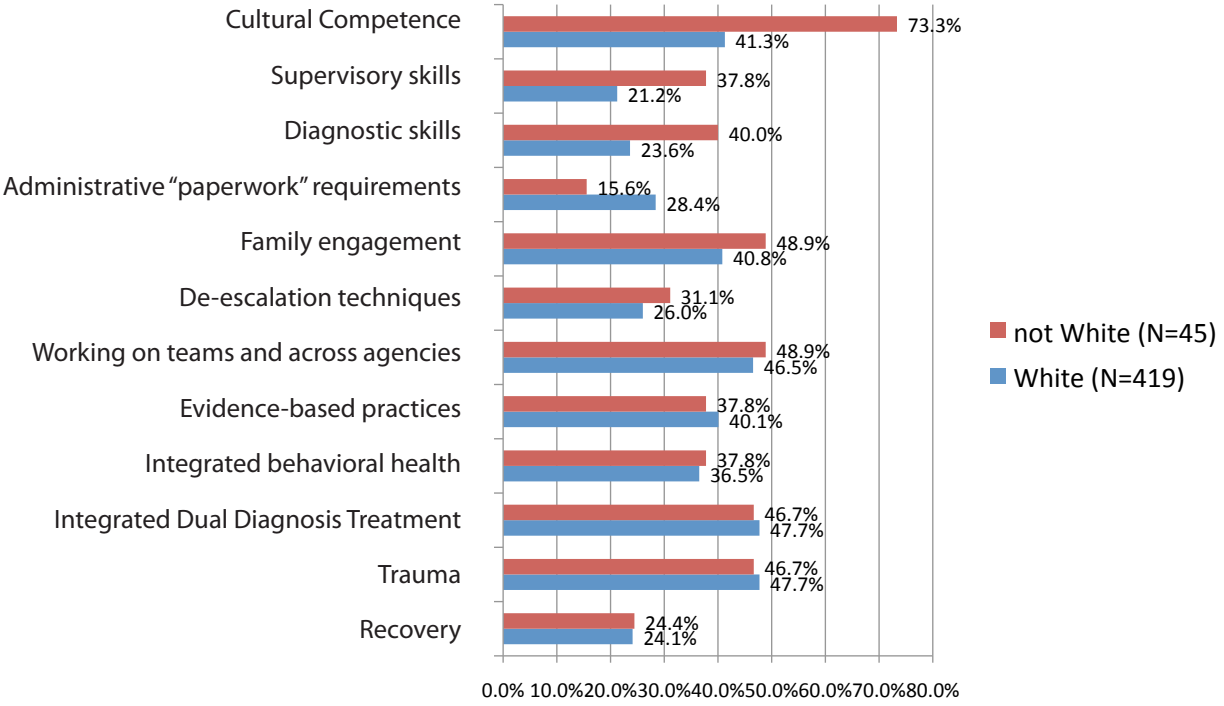
SURVEY QUESTION 5: In what areas do you think mental health professionals and practitioners need more education and preparation?

Answered: 476
Skipped: 37

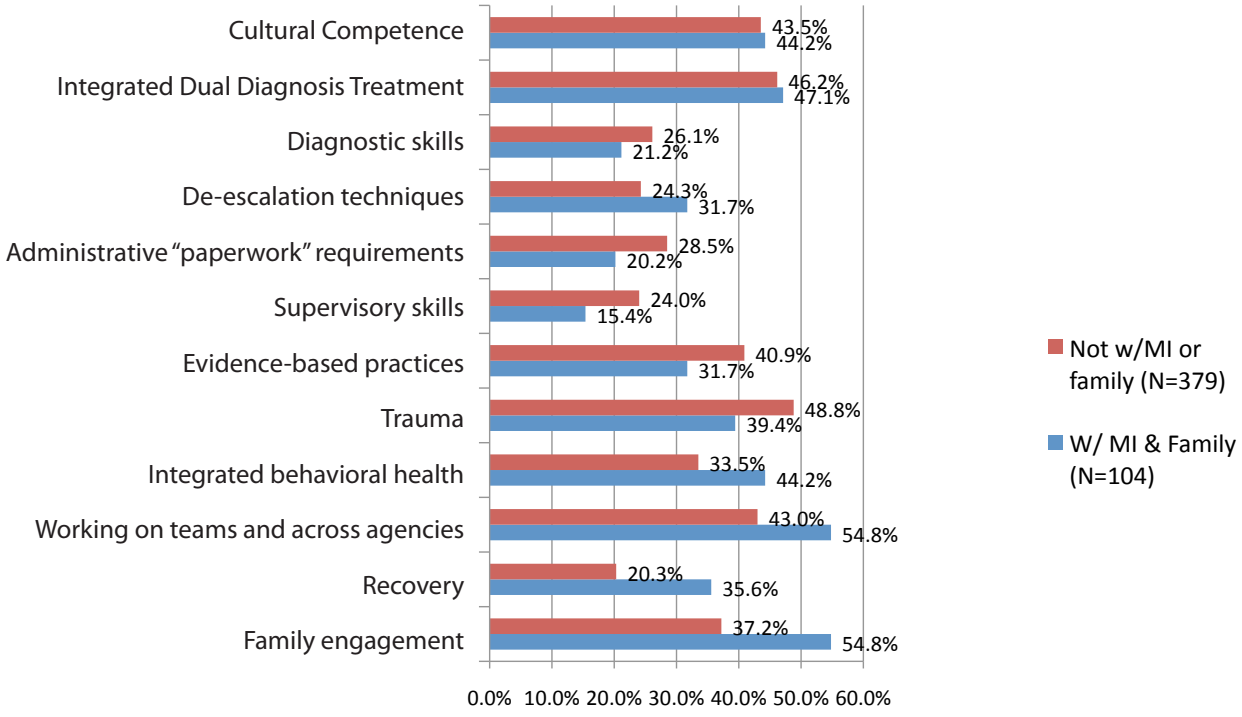


SURVEY QUESTION 5: Continued

In what areas do think more training is needed ? (White/ non White)

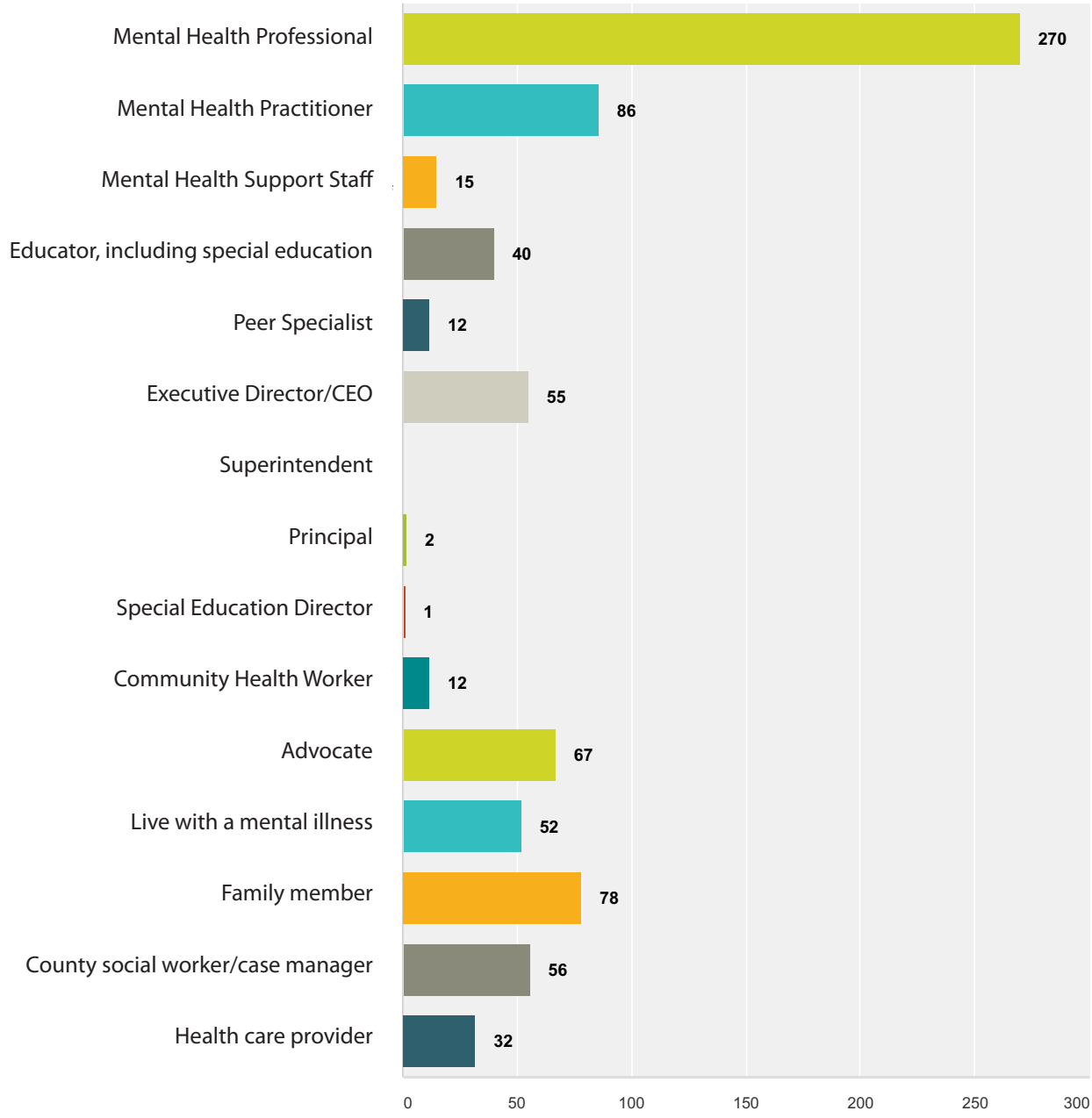


In what areas do think more training is needed ? (respondents with mental illness & family)



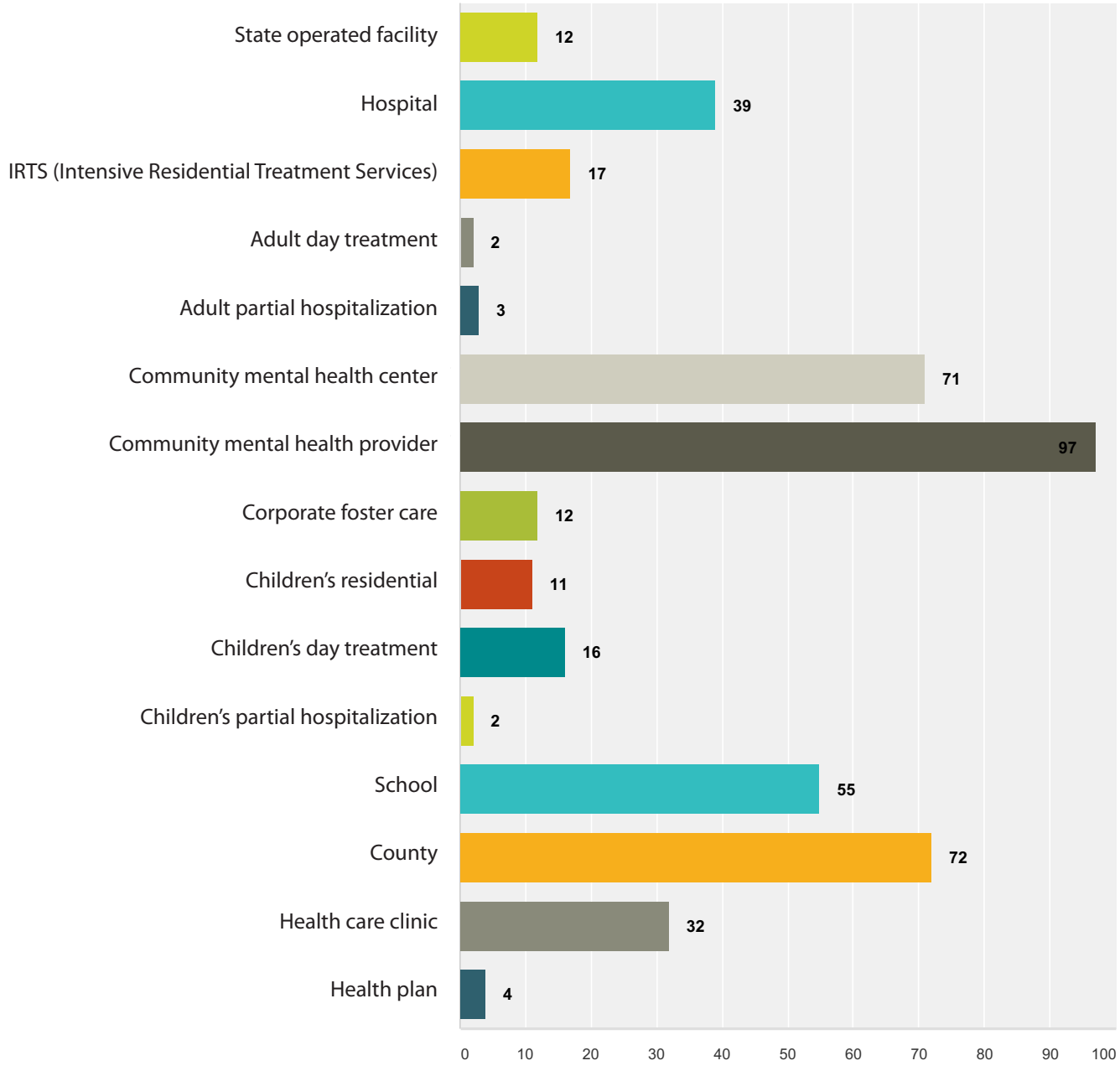
SURVEY QUESTION 12: What is your role? Check all that apply.

Answered: 470
Skipped: 43



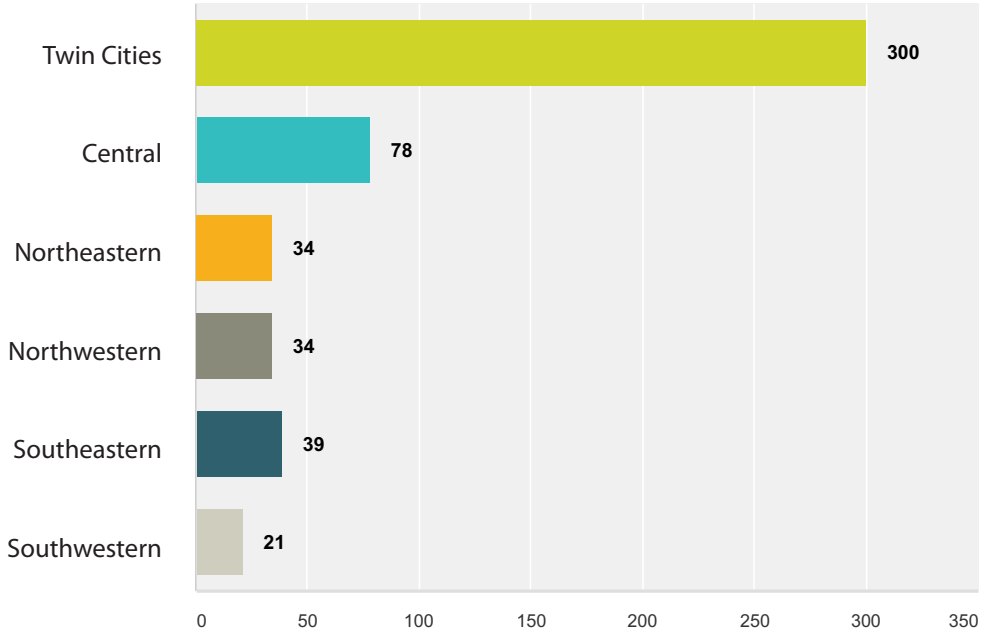
SURVEY QUESTION 13: In what setting do you work?

Answered: 362
Skipped: 151



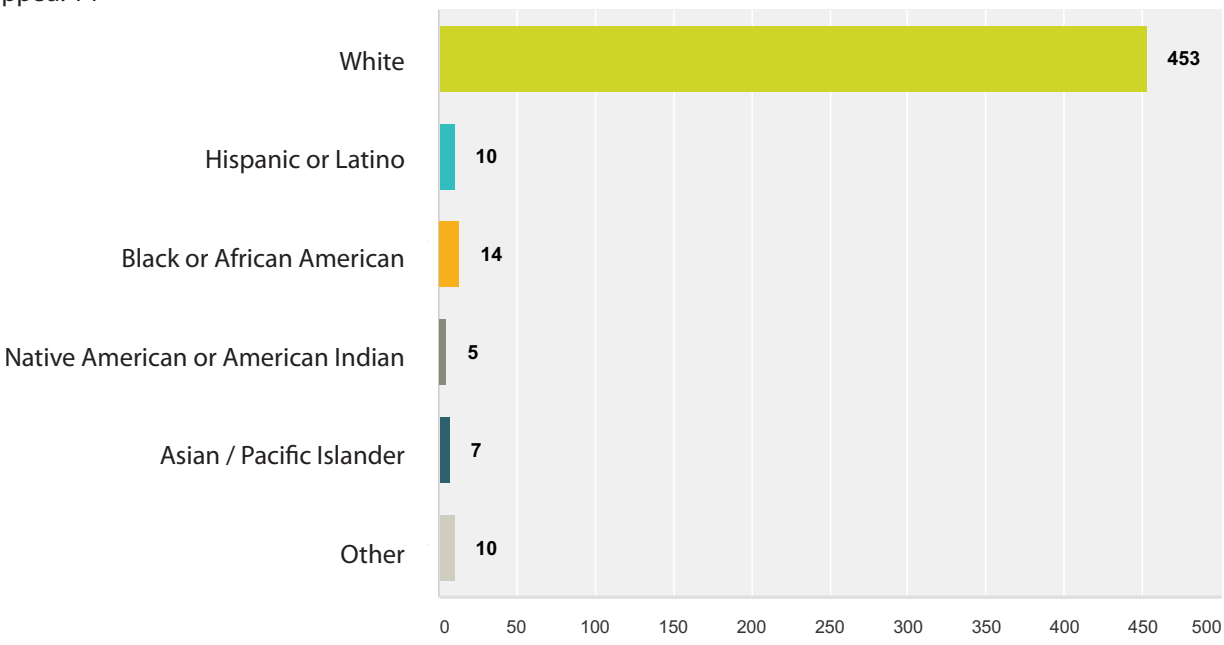
SURVEY QUESTION 14: Where in the state are you located?

Answered: 506
Skipped: 7



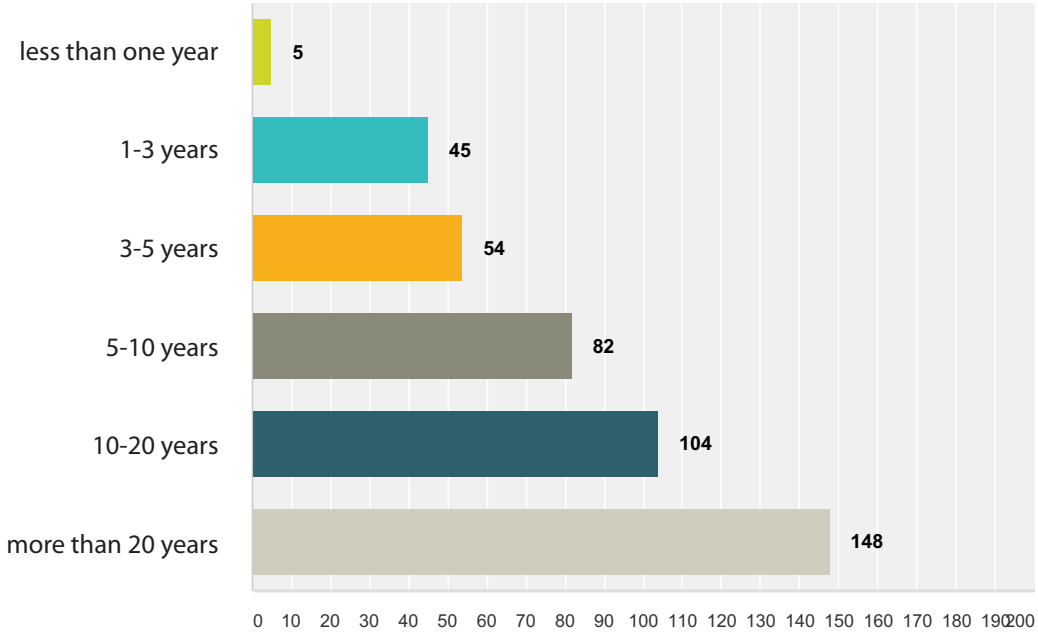
SURVEY QUESTION 15: Please specify your ethnicity.

Answered: 499
Skipped: 14



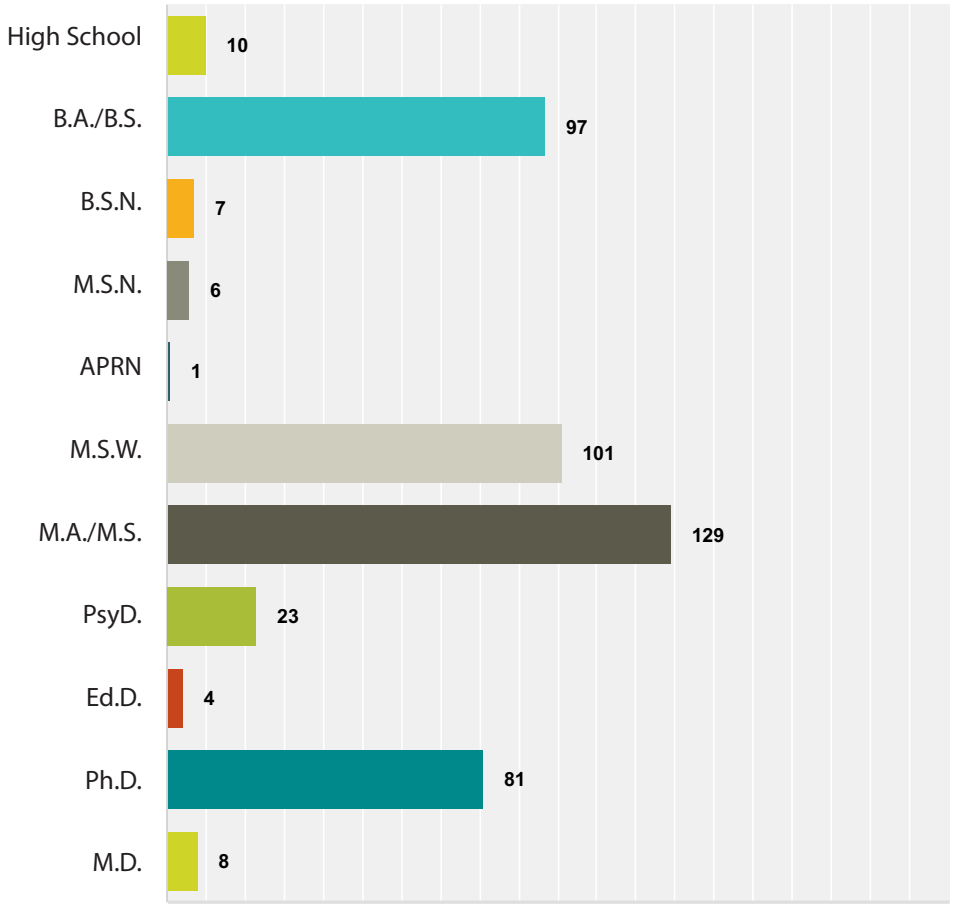
SURVEY QUESTION 16: If you work in the mental health field, how many years have you been working there?

Answered: 438
Skipped: 75



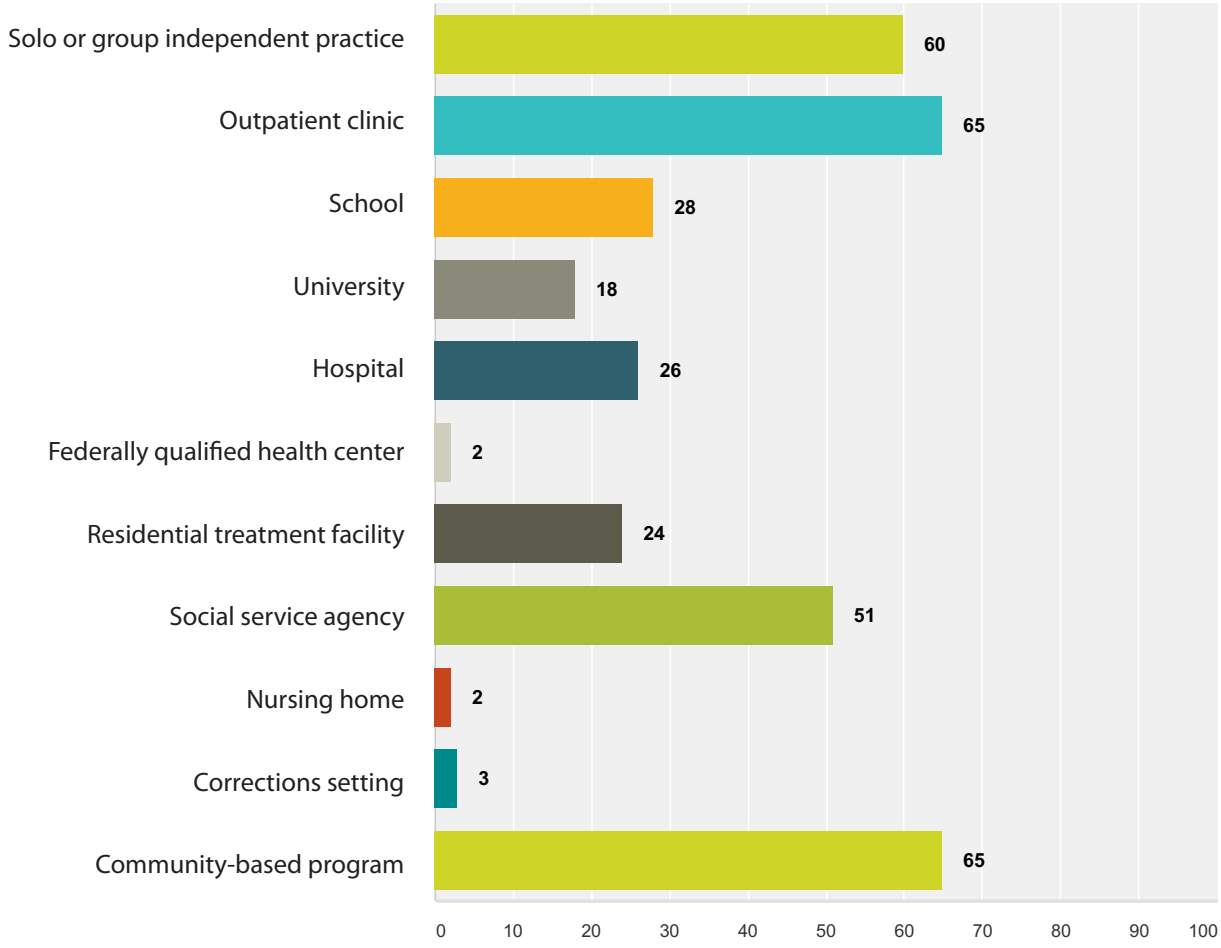
SURVEY QUESTION 17: What is the highest degree you have attained?

Answered: 467
Skipped: 46

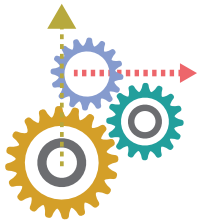


SURVEY QUESTION 18: If you are a mental health professional, what is the principle type of setting in which you work?

Answered: 344
Skipped: 169



Appendix C:
2014 Mental Health Workforce Survey Results



CONTENTS

SURVEY QUESTION 2: If you are an employer of mental health professionals, what successful strategies have you used to recruit and retain mental health professionals?

1	We use them on a consultation basis. Our recruitment methods have occurred through personal relationships with providers.
2	Providing training at all levels as a work force development strategy Using MN Council of Nonprofits website Willingness to hire both FT and PT staff - flexibility of hours for parents, etc.
3	Sign-on bonus; Student loan repayment through National Services Corp.; competitive salary; beautiful facilities
4	Does not apply (I am a consumer of mental health services plus a mental health advocate)
5	(I'll be answering from the standpoint of a rural behavioral health professional and consultant who has also been an administrator and educator.) Offer rural training experiences during their graduate years. The barrier is that this takes time from practicing professionals that decreases their billable hours, so it is hard for smaller rural organizations and practices to support.
6	Hire people from cultural communities.
7	better self care and more opportunity to work in their area of expertise and interest, opportunity to earn license by providing supervision
8	Start and run our own training programs (residencies and fellowships)
9	Our employees tend to stay because we provide a great collaborative supportive respectful environment.
10	(This agency doesn't employ MH professionals at the levels I've identified as most difficult to access.) Recruiting and retaining social workers, mental health case managers has not been difficult as this is a geographic area w/ qualified employees and limited employment opportunities
11	Train our own through licensing, pay well, provide flexibility, good benefits
12	meet their needs for support, salary, and time allowed per client.
13	flexibility of work schedule helps with young professionals
14	offer supervision
15	Offer excellent skill development opportunities as clinical volunteers.
16	Offering supervision and a supportive environment as part of their paid time, paying salary instead of only paying on billed hours
17	Providing great training programs. Many clinicians stay in the environment that they trained in.
18	Online advertising through niche organizations, direct mailings to licensed professionals, attending local/regional/national conferences, hiring incentives.
19	1. Economic considerations such as excellent salary and benefits 2. Consistent client referrals 3. Regular time for consultation and/or supervision and training experiences
20	not been successful
21	We currently have a contract with Ridgewater College which allows LPN's and RN's to complete their clinical rotation at our site. Current State of MN RN contract allows for some tuition reimbursement.
22	HR department recruits. Training important to staff is provided on site prior to beginning employment and ongoing in response to staff input wanting more training around clinical issues.
23	be flexible with meeting their needs - scheduling, transportation, allow them to work in ways that accommodate their lifestyles, provide support and training that they request
24	As a new psychologist in the area, who was looking for work, it was nearly impossible to find a job. I had to take a terrible position at a supposedly highbrow clinic that had a contract that was probably illegal. Finding a job as a psychologist in this area is critically bad at this point.
25	I have promise them a good living, a successful life, and very good professional support and care.
26	I have promise them a good living, a successful life, and very good professional support and care.
27	Offering internships

SURVEY QUESTION 2: If you are an employer of mental health professionals, what successful strategies have you used to recruit and retain mental health professionals?

28	Keeping the clinic small so that everyone knows everyone else and can feel like part of a family.
29	Compensation, other mental health list serves for recruiting or websites. For example psychology today
30	Flexible hours and wages. Be open to criticism and advice.
31	Networking and creating a positive work environment.
32	Contact universities to recruit graduates or provide internships which can turn into employment offers. It is difficult to find individuals who meet the requirements for Mental Health Practitioner status who are have the Bachelors degree and 2000 hours of experience (or 6000 with no degree) so many of our employees qualify with a Master's degree. There is often high turnover because most individuals with a Masters degree will not work long term for the lower wages we are forced to pay because of low reimbursement rates. Our best strategies for retention are providing a positive, understanding and supportive work environment, flexible scheduling and ongoing education.
33	Provide licensure supervision for clinical trainees
34	bi weekly meetings to help with stress and concerns among employees
35	Word of mouth for recruitment Stopping to talk with them from time to time about general life Sending a birthday card and telling them they are important to us We contract with our professionals. One has been with us since the 80's, the other since the 90's We also contracted with someone temporarily for overflow a few years ago and found them by word of mouth also
36	We employ MH case managers. In children's services the greatest obstacle is the times in which families and children can receive a visit, which is generally after hours.
37	employment agreements and financial incentives
38	Not an employer of MH professionals but we have used our funds to help recruit MH professionals. What has worked is helping to pay for their education in exchange for a commitment to serve our area when they complete their schooling.
39	word of mouth
40	Market appropriate salary ranges, benefits, paid CEUs, offer clinical supervision for those working toward terminal licensure
41	take into account the work place climate and financial and other benefits to make the position attractive. IT also means being sure that the person will be successful because i have decreased the risk for failure by knowing the strengths and weaknesses of the person.
42	DIFFICULT. Trying to recruit one now
43	Benefits, and for licensed professionals, access to clinical supervision. If we could offer all 8 hours needed for LICSW, LPCC, LMFT (and provide all the professionals needed for that), I think we'd keep people longer.
44	offering training opportunities, other internal incentives such as formalized praise, building strong internal teams
45	Networking
46	N/A. Our agency makes things flexible, which has kept me with them the past years.
47	Provided supervision; salary and benefit adjustments
48	Flexible workplace (flex schedules, hours) Competitive pay
49	The main strategy has been to use friends and professional contacts to find potential candidates. Once I find one, a lot of personal interaction explaining to the person the benefits of working for my agency...beyond salary or financial benefits...emphasizing professional development!
50	We are in a rural and remote area of Minnesota. We do have the loan forgiveness that is attractive but frustrating when you know that the person will most likely leave when their commitment is fulfilled. The best recruitment is to find people that want to be in this geographical area. Also, you need to hire when one comes along even if you have to grow the program after you hire.
51	Free supervision and extra stipend for those that have a LICSW

SURVEY QUESTION 2: If you are an employer of mental health professionals, what successful strategies have you used to recruit and retain mental health professionals?

52	Flexible, family friendly schedules and policies; support for on-going training and licensure costs;
53	We grow our own by providing internships and paying tuition and expenses for staff we send to advanced training.
54	None. Salary is an issue in Community Mental Health.
55	connect with schools of nursing advertise in more local newspapers that are culturally more specific
56	higher wages, better benefit packages, offered free supervision
57	Salaries that reflect higher education degrees and account for years of experience.
58	Provide free on the job supervision to attain licensure. Provide free ongoing trainings.
59	I am not currently an employer but effective strategies including having clinical consultation easily available; considering factors other than productivity in payment systems; having a mix of patient diagnosis to reduce burnout.
60	Multiple large newspapers, on-line.
61	small inpatient behavioral health unit that accepts and treats only voluntary patients, all working together as a team, all treat and work with inpatient and outpatient
62	My employer uses competitive healthcare, retirement and financial benefits. It also provides a generous PTO and vacation day package.
63	Our group size helps to reduce the frequency of call coverage responsibilities thereby providing a better work-life balance. Allowing providers to be .9 or .8 or .7 FTE is also helpful. Wages for our behavioral health professionals are generally subsidized by other programs. Payer mix and poor reimbursement make it difficult to cover the labor expenses in behavioral health.
64	Professional Development/CEU reimbursement funding each year, of up to approximately $1,500 for LICSW and higher for medical doctors or PHD level licensure.
65	higher than market salaries - still not successful
66	Higher pay, better benefits (lots of PTO, medical, dental, vision insurance, 403b plan, etc...) and the most important FREE SUPERVISION (for Licensure) - ALL DISCIPLINES (LMFTs, LPCCs, LICSWs, LPs, etc...).
67	Supervision, paid training, license fee and competitive salary.
68	It has been very difficult
69	Salary, flex schedule.
70	Flexible schedules, qualify for federal loan repayment in underserved areas
71	Website, networking through colleges, diverse advertising, referrals, placement agencies
72	Competitive wage.
73	advertise open positions, provide training after hire
74	licensure supervision at not cost
75	This does not apply to me.
76	Joined with our county partners to help recruit as far a financially. A county that we work with is assisting us with additional funding so that our small nonprofit can be competitive in recruiting a psychiatrist or nurse practitioner.
77	Maintaining a livable wage and acceptable benefits. Also by providing the services that our clients require in a timely manner. This reduces the overall strain of all the professionals and clients.
78	We offer better than market rate compensation and benefits
79	Word of mouth. However, have been unable to recruit a psychiatrist for my Glencoe location.
80	Offering independence in scheduling and remuneration based on number of patients.
81	Applied for status as approved site for federal loan repayment programs. Used signing incentive payments. Focused on building a positive team culture and designed work to meet individual interests and skills when possible. Made certain that compensation packages are competitive.

SURVEY QUESTION 2: If you are an employer of mental health professionals, what successful strategies have you used to recruit and retain mental health professionals?

82	Provide a work setting that is safe, competent and that provides strong financial compensation.
83	What we are doing is providing internship opportunities and working on ways to provide paid clinical opportunities to increase the number of mental health professionals in our community.
84	For recruitment: mailings, newspaper ads, web postings. For retention: we try to provide a respectful, collegial and supportive work environment.
85	I wish this question asked us what is wrong with the system we worked in; like pay rates, insurance company incompetence, etc. The deep end of mental health is reimbursed unfairly too high and so they sometimes pay $20,000 more than we community providers. Is that what we wan? Everyone working at the deep end???
86	You have to pay them so well that it is difficult on the business due to historically declining reimbursement from 3rd party payers.
87	If you found something successful, let me know.
88	We partner with training institutions to give trainees and us a chance to "audition" each other, enhancing the chances of a good "fit" from the first date of hire.
89	1. Financial sponsorships of professionals who choose to advance through a career ladder program. 2. Creation of a culture of safety and healing; one where professionals feel valued.
90	Extensive training, providing clinical supervision, recruiting from intern pools, flexible work schedule
91	Accessing licensure distribution lists has been effective in recruitment. We have also found it better to post on professional websites versus newspaper ads.
92	Loan repayment program
93	Working in a civil service organization, the wait time for hiring for one particular SW position took 11 months, due to personnel absence and subsequent back-up in HR. That vacancy came November, 2011, with three others in the following February, June and July. The remaining workers carried much of the program until the new workers were hired and trained. At this time, 1.5 years later, I have two new vacancies and have been able to make offers more quickly, as generic lists were available. This was much more timely, but we were not able to specify for Adult Mental Health experience/skills.
94	Cast the net far and wide.
95	Treat them w/respect
96	Our best source of recruitment is to provide internships and then access clinical trainees through this and provide supervision through licensure.
97	Just the typical means of recruiting, ads on website of local non-profits and school sites. Very difficult to locate and hire advanced trained professionals (LICSW, LMFT, etc.). Recruiting agency did not work.
98	Offering a high enough salary and benefits, discussing the service orientation of our agency
99	wages
100	Higher compensation, independent contracting.
101	Working with people from early licensure to being a professional. We have had to work creatively with payment models to keep people.
102	Professional networking.
103	Try to offer competitive salaries. If we can't afford MDs then we try to utilize similar level professionals for when possible. For example, use NP and CNS prescribers more and have one collaborating MD in office, to stretch services to reach clients.
104	promoting from within after we train and supervise, increased salary
105	Pay them a reasonable reimbursement and give them a lot of freedom.

SURVEY QUESTION 2: If you are an employer of mental health professionals, what successful strategies have you used to recruit and retain mental health professionals?

106	I just scrolled down and see a HUGE HOLE in your survey. You need to ask this question to EMPLOYEES, not EMPLOYERS. I am an doctoral-level psychologist employee of a community mental health center. The so-called "pay for productivity" model is a HUGE barrier to quality mental health service, much of in "underserved" populations. Although business management can appropriately be applied to mental health in some ways, mental health is not a "business" in the "profit-making" sense of the word. Under pay-for-production my salary is based on how many people I see. Therefore, my "corporate" incentive to is keep people coming back, NOT guide their healing so they no longer need my services. At the same time, this pay system allows NO compensated time for collateral contact, such as talking to the school counselors or school social workers of my young clients, in-depth phone conversations w/ parents, conversations with ARHMS workers who see my SPMI clients, etc., etc. While ethics require these conversations to occur, in my pay-for-productively system (but there are others) does not count them in my "productivity" or "billable hours" or whatever you want to call them. This, too, is a significant barrier in helping people heal and have less need for services. Most importantly, it forces THE BEST CLINICIANS out of public mental health and into private practice. Even as as a mental health professional with a heart in community mental health, that's where I'm headed. I'll see rich white people with hangnails, rather than the huge issues facing the more-and-more folks near the poverty level.
107	this has been very difficult. I have not found any sure fire ways to do either. I am able to employ clinical trainees, but once licensed, they usually leave.
108	Hosting an internship program with local schools of social work Encouraging graduate education to promote from within
109	The best method is through current staff. The issue with this is we are just shifting resources from one part of the state to another. There needs to be a statewide initiative. MH centers need to pay recruiters to access these professionals. This is money we don't have and cannot recoup.
110	Postings with Associations Groups, MACMHP, MCCCA, Association of Black Psychologists, Somali Psychological Association, list serves at the U of M
111	we recruit through internet, and newspapers. Retaining mental health staff has proven to be incredibly difficult in this rural area.
112	Haven't found a successful strategy yet. I pray a lot.
113	Referral bonuses for employees and retention bonuses for new hires.
114	Star tribune ads, a completive wage, which would be an adequate reimbursement from DHS for IRTS services. List above should include Mental Health Practitioners, bachelor level positions which provide numerous services in the twin cities and throughout the state.
115	It is very difficult to recruit early childhood professionals, there are not enough to recruit.
116	Bonuses for increased productivity, loan repayment
117	• Recommendation; word of mouth. We offer supervision for students so we can get a good look at them before making the choice to hire them on. • By increasing the number of staff qualified to supervise students colleges hear about us. • Flexible schedule. Positive team-very supportive of each other-feel good about co-workers professionally and personally. • Flexible schedule, multidisciplinary practice, self-directed makes people happier and easier to work with. Access to administrative decisions—"Shared control." • In private practice, the biggest barrier is reimbursement. Also, we are aware that good case coordination is paramount to patient care. In private practice, these services are not insurance reimbursable and take up a large portion of time given the population we serve. This is often a deterrent for professionals. • Wages, lack of benefits • Pay benefits of a small business without grants to support practice--this is not a strategy, it's an issue that we encounter
118	flexible work schedule, emphasizing work/life balance, competitive wages and benefits Recruit through active participation in relevant organizations, trainings, educational programs and through volunteer and internship options
119	There are certain graduate schools that have a better reputation for producing high quality therapists who have strong ethics, integrity, and professionalism. These institutions interview candidates in some form before admittance to their program, this is essential to the field, however there are a few programs who do not do this and those students (even the good ones who attend for other reasons) are not afforded the same field training opportunities.

SURVEY QUESTION 2: If you are an employer of mental health professionals, what successful strategies have you used to recruit and retain mental health professionals?

120	We have looked at increasing the rate of pay, increasing PTO time, and increasing training opportunities.
121	We offer clinical supervision as a benefit and offer many options of advancing their career if they stay with the agency.
122	Lower productivity! (But this is difficult given DHS' reimbursement rates)
123	Give them meaningful work
124	This has been difficult to recruit mental health professionals to the rural area. If they end up commuting here, they are quick to move on to a larger city after they have received supervision.
125	Provide quality internships that later we can look to hire quality people.
126	We provide a very collaborative work environment and do not pay specifically related to their generated RVUs as much of their value to us is in their collaborative work with other providers.
127	Networking
128	Team meetings and support- supervision and clinical consult
129	Having a positive reputation and being a desirable work place/agency to work for.
130	Networking with colleagues statewide, employing a professional search firm, use of professional LinkedIn site, help with relocation costs, tuition assistance program
131	Training practicum and intern students and then offering them jobs when they show promise as beginning clinicians. Offering training and competitive salaries are important to young professionals.
132	Highlighting the experience they will get working with different diagnoses, talk about using and learning both DBT and TFCBT theoretical frameworks, create feeling of high clinical standards but fun working relationships.
133	MN Non Profit Job Posting, AAMFT-MN Job Posting, Adler Graduate School Alumni job postings, MSSW Job Posting - least helpful of the 3 options,
134	retention involves provision of good supervision that focuses on staff strengths and capitalizes on their abilities.
135	Recruiting is incredibly difficult, but we have established a robust internship program. Retention is based almost entirely on organizational culture.
136	Recruiting providers who are known to the organization's managers; offering a setting that provides supervision, opportunities for advancement particularly in gaining clinical expertise in new areas; offering possibility of at least short term job stability 1-2 years, offering benefits especially health care, vacation, etc.
137	MN NPA
138	Networking with previous employees and interns; participation with NASW; networking with similar providers; clear job descriptions and much support to current employees; hire with the plan to further develop staff newer to the field
139	word of mouth newspaper online
140	advertise via professional listservs

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

1	Loan forgiveness for working in high need areas and not just federal loans all student loans. Increase supervision opportunities so people needing supervision come and stay. Pay more. Make mental health appealing to people.. Increase safety at in patient facilities especially the high acutity settings
2	We are a Head Start program. We find that there is a significant lack of qualified professionals working with families, particularly that share the same philosophy and TX methods.
3	I would like to see graduate schools focus more on community mental health and school based health programs
4	Safer environment and competitive wages with similar professions that are with private sectors.
5	Include clinical supervision hours for LGSW to work toward LICSW.
6	I believe that the Board of Behavioral Health requirements regarding LPCC licensure is inadvertently pushing potential practitioners out of the field. The current requirement that practicum sites for MA programs not be the same as the students existing work site means that only students who can afford to take significant time away from paid employment can afford to complete the programs, particularly since virtually no practicum sites offer any pay, and often require many hours per week for 9 months. This means that students who do not have family to support them are often unable to obtain this degree, which I believe results in a strong majority of students from upper-middle-class families who are, by default, overwhelmingly white. In my experience, the work of a mental health practitioner and the work of a practicum student are often very nearly comparable in scope and type. If the board would allow a system for existing employment to be expanded into practicum work, I think it would encourage a wider array of potential counselors to enter the field, and encourage diversity, as well as promoting the health and wellness of new professionals.
7	Tuition reimbursement; provision of supervision prior to licensing
8	MN is oversupplied in its metropolitan areas and under-supplied in rural areas. This just caused a community residential program to close down out in our area. First, better recruitment efforts in rural areas are necessary. Second, I suggest education in all training programs on rural behavioral health and rural culture. Third, unless we fund rural training opportunities such as internships, they won't exist to attract practitioners. Fourth, apply the state loan forgiveness program to psychologists and MSWs. Fifth, make tele-mental-health available to rural areas, but make sure that practitioners understand rural culture and behavioral health issues. Sixth, fund rural behavioral health research, so we know what works for rural people and communities. Seventh, fund rural behavioral health services at the level that will allow salaries commensurate with urban ones.
9	Grant funding to subsidize woefully inadequate insurance and Medicaid reimbursement.
10	Higher pay. Options to reach licensure faster.
11	Higher pay, reduce expected daily client contact by 15%
12	We may want to consider training and utilization of Mental Health Workers. This could follow a similar model of the Community Health Worker who is one of the patient's care team.
13	Do not over define and therefore lose the hundreds of trained and qualified professionals and professionals in training. I would suggest a grant based program to support agencies in providing mental health supervision for all categories LPCC, LMFT, LCSW etc. Retained therapists could be required to do so much skills training and stay with agency for designated time or pay back supervision
14	Maintain a practicum program for graduate counseling psychology students on career paths to become Licensed Professional Clinical Counselors and/or pursue doctoral programs to become Licensed Psychologists
15	Offer scholarships with requirement that when student graduates they must work for agency that provided funding. Educate seniors and grad students about scholarships offered by military.
16	education reimbursement
17	Creative Arts Therapists are difficult to access as they do not have license and cannot take insurance or state funding.
18	Stay updated on marketplace salaries, continually work on engaging employees and measuring their satisfaction and making the work meaningful and rewarding for all of us

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

19	Increase job opportunities for those with advanced degrees in the Expressive Therapies such as Art Therapy, Dance Therapy, Music Therapy, Drama Therapy, Poetry Therapy, etc. Recognize that these professionals are trained to provide clinical services in the field of Mental Health and also have capacity to provide services at more than one level in that they are Arts based services. Title Protection is an issue for these professionals in Minnesota and needs to be addressed legislatively.
20	Any form of cost reduction in the education, including grants, scholarships, etc. would be a high incentive to mental health professionals with high student loan debt. Ensuring that there are adequate supports in the workplace that do not result in the provider "burning out" quickly as well as access to consultation and professional development opportunities.
21	Maintain reasonable caseload size, support self-care/wellness for MHPs, continue supporting/providing bachelor and master level internship opportunities that may lead to future employees
22	More of #2
23	Again meet the needs for support, salary, and time allowed per client.
24	Decrease our business in this area so we don't have to hire so many or any of these professionals.
25	include supervision and advancement
26	Change increased social work licensing requirements for clinical sw, especially 8 hrs/mo supervision which is extreme in terms of time and cost. Start promoting this career in high school. It doesn't just happen.
27	Increase reimbursement rates so that professionals can be paid more Offer "satellite" locations from some of the larger agencies to get services in smaller towns so the professionals can access insurance and other larger agency benefits Loan forgiveness for years served (similar to what Head Start agencies can do with Perkins loans but offer them for stafford loans as well)
28	Improve training environments by increasing medical, PA and NP student rotation opportunities in the rural areas. Consider providing stipends for housing during their training.
29	We've already tried just about everything for recruitment. We hope to offer loan forgiveness and/or tuition reimbursement in the near future. Retention is an issue, though. Our public/non-profit agency can't pay as much as other private entities. People work for us long enough to get some experience under their belt, then move on to greener pastures.
30	Work with emerging professionals in training locations
31	do not have new ones yet
32	*It would be nice to have more grants available for Greater MN for tuition reimbursement and other benefits for professionals moving to our area. *There needs to be more collaboration between mental health providers in our community. Increased shared service agreements between providers.
33	Flexibility for families and paid leave for individuals looking to start a family. Smaller case loads
34	I try to pay them as well as possible, bearing in mind the very poor quality of mental health reimbursement from insurance companies, the state and federal government.
35	I try to pay them as well as possible, bearing in mind the very poor quality of mental health reimbursement from insurance companies, the state and federal government.
36	I think the cost of education and training to become a psychologist is prohibitive. Reducing the number of internship and practicum hours required for internship. Allow psychologist to get extra training and prescribe psychotropic medication. To retain more therapists, reduce paperwork, teach better self-care and create creative and supportive workplaces.
37	More of the above.
38	Loan repayment programs Better compensation
39	More connected services
40	Increase pay.

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

41	Allow practitioners to create new programs or at least discuss them without shutting them down.
42	I would recommend recruiting from universities or schools with related programs.
43	Improved reimbursement, advanced practice nursing legislation to allow nurses to practice without MD collaboration, more knowledge about mental health careers and fields to high schoolers and undergrads.
44	Due to being a non-profit agency and have limited funding for salaries we attempt to recruit clinical trainees from local colleges and provide paid supervision toward licensure. Our goal is to train new clinicians with the hopes they will remain in the area as there is a significant need for licensed practitioners in the area.
45	That is a difficult question as our area does not have much to offer spouses as far as employment. We do however, live in a beautiful area with many outdoor activities available to us.
46	Do not overload them- that is when they begin to look elsewhere.
47	Forgive their student loans.....
48	Better third party reimbursement for psychiatry
49	Reduce stigma in general. Increase recognition and appreciation for lower level mental health workers, such as direct support professionals, nursing assistants, and mental health techs/associates.
50	Flexible schedules, use of telehealth, vacation time, good pay, Other technologies to make their work easier, higher reimbursement and longer appointment time allowance.
51	n/a
52	1. Increase funding for better salaries, higher insurance reimbursement rates. 2. Establish coordinated multi-disciplinary career ladder for mental health professionals state-wide. 3. Establish Graduate level education programs in northern Minnesota to train mental health professionals in the most underserved areas of the state where program graduates are most likely to come from, be invested in, and want to stay in. 4. Increase grants, scholarships, loan forgiveness incentives for MH program graduates and professionals to serve in the most underserved areas. Make these incentives more available, less restricted to particular professions or employment settings. 5. Establish centers of continuing education for mental health professionals in northern Minnesota to improve access to continuing education, make it more affordable, and increase educational focus on issues and topics more relevant to practice in rural and deep rural underserved areas.
53	Restart the LPCC training locally Train advanced practice nurses locally Involve Sanford to garner the funding/hire psychiatrists/prescribers
54	more funding from the government instead of taking away money from this very needed section of public health. It seems that mental health always gets cut. Probably because legislators don't understand the public needs in the mental health area. In addition to that, quit treating Mankato as if it were the same as the cities. Mankato does not have the same strengths/weaknesses as the cities. what may work in the cities doesn't necessarily work in Mankato. and vice versa.
55	We will be unable to hire additional workers due to budget constraints. Training, fair pay and the support from the agency assists in retaining mental health professionals.
56	recruiting firms healthy organization culture, balanced work/personal life
57	More Loan repayment programs.
58	Provide incentives such as partial payment of their education costs. Allow some form of loan forgiveness if they work in a shortage area. Increase the reimbursement rates for MH services so more folks will pursue becoming MH professionals.
59	track students from rural communities who might be willing to return and make sure they are being targeted with job opportunities.
60	Student Loan Reimbursement.

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

61	Use student loan pay-back options in more geographical locations (not just rural) . . . and extend the pay back to undergraduate degrees - not just graduate. In 'critical access' areas for mental health - provide incentives beyond "student loan pay-back" such as 'grant opportunities' for various ways to keep life in balance (specifically thinking of athletic type activities, mental health networking or something else that helps keep life in balance). This type of provision allows for a person to remain healthy in a setting that may not be their first choice.
62	Need more competitive salary especially in rural Minnesota.
63	Loan forgiveness programs, competitive reimbursement rates
64	Train more higher level mental health professionals Use the plan developed years ago that requires collaboration among the training organizations so that professional learn to work with each other during training. Those that don't train collaboratively will not do it when they complete training. Training programs are not changing who they train. Silos are more solid than ever.
65	loan forgiveness programs--more!
66	I think we need to pay back loans and reimburse more via Medical Assistance
67	Financial support for educational advancement and continuing education.
68	It would be nice if there was a way for non-profits to compete, salary-wise, with places like Blue Cross, Medica, Mayo, the VA, etc.
69	To retain: lower case loads, higher wages
70	There HAS to be more mental health professionals on a first-responder basis. LicSWs, Psych nurses, Ladcs, Mental health Techs, etc. Hotlines and warm lines are good, but I'm leery of even doctors who diagnose by telephone, sight unseen. Also, we can create a clinic for mental health emergencies (some people say there is no such thing as a mental health emergency). The point is, we have GOT to do better than sending people through the ED. As far as training, there is so much disparity in our field. I envision our field will follow that of business: we will have lower-level skillset practitioners handling more people initially, for less money than someone with a higher skillset. Also, can we distinguish why LicSWs are allowed to practice individually vs. PsyDs who need to practice under a doctor for a longer period of time? This is so confusing for students who are certain they want to do counseling, vs training for a position in Research. Make these programs lucrative!
71	breaks on student loans
72	Maintain working connections
73	Our agency provides a work-from home option which allows you to complete a report at home instead of going into the office. This is nice after meetings and on days where there is risky weather conditions.
74	Supervision; flexible hours/schedules. Field training opportunities
75	Lower caseload for high risk patients Inter-professional collaborative care (share the workload with other MH professionals)
76	It takes too long to be fully licensed, mostly due to the required supervision in order to work independently. Clinical supervision for social workers is VERY hard to obtain! If your employer does not provide it, it is time consuming and expensive for 2-4 years! There should be incentives for employers to provide clinical supervision.
77	better pay
78	Providing a professionally challenging work environment with lots of support and especially good, timely supervision
79	Same as above. Retention of those that want to be in the area is easier but being a "great" place to work really helps. Allowing the therapists to develop their areas of interest and have a role in the overall management of the service really gives them a sense of ownership. Also, we have really encouraged each therapist to become of the greater community that they serve, such as sitting on committees in the community such as through the courts, schools, civic and commerce, etc.
80	INTERNS, CUT PAPERWORK, PAY increase statewide for those in MH
81	help with tuition costs or loan forgiveness if working in high-poverty area; loan deferral until licensed

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

82	See 2 above.
83	We really need a more diverse workforce. Scholarships would be helpful. Assistance with paying for licensure supervision as well.
84	we provide in house, no charge, supervision for licensure
85	loan repayment programs for working in rural areas especially, relocation assistance, cultural assimilation assistance for provider and family, offer presentations and job shadowing for high school students or college freshman to expose them to the field and encourage them to enter it
86	Make educational programs for professionals more accessible and affordable. Address issues related to clinical supervision--costs to agencies and supervisees.
87	better benefit packages
88	As stated above, along with provision of training opportunities.
89	More money for salaries/benefits is always helpful.
90	I work as faculty. If I see students in nursing who have potential, I have tried to arrange internships and shadows, talked to them about the field. The lack of Pysch NP options at a reasonable cost is an issue.
91	Give incentives to providers to continue to work with clients who miss their appointments
92	Licensing requirements should be more consistent throughout all professions. Some of the rules regarding tasks that must be performed by a mental health professional in different settings are frustrating and make it difficult to do business. Allow those individuals who are on the track of being a mental health professional do the duties of the job with supervision. Rule 2960 allows a MHP trainee provide therapy and write treatment plans with supervision, however they cannot approve restrictive interventions. This makes no sense at all.
93	the same as above
94	Eliminate private insurance companies and increase reimbursement rates through medicare and medicaid for mental health professionals.
95	I believe self-care is often downplayed or underestimated. I think insurance companies partnering with gym/fitness facilitites is a good start, but it may be helpful to see more alternative health partnerships. For example, a non-profit or business partnership with a yoga agency (e.g. core-power, Tula yoga, etc.), or companies providing other self-care services for relaxation or retreat (e.g. hotels for getaway, therapeutic massage services). This could also be further encouraged by payroll benefits (e.g. $ added to paycheck for participating in these regularly).
96	LOWER THE CASE LOAD NUMBERS
97	Pay them more. Encourage taking time for self care and days off for themselves to not get burnt out.
98	Provide State funded education loan forgiveness for behavioral health providers in underserved areas, increase the number of training slots for Psychiatry in MN, Increase professional fees in behavioral medicine, fund development of a team based care model in behavioral medicine allowing a multi-disciplinary team to treat a significantly larger population of patients, experiment with group treatment models and reimbursement models.
99	I am an educator. What I have noticed is that many master's level graduates run into difficulties where organizations require multiple years of experience before considering a candidate. Too few slots are available for entry level positions. At the same time, I have heard those who hire mental health professionals complain that there is a shortage of mental health candidates. The problem is NOT that there is a shortage. The problem is that organizations do not want to hire students directly out of graduate programs.

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

100	Pay for fees for additional certifications which may be required, ie, Advance Case Management Certification for Social Workers; Certified Brain Injury Specialists, etc. Increase financial support for CEU training for LICSWs/mental health professionals to $2,500 or more per year to be used at MH professionals discretion - NOT the employers specified training. Administration/Management encouragement and support of more reasonable case loads - not emphasis on "productivity," or focus on paperwork vs. direct service; and build in MH staff opportunities for self-care, clinical consultation and support without it "counting against" the MH professional's productivity; employer support for MH professionals to attend training to become MH clinical supervisors and provide the support staffing to help make provision of clinical supervision an integral part of the MH professional's practice opportunity. Provide educational loan pay-offs if upon completion of a bachelor's or master's level degree program the graduate in mental health field works in a high-needs or agency serving underserved populations. Increase reimbursement rates for LICSWs to be comparable with other MH professionals and in general increase reimbursement rates so that salaries are more competitive and supportive of a MH professional.
101	produce more professionals
102	Pay needs to be appropriate for the level of responsibility and stress that the job entails. Strategies to avoid burnout and job stress: ample vacation time; money in the budget for little surprise catered lunches or a massage therapist to give 10 minute stress relieving treatments; access to training in relevant and emerging issues.
103	n/a
104	Incentives to work in rural areas (loan forgiveness or repayment programs), offering competitive internships/residency programs to train and retain professionals
105	Word of mouth / recommendations. However, skilled providers that are experienced in working with complex mental health issues are hard to find and when identified they often are not taking new clients (as they are highly in demand). There are many 'therapy' providers and medication management and diagnostic assessment providers that are sub-par. This speaks to training, education, licensing, and unrealistic case-loads across all professions that provide these services (LMFT, LICSW, LPCC , PsyD., etc.). Clients, therefore are not being effectively treated. This is extremely disappointing, when a client is motivated to work on their mental health, but remain stuck due to ineffective interventions and miss-diagnosis. These Clients often do not know that they can question their providers interventions, how to advocate for better care, or what kind of results / outcome / changes that should accompany their treatment engagement. Nor do they always know that there should be a treatment plan in place for individual therapy, or they are left out of this process. Additionally, clients do not know or understand that there are various professions providing similar services and that various approaches are used (theoretical orientation and intervention) . For example, individual therapy can be provided by an LICSW, LPCC, APRN-CNS, or LMFT, and further, what their individual approach might be. If providers of all disciplines were assessed and ranked in areas of expertise, skill , and approach/theoretical lens by a signal out-side agency or organization and then this information was made available to the public (on-line), clients could make more informed decision about the care they seek and receive. This too would help other providers, such as case managers and in-patient discharge coordinators, make appropriate referrals or recommendations to clients. With this information publically available to the community through an on-line web site, an assessment tool could be developed to help clients identify treatment needs (e.g., medication management, individual therapy, group therapy, day treatment, long-term, or short-term interventions, male or female provider) and what theoretical lens and interventions that might be a good match or most effective for them. This on-line tool should also match client searches with insurance coverage. When potential clients are left with an overwhelming list of providers that are covered under their insurance plan, they are only given name address, phone number, and sometimes, areas the provider self-identifies to have expertise in by listing areas they "specialize in" (e.g., anxiety disorder, mood disorder, physical abuse). This list is like a shot in the dark, when clients pick up the phone; they are not given objective information on the provider, nor are they informed on what to expect from treatment other than what the provider shares - which is not standardized and influenced by their training, education, experience. Furthermore, new clients to mental health treatment, and many established clients, do not know what services or treatment they may need. Clients are likely to be in crisis when they first come into contact with mental health services and do not have help navigating the system.

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

106	Provide adequate funding so more staff can be hired if the work load expectations exceeds the amount of time available each week (i.e. case load and paperwork requirements match a 40hr work week). Ensure they will be supported (i.e. some companies i have worked for didn't provide adequate supervision for their staff, leaving limited support available when working with high needs clients).
107	increased staffing and salary
108	See above and I use verbal praise A LOT (this is hard work and people need to hear when they're doing a good job and this costs NOTHING). Holiday parties and Summer events for staff and kin (to build a sense of community). Using a person-centered perspective with both clients as well as staff.
109	Increased pay, opportunities to work from home
110	More incentive planning for staying longer.
111	We offer tuition reimbursement and hire from within.
112	flexible scheduling
113	I feel like we are already flooded with Psychologists, LICSWs, LMFTs, and LPCCs. I would love to be a Psychiatrist and am already an MFT. If there was some program that took people with terminal degrees and did fast-track training to be a Psychiatrist or APPNP, that would boost numbers very high!
114	Same.
115	See above
116	The system is set up as a business, where professionals are required to see X amount of clients in a day. Professionals are reprimanded if they do not meet the quota. This is wrong. I understand trying to see as many clients as possible, but it takes away from providing quality care and burns staff out. One idea would be to eliminate this in practice and put more emphasis on quality care!
117	Networking, advertising
118	it is very difficult--we try to provide internships that allow them us to know what we are hiring and they get great experience doing clinical work
119	I would suggest to go to the colleges and go to the schools of social work, family social science, trauma focused departments and talk with the students. Take the time to conduct and informational session about the field in real life and real time and how their degree can be utilized and/or how they can create a position within an organization. I would go to communities of color i.e. coffee shop "Golden Time" on Selby in St. Paul or other local meeting areas and ask the professionals in the room about their work experience and if they are happy where they are at, why or why not.
120	Good job opportunities, capacity to grow in their own areas of interest, free clinical supervision.
121	I am not an employer but my organization pays pretty well, offers some upward mobility, licensure supervision, generous PTO and good benefits. I left this organization to work for another one and came back because I like the culture (autonomy, a sense of trust from those in charge, support in difficult situations).
122	By creating partnerships with the local counties and hospitals, this creates word of mouth through our area regarding our quality services.
123	Better pay with consistent hours, yet flexibility in their job for their personal lives.
124	being a progressive organization that pursues evidence based practices
125	$ help with training and licensing requirements clarity about medicare/other insurance practice requirements
126	More people of color are needed. This includes African American, Asian, Native American, Spanish speaking and LGBTQ. I would recommend a grandfathering for LMFT, LICSW, LPCC etc. I would recommend this as many people of color are not passing the exam not due to lack of knowledge but due to factors that are not taken into consideration such as social economics. People of color start off at a disadvantage because they are often raised in poverty or near it and they tend to have fewer experiences with academic language used in their homes/neighborhood schools. They tend to have linguistically dependent courses which makes passing standardized tests more of a challenge for them.

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

127	The above strategy, mine, is anachronistic. To recruit, offer loan forgiveness or partial reimbursement, find ways to increase job security in the bigger organizations (Allina, Fairview, etc.).
128	Start recruiting people when they are younger, so that we can get them to come back and work in certain neighborhoods, settings, etc.
129	Applied for status as approved site for federal loan repayment programs. Used signing incentive payments. Focused on building a positive team culture and designed work to meet individual interests and skills when possible. Made certain that compensation packages are competitive.
130	It is challenging to provide paid clinical opportunities for non clinical licensed staff due to funding and barriers. If more insurances accepted clinical trainees for reimbursement, that would help immensely!
131	Telehealth strategies for rural areas - address professional isolation & lack of psychiatry
132	Loan repayment, "grow our own" via innovative training programs and field placement opportunities, mentoring from senior clinicians,
133	Reimbursement is a huge problem. We need to be able to pay therapists more, and we need to be able to pay them for time spent doing documentation such as disability forms, diagnostic assessments for case management services, etc.
134	Not telling!!
135	More training for direct care and support staff. Also more funding for direct care and support staff.
136	Having a competitive wage, benefits, and paid time off are great incentives that can help keep mental health professionals. Also a company that respects self care and taking personal days when needed.
137	I would like to work to educate and inform insurers, legislators and others to ensure that qualified LPC/LPCCs are recognized for their competent work as diagnosticians and treatment professionals for mental health services.
138	personal contact with other professionals
139	Create a good working culture.
140	Internship pipeline with local colleges and universities.
141	Reaching potential MH professionals early in their professional development provides an opportunity to shunt folks into more needed areas.
142	Better incentives to stay under contract- loan repayment options would be wonderful. I did the NHSC grant and it changed my life.
143	Same as above.
144	Closer relationships/feeling like your making a difference/personalization
145	Pay better (if we can get the funding)!
146	Bonuses would be great to be able to offer to have mental health professionals stay. Money to improve benefit packages is also lacking.
147	Being flexible with hours and work sites
148	Access students in their graduate programs in an intentional manner culminating in the access of cultural match specifically African American, Latino and Native American MH practitioners/professionals
149	1) Loan repayment programs. If Minnesota could match or exceed what the federal government offers, and offer these programs throughout the state, with hardship pay for less desirable jobs or locations, these jobs would fill up quickly. 2) Pay less for superfluous GI and other procedures and shift that money into mental health. Pass state laws that require this to happen. That will free up money to recruit adult and child psychiatrists.
150	Change this: Due to civil service system, we cannot recruit for specific service qualities or experience such as Adult Mental Health. SWs are considered generalists which should be qualified for any service area.
151	Professional support for the stress of these positions, peer support and flexible scheduling
152	trainings, regular consultation, stress self-care importance

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

153	We have developed a rep as work lay closely w/them at our school sites
154	reimbursement rates be sufficient to provide adequate compensation
155	None, but please share them if you get them.
156	Increase salary and benefits; increase administrative support staff; allow more time per client visit
157	competitive wages
158	Higher reimbursement rates that make programs more financially sustainable.
159	Attempt to make job conditions positive through meaningful supervision, team dynamics and support.
160	One way out there strategy is to look at the statutes related to MH Professionals and to question what is happening to support the development and growth of NP or CNS prescribers. Is someone taking on this challenge. It is my understanding that for some disciplines (e.g., APRN's for example), educational requirements continue to climb and so do the politics around their ability to prescribe. See recently bills introduced to Senate to make NP's responsive to Medical Board and direction under MD's. IN addition, NP's who want to collaborate with MD's in some cases are required to pay MD $5-10K per year for the contract. That adds to the costs and directly affects the supply of NP's/CNSA's at our disposal. So, the costs need to shift somewhere. Our agency can't afford the additional $10K to establish collaborative relationships. Fortunately, here, we have MD's who agree to do this.
161	Licensing boards have gotten out of control with their requirements, simplify them and put them all under one entity.
162	We are not currently planning to recruit or hire additional staff.
163	Increase pay, decrease paperwork
164	flexible schedules, benefit package
165	Student loan repayment programs for working with children, SPMI, families w/ compllicated issues. See above: . I am a doctoral-level psychologist employee of a community mental health center. The so-called "pay for productivity" model is a HUGE barrier to quality mental health service, much of in "underserved" populations. Although business management can appropriately be applied to mental health in some ways, mental health is not a "business" in the "profit-making" sense of the word. Under pay-for-production my salary is based on how many people I see. Therefore, my "corporate" incentive to is keep people coming back, NOT guide their healing so they no longer need my services. At the same time, this pay system allows NO compensated time for collateral contact, such as talking to the school counselors or school social workers of my young clients, in-depth phone conversations w/ parents, conversations with ARHMS workers who see my SPMI clients, etc., etc. While ethics require these conversations to occur, in my pay-for-productivly system (but there are others) does not count them in my "productivity" or "billable hours" or what ever you want to call them. This, too, is a significant barrier in helping people heal and have less need for services. Most importantly, it forces THE BEST CLINICIANS out of public mental health and into private practice. INTERESTINGLY the insurance companies are paying upwards of $100,000 for psychologist who review my plans. Under pay-for-productivity model at my community mental health agency, a PHD level psychologist tops out a $50,000. Where would you work??
166	Higher pay, less paperwork
167	Offer to provide talks in graduate classes about your program in the context of trends in the field of mental health, as it applies to coursework
168	WE would like to increase our benefits to further enhance staff satisfaction. WE also are looking at hiring an outside agency to find and place professionals within our agency

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

169	Have additional levels of mental health professionals. Especially in cultural communities. Often in cultural communities there are people who the community go to for help. they are typically not mental health professionals, but have some knowledge and credibility in the community. Harness this model to increase access to help. My second idea would be to institute mental health education programs in jr high and high school. This introduces the concept to students and goes a long way toward dispelling the stigma that prevents would-be future mental health professionals from considering the field as a career option. When there was a shortage of teachers, money was made available to help pay for the pursuit of a teaching degree. I remember there was a particularly strong recruitment effort to get men into the field. I would suggest waging a similar effort to recruit mental health professionals. The bigger issue is to look at why people are not going into the field. What specifically are the roadblocks and challenges that have successfully kept people out of the field, and who specifically are the roadblocks deterring. Once identified, start building a program from there.
170	Supervisors needs to be aware of how people from different cultures may work and learn differently. We need to shift our ways of teaching- which can help people from different cultures and people who think and learn differently for other reasons.
171	Actively recruit by sharing more information about career opportunities.
172	retain - better salaries however, with such low reimbursement rates for behavioral health care services, agencies can't afford to pay more. Training opportunities especially training in evidenced based practices; DBT, TF-CBT, PCIT, etc. These are expensive and agencies often can't afford to provide these training opportunities. Helping the work force gain the supervision needed to gain professional licensure.
173	We try to be the kind of place where professionals want to work: nice facility, supportive staff. Sadly, pay levels and benefits are difficult in private practice because we completely rely on patient fees & third-party reimbursement for all income, so we try to be generous in scheduling and other ways.
174	Better pay!
175	It is difficult to get qualified staff to apply in this area - we try to "sell" the community to potential employees.
176	Higher compensation for bi-lingual bi-cultural practitioners. The added value of language, therapeutic, and resource skills used, requires more work. Conversely, lack of recognition of this added value higher caseload burden and reproduces social inequalities in the MH system.
177	Make it a more inviting environment for child/young adult psychiatrists to want to move to MN and stay.
178	Reasonable working conditions, excellent wages (see above) and benefits
179	We try to support the few early mental health providers we have with training.
180	Need to look at insurance reimbursement policies, which affects pay and workload. The job is not desirable, because they need to see too many patients for not enough time. It is hard to feel effective and to do a competent job under current conditions. The State of MN has not made mental health services a priority--funding has been grossly slashed--when we treat these individuals and have no place to send them for the home and community services they need, we're fighting a losing battle, which leads to burn-out and relocation.
181	Better pay, including helping new therapists access and pay for supervision.
182	Increase salary, supervision, and training. Recruit through cultural mental health organizations.
183	Higher pay for all mental health professionals, loan repayment programs, being willing to certify them in certain therapy modalities, free supervision towards licensure.

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

184	We tend to retain individuals for some time because we are a very flexible clinic and have a great team. I think that working with a multidisciplinary team is imperative to professionals feeling like they are not shouldering the entire burned of a case, which reduces burnout. I think that 3rd party payers need to truly understand the work we do--coordinated care is in the best interest of the patient, however we often are not getting paid for these case planning meetings, or attendance at an IEP meeting (for a child or adolescent), which greatly decreases the likelihood of a professional to attend. The work we do is specialized and informed--we should be reimbursed for this. I think often people leave the field because the level of documentation and the time required to complete it takes away from the work with the patients. I also think that educating high school students early on about the MH field would be a way to encourage them to go into the field so that when all of the older generations start retiring, we have people to replace us. I think that having more loan forgiveness in the field, perhaps for being trained in specific areas (i.e. trauma)--rather than having loan forgiveness be specific to geographic locations. It could perhaps be applied to the type of clinic you work for (i.e. non profit). I also think that it is very important to be able to bill for the work that students do. There is about 2 years between graduating and full licensure that students are going under utilized because their time is not billable -- and also, the person supervising them often does not get paid for this supervision. In private practice it is not realistic to ask someone to volunteer their time to train a student and not get any payment for that time. If we are going to train good professionals, we need to make it worthwhile to the individuals doing the training/supervising. . Number one barrier to recruitment of professionals is LOW REIMBURSEMENT. Payment systems for mental health diagnoses are too low to support independent practitioners. ALL mental health departments within larger medical systems are subsidized by more profitable departments. It is NOT POSSIBLE to earn an average income as a psychiatrist by supporting oneself through patient fees alone. It is NOT POSSIBLE to run a state-of-the-art practice with supporting professionals like nurses, receptionists, and billing specialists and have this supported through patient fees. Number two barrier to recruitment of professionals is the failure by insurance companies and other third-party payers to allow payment for trainees. This means that in addition to lengthy educational training, psychologists, clinical social workers and counselors must endure one to two years of unpaid or severely underpaid internships. During this time they must work under supervision, but there is little work for which they can bill third-party payers. This has led to a shortage of internship positions, as interns become a cost for any practice or clinic in which they work. Third-party payment structures inhibit and discourage innovation that might make it possible to work with more patients more efficiently. For example, group therapy is an underpaid modality. It's difficult to be paid adequately for nurse education of patients, which would free up psychiatrist time to see more patients. Diagnostic reports are ridiculously lengthy and repetitive. Third party payers will not allow use of outside material as part of the patient record, and DHS now requires a particular format to their reports. This means that innovations that would save time (and add to the effectiveness of the clinical record) are actively discourage. All information must be incorporated into a single document and re-dictated or written by the practitioner, even if the information could be gathered and put into the patient record more efficiently through another format. Mental health professionals at our practice typically spend 7-15 hours per week in unreimbursed time on documentation. Lack of reimbursement for services that are required to get the patient well is another barrier. With children, attending the school IEP conference can make a tremendous difference in the child's daily stress level by educating teachers about the child's mental health problems. This is not recognized as a medical service and is not reimbursed. Lack of reimbursement also means that the sickest children, in residential treatment programs, may not be attended by a psychiatrist at all, or may see a psychiatrist for only 15 minutes per month. LOW REIMBURSEMENT also limits our ability to offer generous benefits compared to other employers in town.
185	Greater involvement with local graduate MH degrees in Social Work, Psychology, and such. Sponsor their clinical supervision hours
186	Case management had a therapeutic component to it, it would be useful if that was reimbursable at a reasonable rate as it would allow for higher pay for therapists which would improve retention. Also, this work is draining leading to therapist burn out, more paid time off (that is mandatory) would help reduce case loads and increase self care.
187	Allowing a more flexible work schedule.
188	Fellowships to allow more people to make advanced degrees more affordable (especially in psychiatry). Changes in training for psychiatrists to pursue more mental health specific training vs. general medical practice.
189	Does not apply

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

190	Same as above. We are a private agency and currently cannot offer a rural loan repayment program. If we qualified , I believe we would have better chance at recruiting more Mental Health Professionals.
191	Pay them more. Smaller case loads
192	Allow LMFT, LPCC to accept Medicare, It is very difficult for pre-licensed clinicians to find work. It would help agencies to allow pre-licensed post graduate students under supervision to see all insurance clients - not just the PMAP plans.
193	Higher wages through more funding, collaboration with other systems to help people in need access the services.
194	Some kind of tuition forgiveness for psychiatrists, such as a similar program for social workers who commit to working in child welfare for a certain number of years.
195	We are working on coming up with ways to recruit and retain mental health professionals. I think it is important to have them move to the community and "buy in" to the community.
196	Help pay MH professionals to complete training on EBP's (through their employer, or through grants or other options). Better pay for MH professionals at all levels.
197	Provide a supportive, safe, collaborative work environment.
198	We want these mental health providers to spend about one-half of their time in work that helps patients adapt to illness, helps other providers continue to provide balanced care including much of the behavioral health needs of patients and we ask the MH providers to teach skills and share knowledge with medical providers.
199	Putting pay on par with education and experience, mental health professionals are paid much less than equally trained medical professionals.
200	Networking
201	Increase pay level. Establish a better system of reimbursement so more people go into the profession.
202	More team builder- self care activities for staff.
203	IT is very difficult to hire licensed mh professionals. the most succes we have had is to "grow our own" which we do by offering internships and supporting professional development with employment opportunities so that graduates can work TOWARD licensure and then decide to stay in our employ.
204	Hiring bonuses, help with relocation costs, tuition assistance program, loan forgiveness program for rural areas, developing staff from within the organization
205	See #2.
206	Pay a little more, if can't pay more pay for the licensing fees, pay for CEU courses.
207	mentor and exposure at K-12 level scholarships/grants to attract and retain students to pursue mental health careers competitive pay
208	This is more directed toward Master Level Clinical Trainees -- as most Professionals are not interested in doing home based services. We use the same postings for both Professionals/Master Level Clinical Trainee -- MN Non Profit Job Posting, AAMFT-MN Job Posting, MSSW Job Posting - least helpful of the 3 options. We also email St Mary's University MFT program, Adler Graduate School, St Thomas/St Kates as we have contact relationships with them for interns. We also have year round internships, and have developed a comprehensive intern training program in FACTS model of services, and we look to hire from interns that have demonstrated passion for services and ability to deliver services, and willingness to learn and received feedback.
209	We need to get into high schools and talk about it as a career choice. Especially for males and ethnic minorities.
210	Currently some of the documentation requirements and complexities of some electronic medical records discourages newer practitioners/professionals. Needing to complete extensive, complex documentation, often after work hours has been a drain on newer employees. We've been attempting to provide training on concurrent documentation to providers--works better for adolescent and adult clients vs. young child clients and families. We've also made adaptations to the electronic health record system we purchased to improve the user experience.

SURVEY QUESTION 3: What strategies, steps or ideas do you have to recruit and retain more mental health professionals?

211	MN NPA website works really well
212	In addition to the above, connect with more bachelor's level professionals promoting mental health professional opportunities
213	providing stipend providing relocation costs grow our own through clinical trainees
214	Make it an exciting, interesting place to work. Provide professional development opportunities.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

1	Advanced job specific academic training
2	Implementation of these skills in college curriculum and extensive training opportunities within the workplace.
3	Competency testing with licensure? Better quality supervision in practicum
4	Personally, I feel that training needs to focus more on family systems, the cultural perspective of poverty.
5	Coordination with graduate programs Collaboration with other community agencies to sponsor events
6	Training specific to these areas.
7	Adequate CEU money for providers who are employed by organizations like a hospital or mental health center.
8	More training options in these areas that are spread across the state and not always just offered in the Twin Cities.
9	Ongoing CEUs.
10	Incorporate into training programs.
11	More workshops, conferences, media stories, & other educational forums on the topic of mental illness & mental health recovery
12	Availability of classroom learning or training brought to the program site. Incentives for coursework and certificates such as time off or pay.
13	Seek educators with experience in rural behavioral health. Fund training experiences in rural areas with experienced rural practitioners, and fund the practitioners to undertake this training. Fund research with rural populations.
14	Coursework, trainings, continuing education, quality supervision.
15	Offer more trainings that are affordable or free.
16	Build into curriculum requirements in undergrad and graduate programs, also built into supervision when working toward licensure. Agencies need to prioritize these elements in practitioners practice. Most settings are not conducive for practitioners to focus on these particular improvements.
17	Current steps of degree coursework internships and pre-license supervision are more then adequate.
18	get credit as part of supervision, agency grants for staff inservice
19	Increased access to psycho-educational presentations and trainings to general public.
20	Encourage grad schools to make these items a part of their curriculum.
21	working with college programs
22	A group of dedicated trainers working non-competitively across disciplines to train in a full -spectrum not just medical pathology model but also community models, prevention, healthy relationships, stigma breaking, resilience-based, family-based, creative expression arts based.
23	Add a class.
24	Offer more DHS sponsored training. Work to make trainings more affordable.
25	Continuing education expectations could be more clear that so many of the required hours include training in specific areas over a period of time.
26	Create a strong integrative services team including training and support
27	Trainings can be written in annual performance reviews
28	Licensing boards could require this as part of CEUs for license renewal.
29	Continuing education on trauma and the effects of trauma on individuals.
30	Trainees could benefit from financial support during internships, adequately paid apprenticeships post-graduation and increased access to well trained supervisors. Mentors would be great help too.
31	Make sure this is covered in master's level courses or available as a CEU seminar options.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

32	Graduate programs should be encouraged to integrate a practical administrative management component to mental health education. Many psychologists while adequately trained to provide competent psychological services end up in ethical dilemmas based on their lack of understanding or skill with paperwork (keeping good progress notes), billing errors, and general business management. Examples of these issues include providing therapy to co-workers, multiple relationships, poor structural supports, poor internal policies that are out of compliance with state and federal law.
33	Too many therapists are being educated.
34	Continue working cooperatively w/ other MH service providers to identify training needs, share information regarding training opportunities, employers support training by providing funding for training and continuing education
35	Graduate schools need to move away from traditional hour long clinical outpatient sessions, more team-based, collaborative/integrated care.
36	make it mandatory, survey results thru the pharmacies for addictive medications. make it mandatory to join the controlled medication data base offered in most states
37	specific guidance during clinical practice on these matters needs to be made clear to supervising entity. Sometimes it is a real stretch whether the clinical internship should qualify for licensure.
38	Include LPC LPCC in more opportunities. We are not using a whole pool of qualified professionals due to definition confusion
39	access to individuals who are diagnosed and recovering and leading productive lives
40	the creation of an accessible data base of resources and training opportunities
41	Offer free, quality training that meets the requirements for continuing education (some licenses limit non-face-to-face training).
42	Include specific trainings within the re-licensure requirements (similar to the teaching license process) Include training into the supervision process (post-graduation) Training and development on in-home therapy techniques
43	Shadowing with real live practitioners in residential, outpatient and community settings
44	Introduce this education early in their training as it can be used I'm all areas of medicine.
45	Emphasize the importance of IDDT in all educational programs. Require a certain number of credits in IDDT and/or chemical dependency as part of the licensure process. Offer a specialized certificate for professionals with training in IDDT.
46	require or offer
47	Have low cost training available in all areas of the state on real world situations instead of academic scenarios
48	DHS working with schools to ensure that these are part of the curriculum
49	IN-PERSON training opportunities where staff can have a dialog with someone live and real in front of them. Have supervision time focus on some of these questions surrounding client care.
50	Staff training and offer time off to employees who would like to attend trainings
51	Integrate training as part of schooling as well as hiring process.
52	More study, which will give a foundation for learning and implementation of better treatment.
53	Topics to be addressed at conferences for some; training by DHS; agencies do some of this as well.
54	Use the MPA training committee. Get requests to them.
55	refocus grad school curriculum
56	Licensure expectation as in other states
57	help pay for continuing education. Make continuing education a longer term and more expanded capability for each person. Get away from simple 6 hours CEU days.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

58	help pay for continuing education. Make continuing education a longer term and more expanded capability for each person. Get away from simple 6 hours CEU days.
59	- Increase BOTH standards for education and credentialing, AND funding to make such education more accessible.
60	Support legislation to allow psychologists to prescribe.
61	Requirements at the school level
62	Hands on training with licensed personnel through internship to work.
63	Add more training in each of the above area for anyone receiving a Masters Degree of PHD.
64	Pay them to get such.
65	Open up supervision requirements across disciplines. Let a licensed mh professional with supervisory training/experience supervise outside their discipline, i.e. LP supervise LGSW for supervision requirements
66	Bring in trainers locally
67	It would be beneficial to have free online trainings for Mental Health Practitioners and Professionals through DHS on family engagement, HIPAA and cultural competency.
68	More state funding or free trainings for non-profit / not-for-profit agencies.
69	Funding from the state and federal level for staff development, time for staff development.
70	make these part of being certified and recertified....continuing education
71	Required ECU
72	Be open to attend trainings.
73	Provide more workshops/seminars/web-based training that is short in duration and covers one topic area at a time.
74	provide presentations by self-help groups, individuals
75	Establish partnerships with agencies and organization that specialize in those areas to receive training curriculum and input.
76	Require more classes on mental health for all nurses. Have stigma reduction campaigns and continuing education for all mental health workers. Utilize evidence based practices at all universities to ensure that mental illness is taught about in a way that reduces stigma. Research had shown that this is best done by interaction between students and people with mental illness in an officially sanctioned capacity where they are equals and working for a common goal. Have more peer support specialists at every treatment center, program, and hospital.
77	Advocacy agency involvement with schools. Perhaps mini-intenrships with advocacy organizations and consumer run organizations. More collaborations between the state and higher education. State/school certification on evidence based practices.
78	Ongoing education and training
79	Requiring certain topics be part of preparatory and continuing ed credits for licensing and renewal.
80	Community based mental health organizations
81	One on one with a peer support specialist as part of residency/fellowship
82	State mandates, licensure requirements
83	Classes at University Require for continuing ed
84	More required trainings
85	again better funding.
86	Continued communication regarding the needs of the families we serve and approaches that assist in engaging them.
87	Every student needs to have a significant amount of time working face to face with people who have mental illness and/or addiction. This should be an internship - something built into their education.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

88	updated training curriculums & continuing educ
89	More CEU's available on those topics.
90	smaller case loads and more opportunities for training
91	Require public institutions of higher education to provide these courses as a condition of receiving state funds.
92	They have to make this type of education (collaboration, crisis prevention and de-escalation, recovery, trauma, cultural competence a priority.
93	Agencies need to commit to getting then training...it's available!
94	Shadowing those who are competent in a certain area.
95	webinars
96	I think it comes down to money and time. If there isn't an increase in the billing for the increase in knowledge, I don't think it would happen. Plus, I don't think the employers will want the employees taking off the time for training, which would mean a decrease in billable time.
97	Relevant training; affordable & centrally located
98	Educational classes in college should be emphasizing the importance of recovery and being culturally competent. Employers need to ensure that their employees understand integrated behavioral health and how to work across agencies. There is plenty of work - view each other as opportunities for the consumer to be assisted, not as competition.
99	Increased funding/training opportunities that are free, etc.
100	Free ongoing training required for agencies, from well-educated and knowledgeable trainers, about recovery, cultural competence, IDDT. Not all agencies offer ongoing training and skill building in their staff, and lack of this type of learning can contribute to burn-out and poor service provision. Mental health professionals and practitioners do not get great pay, so if it were free (and sanctioned by workplaces AND COMMITTED TO by workplaces) it would likely increase quality of care
101	Internships with cross agency collaborations; local workshops and training's other organizations already offer
102	Connect it to a license.
103	Offer state-sponsored continuing education workshops related to these topic areas
104	Training is expensive. We don't have an education budget that is adequate for these very complex activity. The steps necessary is education of funders of what is required and what their return on investment is and if we don't how the mess will get worse and what that means for them.
105	Build into training requirements for employment.
106	their training should include presentations by consumers. they should have to spend time on a nursing home with a locked ward so they understand the importance of community integration wherever possible.
107	Mandate specific training.
108	Involve social workers, who are expert in team building and interdisciplinary relations.
109	Making CEUs more accessible. They're currently extremely expensive to attend, and so people only do the minimum (or what they can afford). If there was more access to more affordable, regular training, that would be beneficial.
110	More trainings and workshops and skilled speakers.
111	Employer(agency) should have mandatory training requirements or education onsite/offsite to accommodate employees.
112	Training at work, during the work day, and more funds for people to pursue education from outside sources that are paid for by the agency.
113	The best education is caught, not taught. Field work.
114	incentives for agencies to provide the trainings or pay for staff to go to outside trainings, access to trainings
115	state-run site for mental health professionals to be able to access trainings or informational handouts

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

116	Adequate trainings in areas that need updating.
117	Required experience and education with individuals, observing as they begin a crisis and go through the process of the crisis, and the after care.
118	It should be a part of their formal education, with continuing seminars and workshops. I also think that license renewal requirements should be more specific to target these areas.
119	local trainings, ITV seminars, in regard to the colleges requiring rural internships, practicum work, and clinical rotations, some type of compensation (stipend, tuition reimbursement, tax deduction) for committing to time working in a rural area
120	Work with NAMI to get the viewpoint of advocacy A team approach to supervisory
121	There needs to be a focus on supporting student prep at the college level.
122	medicare needs to expand counseling options so people actually have access and pay clinical social workers at least what nurses get for an assigned payment. telehealth for medications is a reality we have, but counseling services are so hard for seniors to access because they can't afford it. we only give them medications and this is not best practice. we also need in home counseling services for seniors not just those on hospice.
123	Offer internship opportunities; Develop trainings to address gaps.
124	make part of required training, offer more training opportunities
125	More in-services at the agencies plus more affordable training options
126	College curriculum needs to stay up to date with current government regulated programs.
127	Increase internship support in colleges or those that take interns
128	work with training programs to ensure inclusion of these "skills"; work with DHS to include these skills in CTSS and ARMHS and other funded programs
129	Much more mental health education in medical school for family physicians. Require a mental health rotation.
130	Adjust the current curricula, develop training for those already in the field
131	Work with faculty at colleges/universities to assure integration of accreditation expectations with multicultural, wellness and recovery based approaches.
132	more free trainings
133	requirement of licensure
134	The respective agency needs to promote and support training opportunities
135	Addiction and mental illness should be core components of all education. They "are alive" in almost all populations we see and yet we try to separate them. It is confusing for patients, families and staff. Even this process should have combined both.
136	More realistic classes in Grad school. More help in obtaining an appropriate practicum.
137	Have courses available to professionals during the day and evening. I work during the day and that is when trainings are so often available. I can not do as many trainings as I would like due to this.
138	roundtables?
139	needs to be integrated into their training
140	Licensing Boards are a good resource to get the information to professionals and coordinate the requirements of the training. Universities could work with the board to develop and provide training.
141	
142	Access to training programs, affordable education
143	I am not sure what would be the most appropriate plan to ensure this type of education
144	Employer-provided training, additional degree requirements

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

145	Insurance requirements and documentation need to be limited.
146	interagency training, required training, educational requirements when hired
147	specific DA certificate
148	Free trainings and relevant work shops.
149	My employer does a beautiful job providing in-house trainings to providers across all levels of practice, from direct-service professionals to supervisors/clinicians. Interagency trainings or reciprocity in training between partnering organizations would make trainings more affordable.
150	Requiring that all mental health service providers receive supervision from Master level clinical supervisors who graduated from accredited programs that meet CACREP academic standards and who have received training in clinical supervision.
151	Making sure those professionals who are allowed to dx and treat mental illnesses, with or without meds as part of the tx are educated long enough, in enough areas and that their testing is similar across the board.
152	Providing CEU's (paid or unpaid). Hiring people who actually know how to do the job they are hired for.
153	Update the educational curriculum in training programs, offer statewide CEU's for practicing professionals, reward professionals for gaining new skills and qualifications to address community needs.
154	Programs need to be required to offer appropriate courses in the dynamics of violence against women and appropriate individualized treatment for perpetrators and culturally sensitive treatment of survivors and their children.
155	Incorporate as requirements in Mental Health master's/doctorate level mental health professions. Focus should be on client across all of their environments and include caregivers/family as part of system. Collaborative approach to integrated, interdisciplinary team should be supported in psychology and more medically-based settings. Employers need to be provided with more complete and accurate information about levels of training and licensure, along with description of scope of practice and billing/reimbursement potential for Mental Health Professionals. In particular, the Social Work profession and Licensed Counselors have different levels of licensure and practice which employers seem to be confused by and often result in hiring MH professionals who are not appropriately matched with job descriptions/duties/expectations.
156	build into the curriculum
157	Affordable continuing education workshops. A day-long workshop of 6 CEU's is costing nearly $200 and licensees need 7 of those every 2 years, which is a hardship for many.
158	Communication, training
159	Greater training and supervision opportunities
160	Additional training in working with family members and the other topics.
161	I think on-going quality supervision is a primary area the could be improved upon, in terms of requirements across disciplines, increased knowledge of what supervision should include, affordable access, access to skilled supervisors. Group supervision also is more valuable than emphasized. Additionally, supervision should continue beyond the time a professional is working toward their clinical license. Also, required engagement in personal individual therapy should apply across fields. much is learned by being a client.
162	These situations take longer term treatment. Without increases in reimbursements, no clinicians are willing to undertake the demands of long term treatment.
163	More trainings about these two topics specifically via the agency and adequate supervision
164	1.) Hire people with BAs, MAs or years of experience in the field. 2.) Train staff first - prior to sending them into difficult direct care positions.
165	allow time for training and development
166	More available trainings at lower costs.
167	More focus on community programs while in graduate school. Courses specific to family engagement and team approaches. Education on the specific programs and how they work in conjunction with one another.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

168	More free resources
169	Availability, affordability
170	work with training facilities
171	Better communication practices across groups and agencies
172	It all comes down to the licensure requirements and graduate training program requirements.
173	Graduate school training, DHS Trainings
174	Exposure to the latest data on effective trauma care.
175	Professional schools may need to focus on down to earth stuff, like regulations, how to chart, etc. Prof Assns offer training that can be improved
176	More emphasis on these topics in graduate schools
177	More inter-disciplinary teams between employers and universities/colleges
178	Agencies should be willing to pay for staff to participate in conferences and other education. It only helps the clients we work with to be updated and educated on above.
179	Seminars, workshops
180	Investment by the management of organizations that education and preparation is a valued ideal. Often training is part of an expectation but some individuals do not have much of a say in what those trainings will be for the year.
181	More opportunities for professionals to take time away from work to get proper education and additional training.
182	Improvements at training program level. Training for state boards. Note there is no option for Rural Health Clinic or Primary Care clinic as work setting for mental health professionals!!!
183	training annually, individual counseling if someone is not following through
184	better training in master's programs
185	Organizations would need to allow their providers the time and spend some money on training their staff, which is easier said than done. Research online tools and have an in-service training for those who do not learn well from online training.
186	Lower costs, ITV or SKYPE to reduce travel costs, more opportunities for trainings such at TFCBT, EMDR, PCIT, CPP, DC0-3 assessments.
187	Offer CE courses in relevant topics
188	Electronic tools that are incorporated into daily practice (e.g. note and billing tools) that deliver evidence-based prompts and resources at the time they are needed.
189	Team leaders must be aware by means of surveys like this.
190	We get lots of training opportunities and time to attend outside trainings.
191	offering more free trainings state wide (more in rural communities) as we are driving sometimes several hours to get to good quality trainings
192	Creating caseloads that allow practitioners to complete paperwork during designated paid work hours without punitive measures for non-client time.
193	State publications that are sent to each provider that specifically explain the DA requirements for Case Management and timelines for CASII completion. This will help with the family engagement and overall treatment for the family to access the necessary services (family engagement). Auditing the DA's in the future will test for compliance. Early intervention stats will also indicate compliance and competence.
194	free or low cost, local trainings with qualified professionals
195	educational institutions working more closely with local providers as well as government entities that are responsible for case management services

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

196	Redefining collaboration and coordination of care.
197	The various professional organizations could make available to their members recordings of relevant presentations at a reasonable cost.
198	Programs are set up to establish this. There is a lack of accountability on the upper management side of things.
199	Offer on line courses.
200	Medical integration will take care of itself: It is the future, and training psychologists know it already. Evidence based practice would be facilitated by easy access to "best practice" information.
201	Much of the above are gained in medical school, nursing school or phd clinical psychology programs. Clinicians with a master's degree, of course, would not have the time to gain such knowledge/training/supervision. Ongoing continuing education programs for MD's/CNS/PhD's can provide updated education/prep.
202	Encourage agencies and local educational programs (graduate schools) to cover these topics in their trainings.
203	making training requirements
204	Ongoing training requirements for licensure
205	More publically sponsored, subsidized training in centrally located, easily accessible locations.
206	In larger mh agencies, make the trainings mandatory.
207	Requiring more hours of training - up dated training NAMI classes
208	Fewer and less particular requirements by DHS with documentation, more reasonable expectations on practitioners (over-worked and underpaid, especially for diagnostic assessments/DA's), and reimbursement for consultation between providers and coordination of care.
209	Meetings with hospitals and outpatient providers
210	The Departments of Human Services and of Health could develop model curricula for this education and training, and disseminate this information actively, widely and repeatedly, and seek to establish measures of success in adoption and use of these materials.
211	More continuing education opportunities, and
212	Working with educational institutions for incorporate trainings in these areas.
213	Provide incentive via free CEUs, streaming webcast,
214	State sponsored programs like the program a few years ago on treatment of dual diagnosis would be helpful. More free or low-cost CEU options.
215	I do not think any more steps should be taken to add training to this field. We find that people are very well trained coming out of the training programs on all of the above. To become a professional they then are on a 'licensure track." This has become something of a 'racket" with the boards who now have added a requirement that you have to have a 'supervisor's endorsement' and now we have a whole bunch of mental health professionals not helping people but providing costly licensure supervision. This all costs money and the rates are going down not up and employers cannot afford to pay people enough to recover their costs. With the cost of college and graduate school and now post degree supervision being a racket people are coming out with massive student debt. DON"T ADD ANY MORE REQUIREMENTS. MAKE IT EASIER.
216	not only require a minimum number of CEUs annually (or biennially), but also require that a minimum number of hours be in particular areas, particularly cultural competence, DSM-V changes, etc.
217	Include training in graduate programs. Offer online programs/webinars or frequent in-person programs.
218	Having more trainings available and ones that are affordable.
219	If adequate training and competency is not established in the master's level preparation, that the opportunities are part of the immediate continuing education requirements.
220	Continuing education requirements. Practicum/internship placements that emphasize these areas.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

221	offer more discounted or free CEU type training opportunities
222	This needs to happen in graduate schools and their clinical training.
223	expanding the depth and breadth of training
224	Funding by the employers committed to education and government grants that make opportunities and see the importance of education and equipping the mental health professionals
225	More funding needed from the state level and more training opportunities.
226	More grants available to pay for such training as non profits struggle to fund continuing education opportunities for their employees.
227	1. Start with curriculum revision for colleges. 2. Update orientation to include these critical competencies. 3. Enhance the reimbursement system (partial payment for required supervision, etc.).
228	More in-services at agencies, more graduate classes that apply to such needs...and try to keep the cost of training reasonable in cost.
229	Certification, minimal requirement schooling, internships
230	This needs to be standardized across school settings regardless of professional affiliation.
231	Allow ability to bill for professional time.
232	Access to training by on-line resources for all the mental health people that work in Greater MN that are unable to spare the time and money to travel to the Twin Cities.
233	low cost trainings
234	Mandate through graduate programs
235	I have found trainings that are intensive and allow one to go out and practice the skills and keep reporting back to be most effective. I am currently in the TFCBT program and find it very beneficial to growing in my practice.
236	Utilizing nurse practioners in a more limited, and appropriate role than they are currently taking on. Currently I find that there are a lot of patients who come in on horrific medication regimens, often prescribed by local NPs. Some NPs are excellent, but not all of them. The overuse and misuse of antipsychotic medications in this area is especially concerning.
237	Professionals with supervisory licenses should be utilized to do continuing supervision even after the employees have completed their licensure requirements
238	It takes considerable time to obtain this training and it is an expense that is not fully budgeted, or close.
239	offer it in house
240	Times have changed, those going to school in the mental health field need to know the paperwork greatly outweighs client contact and their ability to spend time with individuals and families
241	content in education, including a realistic focus in internships. Changing definition of MH services from office based to community provision as this is consistent with the client needs and reduces barriers to clients for service
242	Free trainings by agencies shared throughout the area.
243	Work with training programs to include more emphasis on chemical health, physical health, and trauma
244	mandatory trainings
245	Encouragement from state agencies, and commitment from educational institutions that train mental health personal, and adjust the licensing laws for these professions accordingly.
246	I think the areas that I identified fall into 2 categories. 1. Need to understand that we are always developing people and field. Our practice needs to follow that. We frequently are underpaying for preparation and on the job learning to develop people. 2. Clarity is the other major factor when I think of integrated care or administrative paperwork clarity is what is missing. Seasoned professionals struggle and expectations change without good examples.
247	Curriculum provided by state and other agencies so that each agency doesn't have to create there own.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

248	course work requirements, It really depends on the work that they are doing as to what areas they need to be stronger in so a lot of it is work experience related.
249	Workshops specifically aimed at these topics.
250	Allow them to have non billable hours
251	standardized practitioner certification course
252	Go back to doctoral level licensing.
253	more specialized courses in grad school, online prep classes available for learning about beginning therapist requirements
254	There is so much pressure to bill in order to support our positions as mental health professionals - our agencies cannot afford to provide us with the training.
255	Dedicated sections in grad. classes, On-site trainings, accessible and affordable trainings through local agencies
256	Stress the importance of family engagement and involving patients primary care providers and working with other agencies to ensure continuity of care. Show the affect of not doing so (IE utilization of readmission data when family engagement and working with other agencies/PCP/etc. is not completed prior to discharge).
257	I would like to see a MH practitioner certification. Past practice when RTCs existed allowed for a rehab worker to become a practitioner. Now, programs need practitioners to bill and have no way of hiring someone that meets these qualifications.
258	Reevaluate the educational curriculum and ensure these additional educational pieces are included in a significant way. While much has change in the mental health arena, the curriculum training mental health professionals has not.
259	Including it more in education. It would be great if there was some kind of requirement for cultural competence training and attachment/trauma training for CEUs, but this would probably be difficult to do.
260	Affordable, accessible training. On-going training groups that are affordable and well run.
261	More discussion between community providers who and the graduate programs at the colleges and university's. More adjunct professors at the graduate programs who are working at training professionals in their agencies and in the field.
262	Graduate schools need to offer courses in these areas
263	have trainings be more accessible for less cost
264	Have professors and instructors move around -- at least tour agencies where their graduates are working.
265	It has worked well in our agency when the state has paid for the training time, such as in the TF-CBT learning collaborative. With the financial strains being so great, everything is tied to billing. There NEEDS to be a financial incentive.
266	Funding should be available for ongoing training
267	Institutions of higher learning need to deliver better outcomes. Institutions needs to review their practices and fill the gaps. The state needs to do a better job of evaluating services.
268	Have training available from DHS Children's Services. Have the State ask Supervisors for input.
269	coursework which includes the above topics to secure degrees in the behavioral sciences. Also broaden the definition of behavioral science degrees and encourage DHS to adopt the same. DHS current definition of behavioral science degrees is very narrow, psychology and social work and sociology, which significantly limits the requirement pool.
270	Encourage people to become darkly childhood mental health professionals.
271	Medical school training and continuing education. Mentorships that allow enough time to provide actual mentorship (this means reducing patient loads for mentors and mentees).
272	Time and money for training and good supervision.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

273	required trainings and supervision with development goals.
274	good supervision that is PAID FOR- for example MA code for supervision of clinical trainee. We can't afford to keeping doing this for free and do a great job of it.
275	Documentation and working with team across agencies is not taught in the graduate programs (at least it wasn't in mine). My graduate taught a lot of theory, but not enough practice information. Understanding the real day to day tasks and activities before getting out into the field would have been helpful. In terms of diagnostic skills--taking courses in abnormal psychology does not give a complete picture of a person who is living with mental illness. I think it would have been helpful to meet real people living with mental illness and understand their symptoms and their story, more so than reading a case example. Trauma is a topic that was not discussed in my graduate program at all--I am not specialized in treating trauma because it was part of almost every patient I saw. A lot of the children growing up in foster care, or being placed out of the home, have complex trauma histories. If the people working with them are not informed about trauma, and also are not working with the families/systems that these children live within--I do not believe these kids will successfully reunify.
276	-Encouraging training at an organization level
277	Provide training on the process of special education - perhaps through MDE (Minnesota Dept. of Ed.) frequently schools receive reports from community providers of mental health that recommend an IEP, not understanding the process, this confuses and frustrates parents who then come to school with the diagnostic assessment expecting that their child will automatically get special education services.
278	Restucturing of all training programs to be "dual liscnesed" or at the very least increasing the number of hours that focus on addiction and co-occurring disorders, additional course work that explains the difference between Integrated behavioral health (the medical component) and co-occurring disorders. Also, many schools do not require psychopharmacology so most students do not understand the basics about pharmacokinetics and pharmacodynamics which has a major impact on treatment planning.
279	Additional coursework on the above areas and increased demands for opportunities to practice these areas on internships.
280	The education that is offered is SO expensive. Compared to the average salary of someone in the field, the prices are just not reasonable.
281	A centralized hub (website) for listing trainings available throughout the state (professional often find out about trainings through mailing lists and may not be aware of available opportunities).
282	Compensate them for working on family education, working on teams/across agencies.
283	The state could require that mental health wrap-around services be in place for anyone who is placed in a hospital, residential, or partial hospital setting so that patient care at discharge is consistent and services are provided to assist them with recovery. Education on wrap-around and ongoing outpatient resources and follow-up can be offered as part of the continuing education requirements.
284	Continue to offer trainings - and more of them in rural areas. Also mental health programs can continue to offer relevant course work.
285	Time/$ built into schedules to do so. Grants for trainings.
286	More education during school More requirements for licensing
287	State sponsored CEU training...it's too expensive
288	I think that a huge number of people struggling with mental health have brain damage from prenatal alcohol exposure, but it goes undetected as providers are not aware of the red flags, indicators, symptoms. They have old information that is out of date. Requirement on training in FASD would be important
289	part of licensing requirements?
290	Must come from an accredited program;
291	I think more "hands on" experience is needed.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

292	More access to grants providing evidence based training.
293	More access to grants providing evidence based training.
294	Grants and scholarships to pay for trainings. Give employers (e.g. non-profit MH agencies) incentives to get more of their employees trained.
295	progressive internal education as well as supporting external education sources.
296	Provide more opportunities for students across different disciplines to work together, collaborate on cases, or even do supervision as a group. This will expose students to fields other than their own, and the richness that they gain from this (vs. only training with others who represent THEIR field) will outweigh the comparatively narrow focus of any one disciplinary track.
297	Support educational funding to integrated primary care/behavioral health teaching systems. We provide this education and support now in spite of decreasing funding for health professional and primary care education, especially at the graduate level.
298	They seem to respond to licensing and certification requirements.
299	lots of inexpensive training opportunities that are board approved
300	Tighten requirements.
301	All mental health professionals should be required to take coursework in working with families.
302	More free CE trainings, especially in greater MN.
303	Affordable, update educational competences and create better pathways.
304	Require more experience specifically in how to access and work with family support in mental health treatment.
305	Revise or expand curriculum in higher ed training programs; create on-line courses and webinars; expand state contracts for training in EBP's
306	DHS trainings, more systematic training plans for staff and teams.
307	Routine forums where persons in the service delivery practice arena and educators come together to celebrate and review common shared vision, needs and outcomes.
308	Add to college curricula and graduation requirements
309	We have added significantly to our on-boarding process for new staff. It would help considerably if the state or counties could fund more staff training in evidence based practices as it is very costly for agencies to offer this training to all staff.
310	Cheaper more cost effective trainings, more therapy to the therapist groups and therapists advertised and available.
311	toolkits
312	Provide more opportunities for time off and grants to pay for workshops.
313	Need for understanding Family Systems and dynamics of multi-generational systems. LPCC track offers little family systems courses and this has been challenging with LPCC Master Level trainees not having good foundation in family systems.
314	Have teaching staff who have had experience in the field, and who understand trauma and its impact on individuals and families.
315	On going learning collaboratives. Funding for organizations to provide training or send persons to training.

SURVEY QUESTION 6: What steps do you think could be taken to ensure they receive this education and preparation?

316	Specific training on assessing and writing diagnostic assessments using sample, real life, clients that use community mental health services. Training in crisis assessment, use of supervision to document consultation around high risk situation and how decisions were made. Integrated behavioral health--mental health and primary care--how to change mental health services to match some of the operations in a primary care clinic. For example, primary care clinics see clients every 10-15 min. and complete very brief, sometime one word assessments of client's reason for visit and often provides treatment recommendations in that same 10-15 min. time period. Mental Health completes at best a 50-60 min. brief diagnostic assessment before treatment begins at the next session. In order to train mental health providers to work in primary care, seems like we need to adjust mental health expectations to more closely align with the pace of work in primary care.
317	PACC Program at U of M Internal Training
318	free training sponsored by state or counties supervisory classes in out-state MN
319	Create a culture that expects it; Educate payers, institutions, and clinics about the importance of integrating mental health with primary care.

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

1	Eliminate excess courses change licensing requirements to be more open. Tuition and loan forgiveness programs for students after completing programs to encourage students to complete degree requirements
2	I'm not sure, our agency has hosted a number of DC 0-3 trainings but professionals are hard to attract. Mostly motivated by how to report for reimbursement.
3	Build in funding and opportunities for more paid practicum and internship positions Create a reimbursed continuum of care there are jobs available all along the continuum (prevention, early intervention, direct service)
4	Online classes that are mandatory.
5	More hands-on learning experiences or practices
6	More training options in these areas that are spread across the state and not always just offered in the Twin Cities.
7	I believe that the Board of Behavioral Health requirements regarding LPCC licensure is inadvertently pushing potential practitioners out of the field. The current requirement that practicum sites for MA programs not be the same as the students existing work site means that only students who can afford to take significant time away from paid employment can afford to complete the programs, particularly since virtually no practicum sites offer any pay, and often require many hours per week for 9 months. This means that students who do not have family to support them are often unable to obtain this degree, which I believe results in a strong majority of students from upper-middle-class families who are, by default, overwhelmingly white. In my experience, the work of a mental health practitioner and the work of a practicum student are often very nearly comparable in scope and type. If the board would allow a system for existing employment to be expanded into practicum work, I think it would encourage a wider array of potential counselors to enter the field, and encourage diversity, as well as promoting the health and wellness of new professionals.
8	Make part of training from start.
9	Make mental health treatment such a psychiatric services, therapies, and mental health workshops more affordable so that low-income people can access them more readily
10	Bringing training tot he work site; having education classes distributed over just 1 or 2 hours a week and allowing staff to attend
11	On-line education for some courses can be useful, but doesn't convey some of the interpersonal skills and values that are critical to behavioral health. A better recommendation is to create extension programs for the BH professions in rurally-located state universities, but be certain to staff them with qualified professors/instructors. And fund adequate scholarships to them.
12	Offer it. Have organizations and employers require it and subsidize it and allow staff time to attend.
13	making them more localized for people, making them more affordable, and even holding the same training on a couple of different days to accommodate more people.
14	Degree programs in the state are very well-rounded
15	Mental Health Workers - put them in communities, schools and faith communities.
16	above and use own staff
17	have not greater mn trainings to make it more feasible to people to be able to attend
18	Cooperatives, learning collaboratives based on NCTSN models. Spread out the 'work-load' yet be inventive in collaborations. Make learning about mental health and processes fun. Collaborate with MPR, Current, arts orgs. Invest in places like child advocacy centers and already existing frontline community based and trusted orgs like Casa Esperanza, Minnesota Indian Women's Resource Center. Take culture and spirituality into account. Understand the importance of healing touch, alternative medicines, yoga, meditation, NUTRITION.
19	Teach evidence based practices.
20	Webinars, ITV cost little, on-line training is also free
21	online and free. Taking time from work and the cost of training can be prohibitive
22	The AAMFT has been most committed to providing conferences headlining major contributors to the field!

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

23	There should be a way for trainees to return to their communities and give back what they have learned. Currently, there are few very low paid, no benefit options. This encourages trainees to leave their areas and serve the population that can afford them instead of those that might have the greatest needs.
24	Evening and weekend class options increase accessibility for working students. Educators who are also actively working in the mental health field outside of pedagogy and/or educators who have a solid past experience working in the field.
25	Continued support of online education and increased practical competence assessment. Increased "hands-on" work through role plays, modules, and presentations from outside entities. Increased partnership between graduate programs and their regulatory boards to develop a relationship early on in education. Identifying the regulatory body as a resource and a support prior to and after licensure. Increased educational materials on frequently asked questions and frequently occurring ethical issues.
26	It is very accessible. More public education about what therapists Can provide. Wellness care covered like in medicine.
27	DHS could offer statewide ITV trainings on the aforementioned mental health related topics as the Aging Division does
28	use webinars with post tests online at the close of the webinar. Provide training at least once that includes actors portraying clients. Very effective.
29	web based is good.
30	task force to compare educational equivalence
31	more exposure to successful consumers
32	more on-line training opportunities
33	Use webinars and other media training strategies for people who have time and distance challenges of travel time and lodging (rural practitioners), but this can also be true for people just entering the profession.
34	Encourage colleges to increase the number of students they are enrolling, or enlarging departments. Put appropriate pressure on college administration to support the programs in hiring staff in tenure positions to help retention in college teaching programs as well (this can increase the overall effectiveness of the college training for mental health professionals) Offer loan forgiveness programs (not for just those in rural areas) Scholarships programs for students specifically going into mental health
35	To make training and education and support groups available at a no cost or low cost level for people with mental illness.
36	See #6 above
37	Stipends
38	Offer IDDT training workshops for CEUs at conferences like MSSA and St. Louis County Health & Human Services, or through associations like MN Psychological Association and the MN Chapter of National Association of Social Workers.
39	offer, pay for it and give paid time off for it
40	additional internship experiences so they understand the entire scope of services-not just 'in office' point of view
41	It is not just the access to training and education, it is the idea that many hope to work as Therapists rather then work in other areas of Mental health
42	Maybe give employees a sense of the budget for their own training and allow them to seek out what training they think is most beneficial to their job and their professional development. So the employee finds the training and the supervisor approves and guides the process. Also, of course offering all agency/department training sessions where teams can talk with each other about the topics.
43	Allowing staff time-off and agency paying for the education.
44	Increased grant money.

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

45	Make training part of schooling as well as hiring process
46	Less grouping of labels. Humane integrative treatment policies promoted. More study to support a natural approach, rather than emphasis on medication as the catch-all way to treat.
47	Funding to agencies for training; training through webex for those who can't travel to the conference
48	Hold them in other places; not just primarily Minneapolis or Duluth.
49	making it available in rural areas, not just metro
50	free CEUs
51	attend conferences, and workshops
52	good, affordable, continuing education that cuts across disciplinary boundaries
53	None
54	- Improve opportunities for interactive "distance learning" to achieve CE in important areas. - Target funding for education and training to Greater MN. - Set up clinics that allow for rotating experienced supervision/training for example, create a rural clinic that has an attached, secure, furnished apartment or two as part of that same building, or a rental apartment in the same town -- with a weekly housekeeping service -- psychologists could go there for one week per month, with 4 different psychologists the clinic could be staffed on a rotating basis. That would provide a "week in the country" and an opportunity for someone to serve as a supervisor/consultant once a month to local programs.
55	Create more levels of licensed practitioners so certain levels of care could be practiced by individuals with briefer training. Also, focus psychologists training more practically. Make the EPPP more practical and less academic.
56	Have government funding or 3rd party payor funding for services provided by trainees in PRIVATE, for-profit settings -- smaller clinics.
57	Offer reduced fees for lower income attendees.
58	Webinars
59	Utilize local Peer Support Specialists for practice drills in de-escalation techniques, cultural competence with diverse populations: through peer support related activities within the school setting or speakers from diverse population areas, speakers with real life experience treating trauma, family dynamics in affected household and learning from family members how to listen not only to mentally ill individual, but to needs of family as well, teaching to think outside the box to identify available resources for the individual and the family as a whole
60	Medical Schools need to attract mental health workers through conferences for new medical students and residents. Perhaps assistance with medical debt for those who choose mental health as a profession
61	Don't charge for it.
62	Look at schools' curriculums
63	Send out training to everyone to make it more cost effective and affordable
64	Having free online trainings would be beneficial as it would allow for more consistent training across agencies and providers in key areas such as cultural competency, HIPAA and working with families. It would be particularly beneficial for smaller agencies/providers who do not have the budget to develop trainings of their own and would guarantee all practitioners, professionals had access to the same content.
65	Online training, incentives for employers to offer training, supervision, clinical experiences
66	More local trainings in the area. Our staff usually has to travel and take time off due to travel time to and from trainings.
67	More in the northern part of the state. It is difficult to go to the cities all of the time for a meeting.
68	Web based- not expensive- time is reimburseable
69	recruit parents and teachers who deal with mentally ill students to present to psychs in training...and other professionals in training

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

70	online, self-guided courses that offer ceu's that have been approved by the various licensing board
71	Internships and clinical rotations
72	I have sent out emails about an upcoming training that is important and benefit in collaboration, little to no response. Disappointment
73	web-based workshops; cover one topic at a time
74	The professionals need to accept that what they provide is only one piece of the process of recovery. Then if they can acknowledge other methods like self-help that would help.
75	Webinars, online self-guided study
76	The things I mentioned in my response to question 6.
77	Scholarships for mental health professionals who agreed to practice in shortage areas in MN for a set number of years (5?). Online classes with discussion groups available.
78	Webinars and regional training sites
79	Webinars that are free or very low cost. 2-3 session short courses at convenient locations such as community colleges across the state
80	State coordinated training venues.
81	Working closely with peer support specialists
82	web-based, virtual presence communication
83	ITV Retrain 6 months to one year later
84	Each county should put on these trainings.
85	better advertisement. better involvement from family members/peers/people who are diagnosed.
86	Identify what is available. Try to work with administration to be more flexible and put more funds into training.
87	On-line training.
88	Online training makes things more accessible but it is not as effective as face to face training. Our local counseling center is offering a free DBT class for service providers in our community. This is helpful for the staff that have to teach it and members of the community.
89	more web based options
90	Right now only the state provides trainings on CTSS.
91	same as above
92	Provide financial incentives to post secondary education programs to provide the training.
93	Walk out your doors. There are people doing this training and getting excellent results. Open your eyes.
94	It mostly is. The challenge is that it's expensive and 3rd party billers can't always take time off for this training because they lose billable hours.
95	Financial support to those chosing the area, tied to working in the State, or a specific agency
96	webinars
97	I think it should be provided in the areas in which is served by a primary mental health clinic. The training should include people from the county case manager, community provider, CBHH staff that in the closest hospital and local IRT facilities, foster care providers. Anyone that would be part of a team for a person with mental illness, so they all get the same training.
98	Utilize different mediums; face -to-face, webinar, ITV.

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

99	On-line training is much more fashionable these days. People of my generation (55+) are not necessarily thrilled with that opportunity. In-person modules are a must if there is on-line training required. If training can be provided towards the early beginning or later near the ending of "regular" business hours I think that would be more effective than taking people away from meeting with their consumers for the day or week.
100	Funding for returning to school; scholarships/grant opportunities. More lfexible work schedule to allow for returning to school.
101	Make it free, make it mandatory for licensure of a clinic, make it ongoing, repeat trainings on certain topics or discussion groups to further delve into the complexities of a topic (that are ongoing). Goodwill, for example, has motivational interviewing training (2 days long) and then 8 'coaching circles' for staff and interns to participate in to further develop skills learned in the training. All staff have to take all the trainings and re-take them once they complete.
102	Include these as a requirement in graduate school and professional development. This development must include an experience with one on one or group of individuals and families with mental illness.
103	If there is any way to use technology to make this more accessible, we should use it.
104	Web Ex-ITVs--connections with colleges
105	Have colleges and universities use more evidence based approaches to both the content but also the process of providing education; offer post-graduation follow up courses (for example, someone gets their MSW and the school has a 6 and 12 month check in with them to see how they are starting to integrate their education into their practice)
106	We are training too many cardiologists and not enough primary care physicians with mental health training and not enough Psychiatrists. Train more of some train less of others. The number of physicians trained don't change but the specialty can change. Talk to the Dean of the medical school. Stigma and bias are everywhere even in places like medical schools and how the funding flows.
107	Same as number six.
108	lots of professionals with real world experience out there who would be happy to contribute thru a training institute etc.
109	More on line access to education.
110	Involve the schools of social work.
111	More in-house training. My company provides a great deal, and it's high-quality, so that's very beneficial to us. I know from experience from other places I've worked, and from the reports of those who have left my place of employment for others, that in-house training is inadequate, outdated, etc.
112	Webcasts, emailing resources/list of trainings available for the month. Coordinating with pharmaceutical reps/educational agencies to have more trainings on site.
113	It's a money issue.
114	There aren't enough programs to train enough doctors to fill patient need; the trick is going to be getting excellent, qualified professionals to train those who desire to work in the field.
115	one central location
116	More cultural competency trainings.
117	Internships with mental health crisis programs
118	Put in a requirement that companies over x size be required to offer continuing education classes to their employees.
119	Give consumers more input Video tapes of consumers sharing their experiences with the Mental Health System
120	location, online work, ITV
121	My supervisor sits down at our evaluations and asks which trainings I need

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

122	Better support behavioral health training and prep in MN higher education.
123	loan forgiveness programs and health systems advocating and promoting mental health worker education the same way they have done with nursing.
124	Identify training needs; collaborate to provide trainings; make training accessible via webinars etc..
125	Give credit for current or previous employment in a mental health field. Too many good social workers cannot afford to leave their full time employment for grad school practicums that amount to 16-20 additional hours a week. Even enrolled part time in grad school, you can not maintain a full time job and a practicum. I tried in my 40's and became very ill. My health was too important to attempt to finish school and work.
126	webinars, easier access to trainings
127	To make it accessible, employers assume the cost, at least partially, making trainings affordable. To make it more effective, provide more experiential learning opportunities such as workshops rather than just lectures.
128	I know web based is really popular from a productivity standpoint but I think the face-to-face training from a highly regarded speaker is still the best.
129	fund or grants for places like MACMH that have lots of training opportunity and structural support
130	develop education partnerships between mental health agencies and training institutions so that employees have tuition breaks; loan forgiveness or deferral programs
131	Scholarships and Student Loan forgiveness for positions that are consistently difficult to fill.
132	longer, more in-depth internships
133	Online courses, simulations
134	Loan forgiveness--more scholarships for "minority" students pursuing graduate education--more efforts to recruit a broad group of graduate students.
135	have more of them
136	lower case loads so that there is more time to work trainings into work days/weeks
137	More in house webinars for rural counties
138	MnSCU needs a Psych NP program in Central MN. I also think the family therapy, counseling skills etc could be taught as part of a counseling core. Then the APN could have separate classes on health assessment, pharmacology etc. Nursing Theory could be taught online through other MNSCU programs but the core of the program could be at St. Cloud which has better connections to rural central and northern populations. Use our resources wisely and share across systems.
139	More culturally sensitive
140	Various ours and days. Less expensive. Companies get incentives for having trainings.
141	cross communication with providers and agencies, especially with line staff. Too often decisions are made by upper management, who have NO clue as to what really goes on in the trenches
142	Look at all areas of the State to hold the needed training, not everyone lives close to the Metro and it is costly to attend training.
143	Our agency as an in-house training program. I think this makes it accessible and effective. Also helpful are streaming or online trainings.
144	Making it affordable and available
145	Offer trainings through the company where employees are paid to participate, but make sure there are plenty of different days/times offered
146	Have insurance companies streamline their documentation.
147	employers assisting to pay for additional training, employers paying for webcasts or CD trainings to bring to the office environment

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

148	Free trainings and relevant work shops.
149	Targeting information directly to the audience and having trainings with different tiers based on that level of training would be more effective (i.e. Intro to CBT, CBT Skills Advanced, etc.).
150	It is accessible, it needs to be affordable and required.
151	Reduce the price of education for people who are going into this field.
152	Providing scholarships for diverse students and financial incentives for graduate programs for training diverse students from various racial, cultural, economic, and national backgrounds in addition to students with a variety of disabilities.
153	Loan repayment programs for work with underserved populations. More competitive salaries in general for mental health professionals and partity across mental health professions, i.e. psychologists should not be at higher reimbursement rates than LICSWs,
154	loan forgiveness programs
155	Loan forgiveness programs Better pay for mental health providers so advanced education is perceived as worth it
156	communication, time and input from Cm when the state rolls out a new program. When new forms and programs roll out its not user friendly.
157	Bringing high quality trainings to the area at reasonable costs, learning collaborative models for ongoing consultation, buy-in from agencies to allow time for learning new strategies
158	Make trainings relevant to the population we work with as well as the work we do, build in training programs into the agency.
159	1.) Online resources. 2.) Offer incentives for staff to go back to school and/or take trainings.
160	More online courses
161	Lower costs for trainings. More grants/scholarships available for education in mental illness/chemical dependency.
162	My agency provides training as a part of our job. I have found this to be INCREDIBLY helpful. We get paid for our time and it is provided on site. They also provide us with information and permission to attend outside trainings- we can occasionally get reimbursed for attending trainings and this has made it much more accessible for me.
163	reduce cost and provide more incentives for providers.
164	Make it mandatory
165	Accessible= lower cost. Helpers don't typically need to make a lot of money, but they also don't typically come from wealthy backgrounds. Effective = critically examine the number of students a program accepts with respect to teacher student ratio. Some programs have 60 students to every teacher and most are adjunct. That is insane. That is also the standard model in many MN schools.
166	Keep cost down. Providers that have to forego seeing clients to attend training take a bit hit financially.
167	DHS training through interactive television
168	The more hands on training the better
169	Free agency catered/sponsored trainings.
170	Supervisors need to be more in tune with available resources for training and workshops. This need to be an expectation and part of the job descriptions.
171	Make it routine part of training programs.
172	provide trainings through the agency during staff meetings
173	decrease fees associated wtih licensure; $425 a year is challenging when most started MH professionals only make 25-30,000 / year.
174	Take a survey of the individuals learning style i.e. intellectual, visual, audio, experiential, etc. and go from there by tailoring the learning for these individual groups then come together at the end so everyone can learn from each other.

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

175	I like the idea of consultation groups with phone contact on a consistent basis surrounding a certain intervention strategy such as CPP, TFCBT
176	Reduce cost and offer several date options to allow clinicians to work and get CES. Schedule workshops and announce them at least a quarter in advance so clinicians can plan their work loads.
177	Bring educators to the pros.
178	Many mental health jobs combine both unskilled tasks (meal prep, laundry, personal care) with higher level mental health tasks (crisis intervention, diagnosis, treatment planning, referral, etc.).
179	Distribute materials to agencies to create in-house libraries so training is readily accessible and more affordable
180	Professionals are willing to seek out this training if the agencies had more dollars specifically marked for training purposes. Also, State supplied publications that are specific and contain templates that would help providers meet requirements would be useful.
181	grant funding for trainings; more partnerships with experts and contracts to assure trainings on a regular basis
182	the cost of continuing education has continued to rise while resource for paying for it has diminished. State investment in workforce development is needed.
183	tell prospective students upfront what is going to be required for licensure (not just the degree) more qualified sites for practicum and internships funding, funding, funding
184	See above
185	There are plenty of opportunities for education and training already established. No need to create more.
186	Again, on line courses are easier and accessible
187	Cost of graduate training is the main obstacle for all but the best supported undergrads.
188	Choose centralized locations that people are familiar with. Use language that is inclusive and inviting in advertising the training. Target specific groups that are wanted to be in a particular training.
189	Develop an intermediate level of training and licensing so that MnSCU can graduate students with 2- and 4-year degrees who are job-ready
190	access to webinar options, reducing cost to webinars, reducing cost for trainings in general (there are a lot of free trainings which helps but training budgets can be low so having more access to good/ quality info at low or no cost options is helpful
191	Offer free training for core areas of importance.
192	Web casting
193	psychologists should be licensed to provide medication after proper training that would be similar to that provided in the two year training of a physician assistant
194	Webinars by themselves do not seem adequate, but creation of on-line learning communities might help, especially if they could be combined with occasional in-person meeting of the learning community to build support among members and facilitate mentoring.
195	Provide funding to many more sites to offer internship and practicum opportunities to students. For many MH agencies, taking on trainees to give them practical experience, means adding expenses with no additional revenue. If 3rd party payers were required to compensate trainees both before finishing their degrees and immediately after completing their degrees (before they are licensed), more clinics could afford to add practicum students and interns to see clients with supervision by a licensed professional.
196	More affordable options (maybe grant-funded, scholarships, etc), and multimedia options (webcasts, archived content, etc).
197	Some supported funding
198	Use technology to make available to clinicians in greater MN

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

199	The three non-medical boards should be required to honor any post-degree supervision during the licensure track experience. Everyone has a job supervisor since they are practitioners or clinical trainees. Boards should be required to honor any supervision by a QMHP not just in one of the professional silos. There should be a tax credit for employers in this field to make up for the increased costs and then they can pay people more. Also lower tax rates or loan forgiveness for those working in this field.
200	as an example, the Board of Psychology is offering 7 free CEU hours this year to psychologists. Free or low-cost CEUs provided by the Dept of Health (rather than for-profit agencies like PESI) would be helpful.
201	State of MN sponsored webinars. Train rural (and underserved metro neighborhoods) non-mental health providers in screening (not diagnosis) and support.
202	To be able to use work time to get to trainings, instead of on your own time.
203	LPC/LPCC licensure requires an additional (up to 12) graduate credits for licensure. It could be that these core competencies are included in these required courses, or that the license has the option to obtain this training via CE in the initial years of licensure, (instead of grad courses, or to allow more time for that additional grad credits).
204	Accessibility: funding/reduce costs of education. Support cultural diversity in education/faculty leadership.
205	More rural area training opportunities
206	None
207	laddering the training experience may be helpful
208	Greater commitment by agencies and funneled resources to make it happen.
209	In-person training with online cohorts- more options would be needed for best practice
210	More grants available to pay for such training as non profits struggle to fund continuing education opportunities for their employees.
211	Increase frequency of agency training with follow-up within a month to answer questions and discuss if training has helped...and what more needs to be taught.
212	Internships/on the job training as part of education and training in high needs areas
213	Better internship training sites, better trained clinical supervisors who know how to best train mental health staff.
214	Have a state training program similar to case management training that occurs several times throughout the year across the state.
215	Webinars, tela training
216	Cultural responsiveness and awareness are keenly important when working as MH professionals. This is a internalized drive that cannot necessarily be programmed or mandated
217	1) This state has a dire shortage of psychiatry subspecialists, including child and adolescent psychiatry, forensic psychiatry, and neuropsychiatry. If the state offered fellowships that paid well and/or provided student loan forgiveness or repayment DURING THE FELLOWSHIP people would flock here for those programs. Service requirements could be built into these programs so that participants have to work in the state for some period of time.
218	I think we are blessed with really good continuing education options in Minnesota but we have allowed insurance companies to drop partial payments to training professionals. I am talking about people who have completed their degrees and passed their licensing exams but have to still have 1000-2000 hrs of supervised work to become fully licensed and bill insurance.
219	Social Work Education programs could offer a mental health specialty/focus to include current best practice trainings. Some local providers have good training programs, but budgets for training may be inadequate.
220	offer it in house
221	mandatory teaming with community partners, including peer and family specialists
222	There should be more on the job training/orientation. However, that can't happen now because of the "billable hour" and needing to make sure the workforce is constantly productive.

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

223	Again, we provide internships at an alarming level. currently our agency has 9 interns all at a clinical level.
224	A collaborative mentality between similar agencies.
225	more options
226	Greater use of the internet for inservice training and CEUs.
227	Having higher education requirements for who does the education (e.g., having only a psychologist who is trained in cognitive measurement train on ADHD assessment, etc.)
228	On site for agencies (vs sending one staff to a training outside the agency)
229	Student loans at lower interest rates, more grant opportunities. Many of the your practitioners are trying to pay off very high student loans before they can return to school for graduate studies. Continuing Education trainings are also very expenses for agencies to offer and workers to pay for.
230	Do not sign up for higher-priced workshops and training to use competitive market forces to bring down costs.
231	dhs and colleges to disclose that social work and psychology are considered "behavioral health" degrees.
232	Scholarships, grants, financial support.
233	on line training. sharing of resources across agencies/organizations. making videos of evidence based practices.
234	Have it in rural areas as well - it is too costly for an agency in outstate MN to send people to the metro area for trainings. Supportive funding for trainings would be helpful
235	On-site trainings; trainings at local conferences, or collaborative trainings with other local & similar mental health agencies
236	1. Peer education. 2. Information/input/education from other facilities.
237	As a larger MH center, we train rehab works into MH practitioners in our IRT programs. The issue with this is that these programs provide care for the most ill MH clients who are community based. So I am hiring the least experienced staff for clients with the highest need. Then these staff become MH practitioners and move too other programs. This is inevitable because the IRT is the only place that can include the cost of care of rehab workers. All other programs require use of practitioner to complete the service.
238	Please see answers to #6 and#10.
239	More options for shorter, more affordable trainings and advanced levels. It would be great if there was a ranking system of beginner, medium, advanced or something to indicate to people what level of training will be provided.
240	Develop training institutes whose mission is to educate and train.
241	Need funding for ethnic and racial minorities to obtain advanced degree in the mental health professions.
242	Bring professionals who are working in the community into classes
243	lower the cost
244	We would be happy to have people visit.
245	More webcast and trainings in greater MN. My TF-CBT learning collaborative and Evidence-Based Practice trainings were in Detroit Lakes, which was handy. However the vast majority of training brochures I receive are advertising trainings in the metro and not simulcast over web or ITV.
246	Again, for those of us who live in the rural area, it is easier and more cost effective to have a trainer come to the community rather than have more than three of us attend one in the metro area.
247	Because of changing demographics of our workforce, tuition and loan forgiveness strategies need to be in place on condition of service to underserved and marginalized populations including rural folk. Some of the preparation can take place online.
248	Make web based training available for those unable to drive distances. Offer training in different areas throughout the state.

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

249	Educating the current undergrads to the realities of the opportunities in the current workforce. This might be something that is currently being done.
250	Use of technology so rural people can have greater access. We need early childhood mental health professionals.
251	Mentorships that allow enough time to provide actual mentorship (this means reducing patient loads for mentors and mentees).
252	In the workplace, during the workday with financial help provided by the state.
253	use on-line resources as appropriate. sponsor on-site half-day trainings
254	More master's program in local universities- we recently lost ours.
255	Make them less costly or increase the incentives for loan forgiveness or reimbursement. Webinars have definitely been a helpful way to make training more accessible.
256	-Provide small group discounts
257	Students should be carefully screened before admittance to a program. More oversight from DHS or the boards would also be helpful to hold the educational institutions more accountable for who they are signing off on.
258	See above; perhaps partner with presenters to offer scholarships, discounts for non-profit employees, etc.
259	Central clearinghouse of educational opportunities (rather than lots of random emails). Systematic offerings to make sure different issues are covered on a regularly scheduled basis rather than lots of trainings one year on the "flavor of the week."
260	Our agency provides training services for continuing education of mental health professionals. We could be more effective with support from the state to build our training services to reach more professionals throughout the state. Currently our staff is limited in size and can only reach a small percentage of the professionals.
261	Continue to offer trainings - and more in rural areas. Often trainings become too expensive when you add in mileage and paid time.
262	More scholarships/grants that also have clear requirements for follow-up and implementation.
263	See above
264	Education: the mental health field has to be valued by society (i.e. pay well!) so that good, intelligent people are attracted to the work.
265	Finding a way to help with financial aid; scholarships; or a way to "forgive" student loans after the fact.
266	Learning collaboratives that train and supervision calls that check in with professionals over a period of time.
267	Learning collaboratives that train and supervision calls that check in with professionals over a period of time.
268	Similar things like the TF-CBT trainings that trained folks around the state in small cohorts/working groups. Do that with more EBP's. Help small groups of providers to go out of state to obtain direct training, and to participate in train-the-trainer workshops, so they can come back to MN and train more folks.
269	low cost, webinars
270	Provide more opportunities for students across different disciplines to work together, collaborate on cases, or even do supervision as a group. This will expose students to fields other than their own, and the richness that they gain from this (vs. only training with others who represent THEIR field) will outweigh the comparatively narrow focus of any one disciplinary track.
271	Target GME funding to support integrated educational programs.
272	have the state put together large conferences, like MN Psych does, it offers a lot of education, reasonable prices and is all approved
273	Grants, stipends
274	Video conferencing, holding trainings outside of the metro area

SURVEY QUESTION 7: What ideas do you have to make education and training more accessible and effective?

275	More accessible and affordable with clear pathways. Online, hybrid type classes.
276	try to build on internal expertise and knowledge for internal trainings.
277	I believe DHS and their training system should coincide/partner with U of M and other schools to conduct systemic related training to optimize learning. ie annual conference. routine workshop offerings. formalized intro training sessions for new persons in the field. ie: part of licensure could be to satisfy a professional teamwork training session. I have found that multi role professionals learning together can enrich the broad knowledge base and development of better practice to help clients. webinars and workshops are also ways to increase learning.
278	Increasing grant-funded or state-funded training opportunities
279	outside funding for staff training; more frequently offered training by the state.
280	Send out agency-wide or area-wide surveys about what trainings are needed. Then find local experts to provide trainings and have a local agency host the training.
281	FACTS provides training to staff in developing and growing their level of knowledge to better integrate in working with families, with building skills, designing intervention, while also addressing the mental health needs.
282	On-Line training, cost of education at master's level and above is very high compared to the potential providers earning possibility. Potential of scholarships, stipends, etc. could make the field more attractive.
283	more locations across entire state or IT-V accessible
284	Encourage professional organizations to create professional development opportunities.

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

1	College communities and social service fields
2	Hospitals in general but specifically emergency departments too
3	We use specialists within classroom for assessment. Our most successful settings are the sites where we have specialists on-site. Families are more likely to access needed services at these locations.
4	school, community mental health
5	in-home therapy providers
6	Behavioral health hospitals both private and public, Mental health centers, CSPs, ACT,
7	Well, I worked on an ACT team (I'm a Certified Peer Support Specialist). I think peers can help 1:1, in groups, during a crisis, whenever and wherever.
8	Community behavioral health.
9	throughout training and in workplace
10	I believe peer and family specialists should be utilized in all mental health settings.
11	inpatient and residential; Emergency room
12	I recommend working with them in every setting, from individual/family/marital therapy to partial care and hospital work. The issue, of course, is funding, both for the peer specialists and the BH professional to coordinate and work with them.
13	Counseling, skill development, out patient treatment, but it truly depends on how much education a person has.
14	Community Mental Health settings, schools, faith communities.
15	do you mean NAMI and psycho educational work? Yes train by professionals
16	Outpatient/inpatient psych settings, colleges
17	In any, but take cultural and spiritual and community into consideration. Support services that people want in their communities. Community supports are critical. Building that network and access is also evidence based in health and healing capacity.
18	All.
19	Inpatient, emergency departments, crisis, partial hospital programs
20	IRTS facilities, CSPs, mental health clinics, ACT Teams, and ARHMS
21	Hospital, clinic
22	In patient, intensive outpatient, outpatient
23	When meeting with clients in their home or community if they want the person to be involved. Could be a good support and help the client over the barriers to achieve stability
24	Schools, drug and alcohol treatment, inpatient, outpatient, day treatment
25	Schools, community centers, day treatment programs to help with the transition back to school. They can be another avenue to interest minority groups in the field.
26	I do not know what these specialists are but there is a need for educated mental health professionals who have more educational training actually working directly with clients/families than just 150 hours or so for a degree or certificate.
27	County agencies , jails, libraries
28	Peer specialists and family specialists meeting the qualifications for employment across the spectrum of MH services would be an asset
29	Home, school, clinical
30	Crisis intervention, crisis stabilization, groups, educational settings
31	as a group only. more transparency is needed

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

32	day treatment models,
33	community, school, churches, drop in centers,
34	peer specialists are instrumental in facilities including IRTS and residential facilities and community support programs
35	Nonprofit organizations offering community based services.
36	Unsure of what those roles are...
37	All settings
38	Inpatient, outpatient, day treatment, ACT teams
39	I'm not very familiar with this role. Inpatient settings? Community?
40	We are an ACT Team so it is important for us to work towards having a peer specialist
41	crisis, Emergency Departments, groups: DBT, IMR
42	Payment for services is an issue here. There has to be a mechanism for billing and paying for these services or grant funding to support them. Both services would be an asset and enhance the quality of services delivered.
43	Community Support Programs (CSPs), residential programs especially, and ACT teams.
44	Community Support Programs. Residential settings, Hospital settings
45	Peer specialist would be helpful in community mental health centers/hospitals. Family specialist would be great for Child and Adolescent services.
46	Wherever possible as they may fit and support the integrative approach to treatment.
47	agencies will benefit from having these services funded at their sites.
48	Groups
49	any
50	community mental health
51	I see them as being useful to some extent with him a mental health center or similar type of organization but not in private practice or in small private practice groups at all.
52	I see them as being useful to some extent with him a mental health center or similar type of organization but not in private practice or in small private practice groups at all.
53	- Helping people understand and access benefits and resources that they have - helping a la PACER advocates, parents to understand and advocate for children in schools - parents of older children helping those with younger children, think about developmental expectations, challenges, routines - advocating with legislators, voices for mental health care - fundraising for NGO's such as NAMI that inform and advocate - writing letters, speaking out at PTO meetings, etc. - again critical advocacy role - representing and creating local chapters of parent support groups such as CHADD, CAN, SAVE, etc.
54	Community health clinics, physicians offices,
55	alcohol/substance abuse recovery
56	Peer specialists play an important role in the establishment of trust in a new working relationship, they can help to alleviate fears of the individual and encourage growth. Peer specialists can monitor crisis phones, assist vulnerable individuals in setting up and following through on appointments, accompany to appointments when memory or understanding is compromised, assist with teaching or practicing new skills, peer mentoring, home visits for those unable to leave their home, assist on crisis calls.....Family specialists can be important for the support of other family members who may be dealing with their own issues separate from the affected individual and having difficulty finding help or support.
57	I see them as people who can be helpful for individuals who are on the way to recovery, or in recovery.
58	Drop in centers.

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

59	corrections, social services
60	in home, in school
61	I don't understand what peer and family specialists are exactly or what their education and scope of practice should be?
62	schools, therapy, support groups
63	Home settings, school settings, social settings
64	Home settings
65	I don't know
66	support groups, extra visits with clients when needed, help with culturally diverse groups of people if culturally competent
67	in transitional living settings particularly
68	outreach, intakes
69	Clinics, support groups, warm lines
70	Every setting!! Day treatment and partial hospitalization programs, inpatient units, and state hospitals.
71	In hospitals with families and individuals experiencing a first hospitalization. Directors/coordinators of social clubs and drop in centers for people with a mental illness. As supports for people who are experiencing a crisis. As supports when individuals are meeting with their doctor or therapist (if wanted). WRAP teachers. In NFs when people are receiving rehabilitation for physical health issues.
72	Home and community based settings
73	Skills building in support of primary therapeutic interventions with families, support and accountability for clients in recovery programs and with offenders to support therapeutic and behavioral change directives from Courts and corrections officers; as case managers for mental health professionals who don't have case management services more readily available.
74	In-patient units, day treatment, outpatient clinics, as a part of in-home services, as community educators/outreach speakers (health fairs, etc.), in schools.
75	Crisis Stabilization units, Mobile Crisis teams, ARMHS work settings.
76	Any.
77	mental health centers, ARMHS/CSP providers, county agencies
78	Emergency room People attending the University
79	Mentoring parents to assist with parents re-directing their children's behaviors. Help with visioning and next steps to meet their goals/dreams
80	I am not sure.
81	ARMHS
82	after normal hours, in home and social based events
83	When the MH professional determines it is appropriate
84	Start listening to patients themselves.
85	Every piece of the process
86	Not sure what you mean by this. Peer support is important...but it doesn't necessarily replace high quality trained professional staff. The purpose of peer specialists should be to get clients in for appts with well trained professionals.
87	hospitals
88	I'm not sure. I know they have them at the IRT facility, which seems reasonable. I think it would also be nice to have someone at the local social settings like A Place To Belong in Detroit Lakes or the Social Connection in Moorhead.

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

89	Phone support, settings specific to coaching a particular skill(e.g. Grocery store for shopping), Clubhouses/Drop-In Centers
90	Peer and family specialists could be used in emergency rooms to be 'an ear' for the patient. They could be used as a 'mentor' - "been there, struggle with this also" type of person. They could be used as a weekly companion - they could make 'mental health' phone check-up calls - they could be used as a resource for a "light-warm line" - certified peer specialists could be used in county social services to have direct contact with consumers for 'maintenance' stability.
91	Clinical, hospital, in-home therapy/rehabilitation, CSPs
92	Assist Crisis services, assist police dept., assist case mgr's.
93	ARMHS, IRTS, Crisis Beds
94	I think in all areas - can't see where they couldn't be used
95	Rural, urban, primary care. But what is your question/ Used for what? Without training, with the current knowledge base, without back up, without integration of services they should not be used to do something they are not competent to do. Don't you agree?
96	Mentors
97	Assistance in keeping appointments. Encouragement to continue with providers.
98	all settings. hospital settings--great! crisis services--even better
99	All settings.
100	Community settings, nursing homes, schools, social service agencies (public and non-profit), businesses.
101	Multiple! Hospitals, especially during discharge process; clinics as liaisons; in case management and ARMHS as additional provided in-home support; in vocational settings; etc.
102	Upon intake when new clients are received at the agency and thereafter. I have experienced that most families are not involved because they have not been engaged by MH professionals enough to feel welcomed to be involved in the care of their family member. Families have reported that they only feel that they are contacted when an MH issue presents itself. Families should be incorporated in every level of care if they are supportive as they are a vital link to the coordination of care.
103	I think peer and family specialists could be VERY effective on the first-responder level, in a clinic setting outside of a hospital. If they could effectively triage, the wait-time for especially urgent cases might be sped up considerably.
104	communities; hospitals
105	Abuse and GLBT issues.
106	To help to educate the professionals as well as to support the individuals. They could also be use to give community information on the issues they are faced with, such as forums or trainings.
107	As a Peer Recovery Specialist I would say that we can and should be utilized in all treatment settings, including groups, 1:1 contact, and community outreach.
108	CSP hospitals IRTS
109	Recovery houses
110	Staff at csps, crisis response
111	All settings except those that are fee for service and rely on credentials for reimbursement
112	Residential settings, particularly groups.
113	schools with setting 3 and setting 4 placement of kids
114	not sure what these are
115	Have them available upon discharge. They could be located in clinics, community organizations (like CHUM and Community Action Duluth), colleges.

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

116	beyond where they're already being used (IRTS, ARMHS, ACT, Crisis residential), they could be used in outpatient clinical settings, crisis intervention, Community Support Programs (an ideal application)
117	All
118	all of our setting would benefit
119	For family members of someone hospitalized due to mental illness
120	outpatient case management teams; ACT; IRTS programs; short-term inpatient settings; longer-term residential/ inpatient treatment.
121	in those that provide community services, TCM ARMHS ACT
122	Homeless Shelters, Family Psycho education groups, Schools, Hubbs Center
123	Team Decision meetings with a trained facilitator
124	Inpatient, community settings, Recovery
125	School-based
126	Every way. They are needed due to their unique abilities to talk about their experiences in recovery from MICD. They also have the ability to connect with clients in ways that professionals can not.
127	just about any, counseling sessions, hospitals etc
128	Transition between treatment settings. For example if a child is hospitalized and then is going home have those services set up prior or when a child leaves residential and goes home.
129	In ACT. Maybe about one or two per county for other programs. I tried to access some specialists to work with parents with Spmi. We couldn't find anyone. Also, it is not often there is such a need but when there is, the need is great and there's nothing. We need mental health professionals with understanding/knowledge of spmi adults and child development.
130	Mental health agencies
131	support groups with peers by using peers, support groups with either peers and family members might benefit by using family specialists
132	ALL SETTINGS!!!!! crisis, residential crisis, IRTS, group housing, ACT, case management, intake screening, psychiatry offices, consumer support network, trainings, vocational networks, criminal justice system, probation system, mental health commitment
133	Family specialists for nursing homes, hospitals for medical, ie, trauma, ICU and long term chronic conditions, dementia and mental health.
134	Any residential or case management type setting - they seem to fill a gap in services provided by other professionals.
135	I feel they could be beneficial across alot of programs. Residential Support Services, Intensive Rehabilitative Treatment Services, Crisis Residences, etc. One invaluable thing is feeling as if one is not alone. The concept of universality, or helping people understand that they are NOT the only one suffering certain symptoms, and recovery IS possible.
136	Only in supporting services, not as clinical workers, and always under clinical supervision. Their role should be in prevention.
137	Assertive Community Treatment Teams Group settings
138	What are peer and family specialists?
139	There is most definitely a need for peer specialists. I know that we have been looking for a reliable one for one of our clients for over two years.
140	Act

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

141	Working with clients and families expressing culturally diverse experiences across all MH practice areas. Areas of Mental Health and Chemical Dependence (including dual/multi-diagnoses) recovery. Work with adolescents and young adults who have been disenfranchised. Families who have at least one family member living with a disability/chronic medical condition, as other family members are in caregiver/support roles.
142	CADI CM in all living situations for support to the clt.
143	Family support programs, for children/teens on the autism spectrum
144	All settings. Peer and family specialists, if services are billable, could be assigned to case management, ARMHS, and ILS teams/work groups. They could serve as consultants to any mental health service provider, and their services should be more widely available.
145	Peer specialist may be helpful in mental health similar to the way sponsors are helpful in AA.
146	In conjunction with Mental Health Professionals & Medical Professionals. We all need to work together in order to support folks.
147	All
148	In engaging patients and families in treatment and helping them navigate the complex social support system available.
149	Therapy settings, home settings.
150	In IRTS facilities, DBT programs and MI/CD support groups or outpatient treatment.
151	group treatment or advocacy for mental health
152	recovery groups for clients
153	School, home, long term healing
154	The great thing about a family specialist (I am guessing you mean MFTs) is that they can do so much more than an individual-focused therapist. They can work in every setting an individual therapist can and then some.
155	Case management, support groups
156	social services cases and court cases
157	Learning skills such as parenting
158	In areas where there is a lot of supervision available to ensure proper boundaries.
159	Outpatient, inpatient
160	I am unfamiliar with these specialists.
161	In-Home settings, community agency settings. I have seen them utilized successfully in crises settings as well.
162	agency trainings
163	drop in centers, support groups
164	In all settings: health clinics, private practices, school, correctional facilities, or hospitals to name a few.
165	Hospital settings, outpatient settings (family sessions), IRTS programs.
166	acute behavioral health/inpatient setting, chemical dependency in/out patient setting
167	We use them in our drop in setting which has been wonderful
168	Seminars about what instruction is needed.
169	Transportation is a big problem, so assistance in going to appointments, the grocery store or food shelf, would be helpful. Training/support on independent living skills such as basic hygiene, medication management, making and keeping appointments and scheduling transportation, budgeting, and services available to help with these things. I think a lot of people currently working in mental health got started because they have personal experience with mental health issues, either their own or family members. So even though they are licensed or are mental health practitioners, rather than peer and family specialists, there might be more sensitivity to peer and family issues in the current workforce than is recognized.

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

170	Recovery-CD treatment
171	Peer and Family specialists would be used in almost every Children's Mental Health case due to the whole family being effected by this mental illness. Parenting skills need to be modified, as well as the whole family dynamic.
172	school based mental health services
173	youth act, parent to parent support, transition aged group skill development, efforts like Silver ribbon campaign as south high school
174	clinics with good supervision for practical/case management needs
175	All settings related to family and or individual services.
176	Don't know
177	Schools, crisis centers.
178	Hospitals, schools, day treatment and other outpatient programs.
179	resource to go in home with clients, mental health clinics
180	peer mediation by students in schools
181	In situations that don't involve dangerous behaviors.
182	unsure
183	Integrated care settings would be an ideal starting point. Peer and family specialists could be used in any setting, but integrating them into normal clinic, inpatient or partial hospitalization workflows will get complicated quickly.
184	Unsure
185	Not quite sure what you are asking.
186	Another emerging racket. What happened to the case managers.? Isn't this what they are supposed to be doing? Adding more people around the table complicates treatment-it does not make it more effective.
187	Rural clinics. Schools. Community medical clinics/mental health centers. Community centers.
188	I think having a peer or family specialist work with each family in treatment would be beneficial to their treatment.
189	I don't understand this question; it seems like jargon.
190	Don't know
191	IRTS
192	bridging acute care and community care
193	community based outreach and rehab
194	Crisis services would be preferred. Boundaries are tricky in longer relationships.
195	Community-based services (i.e. ACT Teams, ARHMS, Crisis, etc.)
196	Schools, group homes, in-home services.
197	Schools, in home suicidal services cases
198	Residential units, group events, case management.
199	club houses. community programs
200	Across many settings the use of family specialist is appropriate. As families are available and accessible to specialist, individuals are may be accessed
201	I don't know what The requirements for being a peer or family specialist but I would certainly want to look at the available pool of mastered educated LIACSWs, LAMFTS, LPCCs and LP persons who are prepared to work but need hours for licensure
202	I would like to see them much more available to work with people receiving AMH Case Management, as well as Crisis support, outpatient educational and therapeutic programs.

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

203	ACT
204	all as consultants and outreach
205	Many
206	Outpatient mental health, partial hospital programs, inpatient, IRTS, crisis programs
207	They can be used in multiple settings, community agencies and schools especially,.
208	Integrated healthcare settings
209	I think they could be used in many different areas. The question is how do we pay. Pay seems too low to make it work easily.
210	CTSS
211	Mental health case management, school based mental health, Day Treatment.
212	valuable in all settings
213	I disagree with the use of "peer" specialists as a replacement for my graduate level and supervised training. Mental health provision should be by qualified mental health providers. In what settings might you prefer peer and family specialists over a nurse of doctor? "Nuff said.
214	residential tx
215	Intensive home-based services; schools; residential treatment
216	I believe these specialist would work well with ARMHS. They could also work well in ACT, but not suing the assumption that they could provide the same level of work as a MH Practitioner. Because their role is different, it is unfair to both positions to treat them equally. Also with the rate structure for IRT and aCT, when a specialist leaves it could ta longer to recruit and train a new specialist. This could negatively effect the rate the following year for that service. Additionally, when adding staff to ACT and IRT, the reate would not cover the new position until the following year.
217	In the academic setting, clinics, in peer-to-peer or family-to-family type support groups.
218	All settings would be great.
219	parenting groups, as a support to trained therapist in various groups for children (divorce, trauma, family member with illness, child with illness, etc)
220	residential treatment centers, outpatient mental health, CTSS and ARMS
221	Community mental health
222	I would really like to see them used more in child pscyhiatry settings to link with families and community resources that the child might need.
223	multiple settings...day treatments and Outpatient Clinics
224	Peer and family specialists might be used in schools and health clinics.
225	Community mental health centers
226	Natural setting such as community rooms should be used in their natural locale. For example, reserving a a small meeting room that is private in a nearby building.
227	In smaller groups affiliated with licensed qualified settings.
228	Currently using Certified Peer Support Specialists in IRTS and ACT in the State.
229	We need early childhood mental health professionals.
230	I'm not sure--I work on the diagnostic end.
231	in home therapy schools, outpatient and inpatient settings
232	unclear question.
233	rarely- maybe group work.

SURVEY QUESTION 8: In what settings might peer and family specialists be used?

234	Support groups, advisory boards, in a mental health practice it may be useful to have this position to help de-stigmatize getting mental health treatment.
235	schools, faith centers, hospitals, treatment centers, MH drop in programs
236	Hospitals and community clinics; shifting social service model from case management toward community connection and family-led initiative (as in: http://www.fii.org/approach/)
237	Hospitals, waiting rooms, schools with school based mental health, support groups, online/phone support.
238	Hospitals, clinics, schools, workforce centers, juvenile justice courts and facilities, probation, and anywhere else that people with mental health disorders may need assistance.
239	Schools. Family therapists should be seeing students and their families before/after school in school buildings with school staff accessible. IE teachers should be accessible to be brought into family sessions to report their observations of students in class.
240	Every setting might use family therapy. As an LMFT we see an individual as part of a system - whether it be marriage, family or work.
241	Hospitals when people are close to discharge process, as well as Residential Treatment Centers.
242	Medical Settings. Primary care, specialty care, tertiary settings
243	volunteers for community agencies; support groups
244	This may be helpful in areas where there are few services.
245	Club houses for SPMI adults and organizations that offer ARMHS to aid in maintaining positive mental health.
246	Club houses for SPMI adults and organizations that offer ARMHS to aid in maintaining positive mental health.
247	County child welfare and county adult services! Navigating government systems or other large systems (e.g. university health care systems).
248	emergency rooms, understanding hospital services
249	Peer and family specialists could be used almost anywhere, just as individual (read: Psychology) or addictions (read: LADC) specialists could be useful.
250	Primary care clinics, mental health centers, school-based health.
251	Child protection and family outreach
252	Day to day dealing with emotion regulation and interpersonal skills.
253	all
254	In almost every mental health setting. We could be stepping up our efforts in this area.
255	I do not know the information as to the effectiveness of this and so have no opinion to offer.
256	on site at the agency; in-home
257	ACT Teams
258	Within family therapy and school-related interventions.
259	We do not use peer and family specialist. We only have Master Level Trainees and Licensed Professional providing services in the home based services including the intensive Bridging (CIBS) services.
260	This personnel would often be very helpful to clients, were there a reimbursement source.
261	In-home settings
262	Almost all settings!

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

1	committees dedicated to this within the workplace and implementation into organizational practices.
2	Make mental health jobs appealing. Create opportunities to partner that dint create more work for supervisors (more field practicum advisors)
3	Develop a much deeper understanding of how people in poverty or crises prioritize needs, access services and support. Many of the providers we contract with spend several years learning to deal with the socioeconomic factors that affect the outcomes of the services they design.
4	Review policies that may limit agency or providers ability to respond to clients in a culturally competent way Make sure that a range of services are funded to accommodate the needs of diverse community groups
5	Provide mandatory training.
6	Education and training
7	People need to have lived experience and they need to be a member of the culture or able to consult with a person who is.
8	education and exposure are key.
9	Increase in a diverse workforce, more trainings, opportunities for learning from diverse colleagues
10	Improved coordination with cultural resources/centers in community.
11	Offer training workshops, classes, etc. on cultural, racial, and sexual diversity, to include, for example, GBLT (Gays, Lesbians, Bisexual & trans-gender) communities.
12	Incorporate the "Patient, Doctor and Society" training model/curriculum at the U of M Medical School. See this link - C:\Users\pweec80\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\NXWI8ZI0\Patient Doctor and Society (PDS) - MD Program University of Wisconsin School of Medicine and Public Health.mht
13	As above.
14	Professional and community education.
15	Not sure what that means, culturally competent.
16	Engage and actively recruit people of color into mental health positions and required continuing education for licensure
17	Teach the culture is not necessarily skin color or racial background. Recognize that the diversity of our backgrounds requires and multifaceted lens.
18	Reach out to diverse populations. This is not a one size fits all delivery model - every culture perceives mental health issues differently and we need to tap into people within these communities to help us develop a sound model.
19	have professionals train competent individuals at a "para" or practitioner level at some basic educational strategies for dealing with mental health need and support
20	Somehow inspire personal interaction and relationships among people of varied backgrounds.
21	Teach more about social psychology.
22	Identity disparities in the mental health system between gender, age, race, and sexual preference. Work to combat stigma in Asian and African American culture, which seem to prevent people from accessing care. There also seems to be a lot of white female providers in this field. (As one of them) I find it extremely helpful to work in an environment where it is okay to talk about race and gender and how these social identities impact our work and professional relationships.
23	Promote continued training and find ways for agencies/organizations to be appropriately funded/reimbursed for having representatives from communities even if they do not necessarily have a traditional training.
24	Hire a culturally diverse group of employers. Regular trainings around cultural competency

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

25	We have little diversity in our county, but when working with a person that would like a therapist or psychiatrist who may share the same values or norms we assist the client to connect with a professional in the cities. Very little MH professionals in our area with diversity
26	Continue to have open forums of discussion
27	I have no idea how this could be done but it would be great if trainees were required to work outside of their community with a population they do not know much about. I think a trainee should have experience working outside of their own social economic, religious, ethnic and sexually identifying group. Additionally, there should be more opportunities to serve children, veterans, and the elderly.
28	Hiring more culturally diverse educators and including cultural topics in more classes than mainly the diversity courses.
29	Increased awareness of specific cultural needs in mental health. Identified data regarding the access to care, and identified needs of varied demographics.
30	I think it is ok now.
31	When possible, hire individuals to create a more diverse work force, partner with other service providers who may have a more diverse workforce, invest resources - time, $ in training to increase competency
32	Recruiting more diverse population, and make sure classes and learning groups are mixed
33	webinars could be used for this also, to discuss more appropriate ways of handling issues that present in culturally diverse settings
34	peer education para and practitioner level
35	Encourage hands on training/interaction with a diversity of clients.
36	Exposure to and experience working with diverse clients. Short of that, training on working with specific client populations.
37	Encourage research in areas of cultural impacts on therapy, counseling, family practices, child rearing, etc to help inform the evidence-based practices
38	Set specific targeted improvement objectives and pair potential workers with mental health workers of their own culture.
39	Require/offer CEUs focusing on issues with significant impact on various groups - immigrants, veterans, homeless.
40	Provide training incentives to interested people of color Provide scholarship monies at the BA level through graduate school for those wishing to become psychologists or medical doctors
41	Pay competitively Have a positive work environment
42	Assist people to understand it is not just race
43	Marketing and education about the rewards of mental health work, and increasing the salaries and the image of the mental health professional and practitioner. For many families investing in education must bring rewards to more than just the individual and salary and potential makes a difference. In addition the investment in many years of supervision that has to be paid for to end up with a pretty low salary as compared to other graduate degrees has an impact.
44	Realizing this is a cultural shift the whole organization accepts as it seeks to include individuals with various backgrounds who may come with different attitudes about work in general and different approaches to the profession in particular. Realizing on the top levels that to be truly culturally competent is more than just hiring people who have diverse backgrounds, it is listening to them and integrating some of their perspectives in the approaches of the whole company.
45	We currently are working with DHS and we are part of a pilot revolving around cultural competence.
46	Training
47	Open discussions, more on-going education

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

48	Conference sponsored by DHS or paid by DHS or counties.
49	get info on common complaints or mistakes out to practitioners
50	define culturally competent much more accurately and realistically rather than politically.
51	define culturally competent much more accurately and realistically rather than politically.
52	include community members of various cultural groups in training professionals.
53	- First and most important, educate white mainstream mental health workers about their own implicit bias related to white privilege. Help them become aware of their own cultural background and baggage, and how these may affect assumptions, perceptions, and interpretations. Then -- provide more interactive online or webinar based CE for all - talk to people from the VOA which is doing an amazing job with too few resources, for example David Schachman of East African & Somali Mental Health and Rebecca Goffman at Deaf Services. Also talk to Alyssa Vang Phd in Saint Paul about working with Hmong patients. Also talk to Heather Hackman from St Cloud State.
54	Make more accessible levels if training to appeal to a wider audience of potential health care providers
55	Further training Part time internship-type program for professionals to work alongside colleagues who are members of various cultural communities within those communities (e.g., doing a time-limited group)
56	Submersion into cultures
57	Bring in tribal spokespersons, persons of color or other races, rural vs. city, rich vs. poor, young vs. old- teach well rounded to account for differences in population. Older individuals or poorer individuals may not understand new treatments or options available to them. And, not everyone owns a computer or a cell phone; things that others take for granted.
58	This is a tough one. I don't know.
59	Teach cultural competence and pay staff while attending the teaching.
60	Cultural competence needs to start with the worldview of the mental health professional. Too often, MHPs think about how they can gain knowledge about working clients who are different than themselves without much examination of their own culture frames.
61	Supporting Cultural coaches with reimbursement to work with various agencies which are open to the coaching
62	Trainings locally
63	Again, provide online trainings through DHS. Also occasional roundtable discussions or panels including families/individuals from varying cultural backgrounds would be very beneficial. Does DHS have any FAQ sheets on different cultures and their various perspectives on mental health services? This might also be helpful to have a section on DHS provider website specifically for Cultural Competency information.
64	Diversity training requirements implemented by agencies
65	Lots of culturally specific training- web based- and free
66	advocacy for requiring cultural course work in all fields (social work programs do this great, others like LMFT, medical school, etc, not so much).
67	Encourage clients who are of a different culture and doing well in recovery to train to become peer support specialists. Required CEU's for current mental health professionals and culture immersion experiences for students.
68	include people from other cultures in developing any training in cultural competence
69	have presentations by consumers from various backgrounds - like a panel
70	Listen! Rather than making assumptions, listen to people from all cultures and use what you learn. Increase cultural diversity on Boards of Directors -- the YWCA has a great program that matches young people from a variety of cultures with established Board members in a mentorship program. The agency has a chance to learn from the young person, and the young person has the chance to learn how to be a good board member.
71	

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

72	More financial support for individuals of underrepresented cultures to get education in behavioral health. Discussions with key informants in the culture to inform main stream services. Allowing variances in provision of services for providers that focus on diverse populations.
73	I would not have good input on this as our county is comprised of 98% northern European descent and little cultural diversity.
74	Coordinate training efforts between mental health providers, higher education professionals, and leaders in local/regional communities from cultural minorities. Establish regional networks and training centers to facilitate these efforts, make the training more affordable and accessible, and more sustained and consistent.
75	Search out immigrants/refugees who were educated/licensed in their home countries and make it possible for them to easily become licensed here; work toward incentives such as relief from student loans in exchange for work in the field; increase use of peer/family specialists.
76	Fund NAMI to create & provide culturally appropriate training venues; they have the resources.
77	Examples of mental illness that are not so obvious
78	Require training for individual licensure On-site training
79	Training on the different cultures that we work with including family culture.
80	Create more hands-on training opportunities that cover this area.
81	Simple answer - to a complicated question. Hire culturally diverse staff. This should not be a mandate - but a movement. Find young people they are interested in going into the field. Give scholarships and internships (required for their education). They should be recruited by their community but sponsored by all. A diverse workforce will help to create a culturally competent workforce.
82	College scholarships for minorities.
83	allow time for more training opportunities, smaller case loads
84	More training and internships in areas where there are groups of people from other cultures
85	Uh..They are out there. Start hiring them.
86	Offer tuition support to culturally different people
87	I think this is a very difficult area because not everyone follows their cultural traditions. Each person still needs to be treated like an individual. It would be nice to have a resource on-line to be access when needed.
88	It is difficult to train professionals to be culturally competent. We need professionals from within the various cultures to ensure a competent workforce.
89	Ensure that providers understand that speaking a foreign language is NOT the same as being culturally competent.
90	Hire more people from different cultures. Offer free language and culture classes taught by members of cultural communities. Invest in this.
91	Create a state requirement that schools that offer licensure (medical, mental health, etc.) integrate cultural sensitivity (I don't like the word "competent" when discussing this) in each class they teach, instead of having one stand-alone class focusing on cultural sensitivity
92	Training needs to incorporate the patient into active treatment. Pay patients from culturally unrepresented groups to participate in training.
93	More diversity training.
94	scholarship programs and grounding in privacy and self-direction rights under our constitution. Many immigrants including professionals come from cultures where relatives or elders make care decisions for someone, and don't understand that our constitutional rights bring other self-determination considerations and choices for the individual and that some of their cultural norms must take a back seat.
95	Recruit and support practitioners who hare culturally competent and also those from diverse backgrounds.

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

96	More training. Places like Anoka, for instance, need training in things as simple as providing appropriate toiletries and hair/skin products for individuals. Right now, they only provide grooming products for a white population. We also need to recruit more, in social work & family therapy, among diverse communities so that we have more diverse practitioners.
97	More diversity in workforce. Periodic trainings and workshops addressing this area.
98	Hire more culturally diverse staff on all levels supervisory, administrative, and training wise as this will provide a culturally diverse outlook within.
99	There is a lot of good teaching and training, but again, like learning a new language, people need to be submersed in it. I like the idea of avatars representing patients with different cultural backgrounds, responding with culturally appropriate responses to an interviewers questions.
100	training supervisors and high level agency personnel to promote culturally competence at an agency level, having active diversity committees at agencies
101	available trainings surrounding culture and mental health
102	Role playing different cultural situations.
103	Encourage the workforce to ask questions. Teach existentialism to the degree of training professionals how to "be" in the moment with individuals and meet them at their level.
104	Hire more immigrants
105	Training, having cultural diversity in the work setting, having requirements that students must connect with diverse cultures in the college setting before they even enter the workforce, also there needs to be accurate information being taught in the schools and that starts when children first enter schools--we can't ignore boarding schools any longer...we've had holocaust in the US, we need to start acknowledging it and healing from it.
106	Provide documents in other languages and interpreters.
107	Focus on this in internships, integrate into education at the college level.
108	there are too many barriers for people who want to be mental health workers and the number one is cost of schooling.
109	Training, training, training...and consistency between the policies and the behaviors of the agencies/their staff!
110	work with cultural specific agency's to advertise, promote
111	get rid of the phrase "culturally competent" - overused to the point of losing it's meaning; culturally responsive workers have specific strategies for how they join and accommodate cross-culturally as well as utilize the resource of culture in the healing process; work with training programs to determine best/promising practice as well as assessment/evaluation strategies to determine skill set
112	aggressive support for diverse populations to enter the MH workforce-- scholarships, stipends, etc.
113	Change in Graduate School training. Asking diverse communities what they need, supporting that and then learning and training in that direction.
114	Culture and diversity training
115	I think that it starts with training in theories and methods of mental health practice but also involves ensuring that professionals have exposure to diverse clients/patients when they do their hands-on training.
116	unknown
117	Trainings by experts in the communities of Natives, Somali, Hmong, etc. provided in those communities targeting mental health case managers, practitioners, doctors, psychiatrists, as well as clients and families
118	Training based on the cultural composition of the community
119	educational requirements in accredited programs, certain number of CEUs in cultural competency
120	1. Offer a standard curriculum and resources that is easily accessed for faculty.

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

121	I believe the workers have to be culturally sensitive, open, and willing to change their own cultural perspective.
122	more training, perhaps having staff shadow people who are encountering different culture populations.
123	I find that cultural competency is geared towards ethnicity, this is just a part of culture. I would like to see training on working with individuals who live in poverty and it should not be training on how to get them out but how to work with this population. In rural areas the training needs to focus on more than one ethnicity because there often are not large ethnic populations, however the diversity of a community can be great. Once again provide the training and resources in areas other than the Metro or Duluth.
124	On going training
125	I believe that we have a culturally competent workforce in this area
126	Offer cultural trainings
127	training and education for those already in. getting into high schools and colleges to recruit culturally to bring awareness to social work (that it isn't only child protection) and increase interest
128	Increase the entry level salary.
129	I think hitting things head on is what agencies need. Having real conversations about privilege, aversive racism and marginalization is what we need to do. Getting away from "politically correct" tendencies and being honest about our faults/biases, assisting each other to work through them.
130	Require minimum cultural competence standards in both undergraduate and graduate programs, and require a minimum amount of continuing education hours in this area annually.
131	CEU's and exposure.
132	My observation has been that both faculty and students in many programs tend to be overconfident and under prepared. Increasing the documentation of educational inputs with regard to multiple forms of diversity across mental health professional curricula and courses is needed. Perhaps it might also help to have state mandated continuing education in diversity required on an annual basis.
133	Require educational curriculum and clinical/practicum experience to incorporate focus on culture and identifying one's own cultural experiences, bias, weak areas of knowledge and offer consultation, mentoring, education, etc. to support ongoing learning and flexibility of changing one's practice to be respectful and reflective of the individuals and families one sees and works with.
134	build coursework into the curriculum
135	Continue to require coursework in culturally competent practice for licensure in all mental health work. Consider requiring periodic CEU's after initial licensure.
136	There is very limited if any prevocational programs that provide interpreters to clients that speak different languages or sign in ASL. The CADI waiver does not have the funding to provide an interpreter for a clt to work.
137	Increased training and education, recruitment of people of color into professions
138	Intensive training beginning with understanding power and privilege, including one's own, followed by training on providing culturally competent and congruent mental health services. Further, culture should be more than a token part of assessments.
139	Most mental health practitioners seem to be white middle class Americans so having more diversity in the workforce would probably be the best way to do so. However, if that isn't possible, maybe have more discussions about it to build cultural consideration. I feel like cultural competence is a lofty goal.
140	1.) More trainings related to this! 2.) More of an emphasis on this in school settings and employment settings!
141	training
142	Encourage culturally diverse workplaces
143	Ongoing cultural competency trainings. Courses in Multicultural MI/CD.

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

144	improve awareness of own cultural identity as well as cultural identity of others. Increase resources available and identify culturally specific barriers to treatment.
145	offer more cultural trainings, make them mandatory
146	Outlaw ex-gay therapy.
147	Training to include specifics on common mistakes in cultural understanding.
148	Education and immersion
149	Having management ensure respect for all employees. Continued discussions and in-services.
150	Employment of culturally qualified individuals/professionals.
151	Training is important in all aspects of cultural knowledge but spending more time on privilege and what that affords many of us. This area is tipped toed around because it creates a great amount of uncomfortability in the white,male,christian population, which has a great deal of power in our agencies.
152	In addition to ongoing training around cultural competency, we need a diverse cultural workforce.
153	need trainings by people in the cultural group
154	Students coming out of grad programs hear a lot about being "culturally competent", but what they often don't seem to get is what it means to be poor. Being "broke" as a grad student is not the same thing as living in poverty. Knowing how to speak Spanish is great, but it doesn't give you insight into what it's like to be hungry. We have to talk about "class" and culture.
155	at this point, there is such a high demand for well trained MH professionals plus the fact that this is covered almost incessantly in graduate school, that this is the least of our worries
156	Administer more meaningful trainings that the providers can apply to daily situations.
157	Yearly in-services and making hiring culturally knowledgeable staff a priority. Hiring a Spanish speaking staff person would be very important as well as persons from other representative cultures and groups.
158	Employ individuals of color and from different cultures.
159	Ask culture leaders to assign a colleague to a cross cultural discussion. Twin cities only recently grew by incorporation of diverse cultures.
160	ongoing trainings in these areas
161	Concentrate on the rural counties. They receive little training maybe once per year and have little interactions with any other people with different cultural needs. When they do, it goes poorly.
162	Each employee needs to complete more culturally competent classes/trainings. More education in secondary education regarding this, and then ongoing through our professional career.
163	develop internships that provide work experience working with diverse populations
164	reasonable, accessible training funding
165	The tools and education that is out there is sufficient. You can't change a person's beliefs or values. Regardless of the training that is provided. If a person is bias this is something that was developed long before they became a professional. The issue is addressing issues of cultural bias when it happens while not minimizing the perceptions of the person who has reported a cultural bias.
166	Offer trainings on line
167	It is difficult to recruit culturally competent providers in rural settings. I think creating more opportunities for providers to network and receive training would be beneficial.
168	Is "cultural competence" a training issue, as it is being treated now? Or is it best accomplished through experience in culturally diverse communities, supervised by experienced supervisors; and by having multicultural co-workers? I don't think "diversity" training accomplishes much in terms of real learning.

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

169	Have training programs require students to work in more culturally diverse settings, similar to categories of trainings that are currently often used (therapy practicum, assessment practicum, etc.)
170	Provide incentives for people of multiple cultures to want to join the identified workforce and provide more anti-racism training in the work force to invite and support a more supportive work environment.
171	Interact more with the American Indian Mental Health Advisory Council of MN, CLUES of St. Paul and African-American Family Services and the MN Asian/American Health Coalition
172	This would be part of the curriculum mentioned in question 6 above.
173	Create a setting in which it's ok for people to ask questions, even if they're awkward or oblivious. If you don't ask, you'll never know, and questions can be great opportunities for education. (Questions I've heard/dealt with: "Are transsexual people gay?" "Do all Latinos celebrate Cinco de Mayo?", etc).
174	Integrate coursework on cultural competence into mental health professionals' training, and provide more CEU opportunities.
175	I think we do plenty in this field. People are people-some basic training as we have now is enough.
176	Develop task forces which include constituents from organizations representing different cultural/ethnic groups.
177	Hiring people from a diverse background. Having material in more than one language.
178	Again, if these competencies are not offered through existing graduate coursework, that these core competencies are included in post-degree training via grad class time or CEs.
179	Support cultural diversity in all areas of leadership and decision-making.
180	That comes down to pay again. If you want talent the pay has to be there or they will be more attracted to higher paying professions.
181	Training is key to awareness, competency and sensitivity to cultural issues in mental health and in general
182	Not sure
183	FREQUENT mandatory trainings.
184	We spend time discussing cultural competence and what we can do to continuously improve; we invite presenters (i.e. education about Native American culture and traditions, etc.).
185	Appropriate and frequent agency in-services taught by those who understand and live in the diverse cultures.
186	Experience and working in diverse areas
187	Increase the number of professionals of diverse backgrounds, increase requirements for working with diverse populations before licensure), increase requirements for ongoing training, increase competency of clinical supervisors to discuss and challenge workforce.
188	Ongoing culturally competency trainings that emphasize cooperation, understanding and learning.
189	It is my belief that cultural competence is not at all achievable. The terminology foes not even belong together. Competence is a summative process whereas culture is ever-evolving!
190	My daughter is in the LMFT program at St. Mary's University and is receiving an excellent education in cultural diversity. I think there are model programs, not to mention metro clinics that specialize in culturally diversified clientele. More paid practicum and internship site would draw people to these clinics.
191	Train and test for knowledge in cultures served and the ability to engage in conversations with others of a different culture over time and development of relationship. It's not about Q and A from an assessment.
192	money to pay for education and training
193	using family and peer specialists in the workplace and as consultants
194	Trainings
195	Increase availability of formal trainings regarding various cultures; increase availability of coaches or mentors

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

196	Licensing education requirements should include competency in multicultural content.
197	Having licensing boards require a certain number if CEUs related to culture.
198	We have to do something about our board tests. We have too many people failing their tests and giving up. I do not believe the tests are culturally responsive.
199	Fees for service be adequate to allow budgets to include training time.
200	trainings and mentorships. Partnering with diverse agencies.
201	Allow practitioners and various mental health settings to determine where there are needs and opportunities, and expect them to develop the competencies needed to gain market share in those areas. The answer to this question is also strongly tied into the reimbursement and administrative demands issues.
202	increase staffing so there is time away from work for training.
203	Minnesotans are culturally encapsulated. The best training is immersion. Training programs in the neighborhoods of "cultural" folks.
204	a list of resources available for who does trainings
205	Promote mental health professional fields among minority college students. Create a more welcoming, receptive, open environment for people of color. Eliminate obstacles towards licensure that are nothing more than political turf wars
206	Required diversity trainings; extensive class content required for degree
207	Education of staff is the essential component required to enhance culturally competent care.
208	Just having a workforce that is available would be a start. I believe as the workforce grows culturally competency will improve. This is also something that raining can assist with.
209	Experiential learning. Require a certain amount of cultural experience. Have cultural competence be an item on annual evaluations. Develop each agency's cultural values, and how all staff will exemplify these values in their daily work. Identify where and how the experience can be obtained and articulate clearly the cultural competence expectations. Please note that this does not only pertain to race. Cultural competence is essential when working with elderly, GLBTQ people, or even youth.
210	More trainings available and required at agencies and at school. Also, being exposed to different cultures and working closely with people of different cultures and diverse backgrounds can help people gain interest and competence in other backgrounds and identities.
211	Actively recruit a diverse workforce. Incorporate their ideas, culture, style into practice.
212	Listen to what the professionals from diverse populations are saying. They are out there and need more forums to provide consultation. Graduate programs to have cultural competence criteria to be met before graduation. Professional Board to have cultural competence criteria for application for license and for renewal. Agencies to have criteria for performance and performance evaluations.
213	Provide trainings that address cultural competence, particularly around white privilege
214	Trainings and exposure for all professionals - they need to see that
215	Undergraduate and graduate level coursework should always include course work around cultural competence that is integrative and experiential.
216	Make experts regionally available? Identify professionals who can do in-service training? Publish an on-line curriculum using video illustrations?
217	Five to 10 clock hours of instruction in cultures, focusing on verbal and nonverbal communication, history and basic language phrases.
218	Honestly, cultural competency has been such a huge push in my area of the state (northern MN) that I think what's being done is working well. We have several opportunities for trainings on applying clinical practices to different cultures. (Example: the Native American Cultural Awareness with Applications in Crisis conference in Mahnomen.)

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

219	Provide trainers who are culturally competent and evidenced based practices that are normed on minority populations.
220	Cultural competency comprises a complex set of knowledge skills with specific best practices that are known. These are used by practitioners who currently assume such responsibilities on an individual basis, often without institutional support (see response 3 above). However, few practitioners or institutions use cultural humility. Cultural humility in combination with cultural competency could enhance community ties and become a powerful force for strengthening better treatment outcomes.
221	Continued training opportunities that are enlightening, experiential not just talk. What do we need to know culturally specific to the people coming for services?
222	Don't have any good suggestions, MN is still a Caucasian workforce, and we are working with a very diverse population. Next conference on mental health look around and see how many minorities are in the room.
223	We need culturally competent early childhood mental health professional.
224	Again, mentorship. There is only so much that formal coursework can do, although we need this, too. It's so important for the experience to involve cultural groups specific to the geographic area. Here, it's important to understand Somali and east African cultures, as well as southeast Asian.
225	require cultural competence of all providers for licensure. Hire more providers of color. Universities recruit students of color. Integrate multi-culturalism into all agency initiatives and practices.
226	training, experience
227	Training, training, training. We do not have a very culturally diverse area and therefore do not have culturally diverse providers or patients that are seen at my clinic.
228	There is a tremendous lack of diverse professionals available to meet this need and expand understanding. We need more minority recruitment and advocacy in this area.
229	-Webinars with continuing education credits that are targeted at a specific region (e.g., twin cities)
230	Students should be required to perform a certain number of their practicum/internship hours in a setting that is different from their culture. (We teach it to them in class but they cannot apply it until they have experienced the culture)
231	Additional training opportunities
232	We have to continue to work on being a more culturally competent society as a whole. The change is at the individual level as we each examine our own relationships with power, culture, stereotypes, etc.
233	Earlier in the educational process, have shadowing/internships as way to determine if the people going in to counseling jobs have good listening/people skills. Many don't. Investigate barriers to diverse populations pursuing education in psychology careers.
234	Require that training on cultural competence be a part of continuing education for all professionals.
235	Invest more in targeted recruiting (starting at graduate school levels and beyond). Enforce more stringent cultural competence standards on agencies. Maybe even financial $ for recruitment of workers of color.
236	More therapists of color coming to schools.
237	Educational/internship requirements to spend internship/practicum time in culturally diverse communities.
238	More education and hands on experience.
239	Local trainings for all organizations and community members about the different cultures in the area.
240	Local trainings for all organizations and community members about the different cultures in the area.
241	Improve training/education in graduate schools (and undergrads) on cultural competency. Require ongoing education. Address racism and white privilege in myriad ways. Too many white people don't understand the concept of white privilege, and without understanding that concept, it's very difficult to fully embrace cultural competency.

SURVEY QUESTION 9: What suggestions do you have to create a more culturally competent workforce?

242	Require students to do in-home therapy as a part of their training, alongside targeted internship sites that are located in diverse communities. If students only see people in their own training facilities, hospitals, and clinics, they will not be exposed to a broad range of clientele.
243	Continue current efforts plus provide educational funding for trainees with a more diverse background. Encourage patient participation in evaluation and shaping of mental health programs. Provide increased support for peer-support programs which will engage a more diverse population to participate.
244	Build communities which are positive for professionals of color to live and work.
245	we need trainings that specifically offer white privilege and racism understanding. like the book courageous conversations have done for education. we have all sorts of cultural trainings, but few ever address racism's impact on our clients directly
246	training, open dialogues
247	Only way this will truly happen is by hiring a diverse workforce.
248	Targeted recruitment; mentorship programs
249	Discussions about culture and teams to discuss cultural issues
250	I have no suggestions.
251	Create educational and career-track opportunities for minority group students and working professionals
252	grants for diverse populations to attend graduate school and other mental health training
253	Recruit clinicians from different backgrounds through the school programs and have them network with their alumni
254	More experience through trainings but also through hiring culturally diverse workers.
255	Where do we find places to post ads, expand reaching out connections. To learn more about opportunities to incorporate training, staff development, into practice. An idea is to have some way of having interactive learning where all people get to hear, know and understand how relevant being "culturally competent" is to working with families.
256	Reform some of the licensing procedures and reduce the cultural bias of the licensing exams.
257	Increase awareness in day to day operations for organizations. fund staff to provide assessment and ongoing organizational support for inclusive practices

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

1	committees dedicated to this within the workplace and implementation into organizational practices.
2	Training individuals within the representative cultures to act as providers or cultural liaisons.
3	Decrease barriers to licensure: stipends for training; workarounds if test becomes a barrier due to cultural bias; more use of cultural brokers to interest members of diverse communities in the field
4	Training including role playing scenarios
5	Go to the groups that advocate for the particular cultures, become immersed and learn their perspectives, include representatives of different cultures on all policy making and planning groups and task forces.
6	Recruit from among various ethnic groups.
7	Same as #9
8	Use culturally diverse training instructors and team to conduct ongoing training. Obtain feedback from culturally diverse clients to help measure outcomes and provide report cards.
9	Recruit from rural populations, including people who want to switch careers to BH.
10	Training programs, grants to subsidize education.
11	group meetings, trainings, and staffings
12	Recruitment fairs in diverse neighborhoods.
13	engage, recruit and retain people of color and a diverse background
14	Recruit and develop diverse methods of psychotherapy, for example use the expressive arts therapies: music, drama, dance art, play and sandtray therapies to bridge the cultural divide and heighten our universal needs
15	See #9
16	above
17	Same as above,
18	Support models other than just pathology and western medical model.
19	Make school affordable/a good investment.
20	It is important to provide a welcoming environment to all people that celebrate the ways in which we are different and unique.
21	Recognize that certain communities/cultures are not easily represented because their education opportunities are limited at this point. Finding ways to promote payment to agencies that include culturally diverse practitioners in spite of differing training.
22	Work with vendors, supported employment agencies to seek out a culturally diverse place of employment for clients that wish for this
23	Hire diversity
24	Reach out to underserved populations and make it a respected, adequately paid career option.
25	Grants for students from underrepresented cultures in the field.
26	Reduce poverty.
27	As mentioned, hire, when possible to increase cultural diversity, review current culture of the agency as to what may or may attract and retain a diverse work force
28	education, time spent training with peers
29	peer education para and practitioner level
30	To engage in more community outreach in under served and diverse communities
31	Online training videos available to anyone, for free, the speaks to cultural traditions practitioners needs to be aware of.
32	Go to high schools with a high number of minorities and inform them about careers in mental health.

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

33	Recruit And make presentations in schools that's are more diverse.
34	Begin introducing kids to behavioral health as a career option at an earlier age. Unless they receive services, most kids aren't aware of the field until later in life. Highlight the fact that it's a "helping profession". Kids tend to be curious and inherently sympathetic, so they'll want to understand why someone behaves a certain way, why another person hears voices, why the kid down the hall needs special classes, why another is so excitable one week and grumpy the next. This could also help eliminate the stigma around mental illness. If kids understand more about the issues in a basic sense, they'll likely be more accepting of individuals with mental illness or developmental disabilities they encounter and more willing to seek help down the road.
35	Don't know
36	We have had several interns of color and all had the goal of doing therapy in a clinic rather than working in the community with clients. Creating more services, housing and access to resources for clients has a direct impact on our ability to hire and retain staff who get burned out after 2-5 years with direct work with clients.
37	Having an organizational that is balanced between hierarchical and flat structures so that anyone coming into the agency automatically senses that they have a voice and that their opinions are respected alongside everyone else's.
38	Increased advertisement regarding open positions in the community. Reaching out to cultural leaders in the community.
39	Provide incentives such as lower cost schooling, transportation assistance and presentations in high schools
40	We struggle with this; don't know if I have any better ideas outside of advertising in culturally relevant sites.
41	target outreach by schools
42	increased educational levels, professionalism and rate of reimbursement for people who are actually doing the job rather than creating political networks and wanna be situations.
43	increased educational levels, professionalism and rate of reimbursement for people who are actually doing the job rather than creating political networks and wanna be situations.
44	pay enough
45	Fix the educational disparities in MN at the grade school and high school level so that more Minnesotans of color, and people with disabilities, are ready for college. Provide technical and vocational college programming related to careers as a mental/behavioral health aide (supervised by a professional). Exercise affirmative action at the undergrad, graduate, internship, and postdoctoral levels (or residencies) in professional programs. Improve reimbursement and limit excessive paperwork -- or train some people as mental health scribes -- so that bright, capable students of color and people with disabilities are attracted to mental health professions.
46	Make more accessible levels if training to appeal to a wider audience of potential health care providers
47	Consult with mental health professional-members or leaders of various cultural communities.
48	Connected partnering
49	Make training accessible to more diverse groups and let various groups know about trainings. ITV training?
50	Get more culturally diverse populations to attend college and get necessary education.
51	There needs to be better funding for these populations. Training institutions needs to be more accountable for how well they train their students. Unfortunately, diversity often gets segregated in the curriculum and only comes up if a student recognizes a cultural difference.
52	Redesign licensing exams.
53	Recruit from a variety of avenues, agencies or groups that promote cultural diversity. Reduce the requirements for Mental Health Practitioners to allow for more access by other cultures.
54	I think it needs to happen naturally. The ability to speak fluent English and be understood is VERY important. The person with mental health issues is already dealing with so much- they do not have the patience to try to figure out what there provider is saying.

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

55	Emphasize the need in high school and college level psychology courses.
56	train people from diverse cultures to be peer/family specialists
57	recruit at colleges
58	Create culturally specific programming and recruit people from that culture to run the program.
59	See above
60	See #9 above
61	Collaborate with and invite interested members of cultural communities to discussion forums, workgroups, conferences to identify the obstacles, philosophical differences, needs, etc. and use this knowledge to develop career ladders, funding programs, support services, internship sites, and academic programs designed and provided specifically for this purpose.
62	see above
63	Broader access to scholarships for economically disadvantaged & Native populations.
64	Education.
65	Train supervisors on the importance of it
66	Right now we hire off a list which includes people who have passed a test, identified that they want to work in this area of the state. Cultural background is not identified to the agency requesting the list.
67	
68	I live in International Falls. We have a hard time finding medical professionals that want to live in our rural community. We have been most successful when our children have moved home after receiving their education and some experience. We need to raise our own leaders who will come back home to work. Our city and county needs to create incentives for this to happen. The employer needs "a local" to work at recruitment. This type of thing needs to happen in our community and others.
69	active recruitment
70	College scholarships for minorities.
71	very hard in rural areas, and also with experience requirements to create and maintain
72	Incentives for individuals who desire to serve in areas of significant groups of diverse populations
73	Hang around in different circles.
74	Target existing college students in their freshman and sophomore year and recruit from this pool.
75	Discussions with community elders to ensure they support people from their community to come into the mental health workforce; they could create "a bridge" between the professional/s and the community. Recruit / entice 'diverse' high school students to become mental health professionals
76	Special educational grants for minority individuals who show a strong aptitude and desire to work in this field.
77	See above
78	Recruit and provide training/technical assistance/education for diverse individuals who might have family members with mental illness.
79	Same as #9 as a start. Then create either financial or other incentives to draw workers to certain areas of the state (specifically more rural areas).
80	the university of Minnesota is recruiting minorities into medical school. I don't know if there is support for them to train in a non-multicultural world. Need to look at the numbers of graduates and what happens to them after graduation. Get the data,
81	??? That is based more out of the area of the state you work in.
82	if there is a demand for more cultural diversity in the workforce, and that demand is adequately paid, there will be workers/professionals.

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

83	Offer tax breaks or subsidize education and credentialing.
84	Raise salaries.
85	Increased recruitment. Better pay. Outreach of the social services/mental health professionals into various communities, especially in rural areas, so that knowledge of these services is spread to communities where individuals might want to go into the field but not realize it exists. Psychiatrists need more incentives, in general, to become psychiatrists as I hear it's not as lucrative as other medical specialties and requires more training.
86	Same as above.
87	Mental health has always gotten a negative perspective, especially in other countries. In entry level areas (e.g., high school and college campuses; summer camps or on-campus camps or retreats) where we can reach more diverse cultures; we could begin introducing the importance of mental health specialists and try to turn around the negative stigma.
88	not sure
89	Hire more diverse and qualified employees.
90	Agencies should advertise at universities with various cultures, in culture centers, and in cultural newspapers in the community.
91	Don't just educate on race/ethnicity, offer education on sexuality, age (especially with the aging population), economic diversity
92	Have a staffed interpretor and someone to translate written documents you send to a member
93	Alternative licensing, better recruitment, more focus on this at college level.
94	there are too many barriers for people who want to be mental health workers and the number one is cost of schooling.
95	Increase accessibility to education. Less talking about cultural diversity and more modeling. Remove or revise standardized testing
96	Our facitity works with a university where the therapists are culturally diverse. this has provided some diversity in a very homogenous environment.
97	free trainings or info sessions in cult diverse agency
98	scholarships, mentoring, communications/marketing, supported pipeline - behavioral aide to mh practitioner to mh professional to clinical supervisor
99	same as 9
100	Scholarships and Loan forgiveness for folks from diverse backgrounds. Being willing to change the way we do things.
101	Target high schoolers and college freshman in diverse communities or target cultural-based organizations
102	Shift the cost-benefit balance so that entry into the mental health professions is more financially rewarding. More financial assistance and scholarships. More role models--tenured and tenure-track faculty of diverse social identities.
103	unknown, but definitely more training
104	Grants and funding for low income people, culturally competent mentors recruiting students from high school and in community colleges
105	Hiring personnel from the culturally diverse population we serve
106	I think it happens as the diversity of the community changes. Each area could identify diverse communities in their area and make certain there are strategies to connect with the diverse workforce.
107	Advertise jobs with a culturally sensitive lens.
108	eliminate the different class statuses in the work place

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

109	Find more money to pay mental health professionals especially in the smaller private non profit agencies.
110	More trainings offered
111	nothing specific at this time
112	Our company has a cultural committee who introduces staff to opportunities to learn about other cultures.
113	workshops, trainings, bringing culturally different speakers in to talk
114	mentorships. active recruitment of people from diverse backgrounds into the social service field.
115	Recruit in colleges that are diverse.
116	Hiring from different communities and ensuring that the agency is available to those in different sub-cultures. Making services available to individuals in different areas would also be big.
117	Employers should participate in and provide continuing education for employees on diversity issues. Also, initiatives in which task forces composed of individuals with diverse cultural backgrounds work together to examine issues related to mental health (or other relevant issues), so that mental health professionals have the opportunity to experience other cultures directly and to learn from each other.
118	Recruit diverse people, make pay rates and reimbursement more appealing to people.
119	Look for employees from different areas.
120	It's a long term process given the years of professional training and licensing.
121	Many master's programs are seen as major sources of income at many universities. Tuition tends to be high and scholarships are not readily available. Scholarships for diverse students and financial incentives for graduate programs that effectively graduate diverse students and that provide demonstrably effective learning outcomes for majority students on cultural diversity are needed.
122	Increase the wages/salaries of the social services/mental health-related fields and jobs. Provide benefits and opportunities for training/education to be paid for, perhaps in exchange for a work commitment of a certain amont of time. Assess students in high school and undergraduate programs and identify those who may have skills/interests in mental health/social services fields and create a financial incentive for them to want to pursue these areas as careers - means has to have a higher income potential and less work/job stress relative to demands of the profession.
123	Flexibility in educational and licensure expectations that take into account barriers for people of color
124	Have access to interpreters. How can clients go to work if they cant speak english in the programs that we work with? Provide funding for the CADI waiver to provide this service.
125	Recruitment from academic institutions that have higher ratios of students of color than local universities, including going out of the state. Hire supervisors and managers from culturally diverse groups.
126	Hire more employees with culturally diverse backgrounds. If the hiring pool doesn't provide much diversity, peer supports may provide more access cultural diversity.
127	1.) More cultural diversity on HR teams!
128	job fairs at colleges
129	Recruit culturally diverse populations into mental health fields
130	Unsure.
131	Recruit from community organizations that already have natural helpers volunteering for them.
132	Remove barriers
133	Cultural diversity trainings for all including supervisors & up.
134	agencies should be recruiting young people of color from the time they are in high school. There should be job shadowing, trainiing, internships etc to give them the interest and provide opportunity. Also some types of grants, scholarships would go a long way for some people to get engaged in a field that does not generally have a great financial payoff.

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

135	A diverse workforce will only happen if we support culturally diverse individuals getting into the field. This should start, at minimum, in the high school, but can start even earlier. There should be a specific focus on these areas directed throughout a person's education career.
136	Money would help.
137	we have free monthly trainings for staff and good clinical supervisors--see above
138	INTENTIONALLY SEEK OUT DIVERSE POPULATIONS!!! Do not continue to give lip service by stating that efforts have been made to seek out culturally diverse staff but actually do it.
139	Expand publicity re influx of immigrants
140	Increase the number of trainings and model them after the different reconciliation projects happening on a large scale. Being respectful of other cultures becomes more important to people once you know their story.
141	People coming from minority or the none dominant culture having access to education and employment experiences to compete with employment candidates from the dominate culture
142	reasonable, accessible training funding coaching/support during training
143	More people of color are needed. This includes African American, Asian, Native American, Spanish speaking and LGBTQ. I would recommend a grandfathering for LMFT, LICSW, LPCC etc. I would recommend this as many people of color are not passing the exam not due to lack of knowledge but due to factors that are not taken into consideration such as social economics. People of color start off at a disadvantage because they are often raised in poverty or near it and they tend to have fewer experiences with academic language used in their homes and neighborhood schools. They tend to have linguistically dependent courses which makes passing standardized tests more of a challenge for them. I recommend a grandfathering for one year to allow several unlicensed professionals the opportunity to be licensed. Many people refuse services due to the mental health professional not being able to releate to them due to cultural differences. Many professionals are not given the opportunity to work with people of color due to a perceived notion the professional who happens to be female and most of the time white represents the "system" the client feels is against them. Or they believe the female mental health professional is unable to relate to them. Sadly, if they were raised in a rural area or in an area where they were never exposed to people of color until they started working in Twin Cities.....they don't relate. The same as a person being raised in the inner city may find it difficult to relate if they moved to rural MN.
144	Encourage at the high school level careers in health care.
145	Collect data, please. Do young people of diverse backgrounds enter the mental health field at a smaller percentage than they finish college, or is the real stumbling block at the college and pre-college level? We can't have more diverse MAs or PhDs if we don't have sufficient diverse BAs and BSs.
146	Develop programs to recruit a more diverse workforce from a much earlier point, perhaps starting in k-12. This might include targeted scholarship programs or other similar measures to make the mental health provider workforce more diverse in a more appropriate manner.
147	The entry point i.e. I believe a program's website can send a message of being culturally friendly (or not), the supervision needs to reflect cultural diversity. Work of mouth is powerful so there also needs to be happy employees giving the message that it's culturally friendly work
148	Reach out to the above-listed agencies to give in-services about NHSC Loan repayment and the state loan repayment programs.
149	Recruit in higher education institutions
150	Active recruiting in all cultural groups will be necessary. This will involve working with educators to introduce young people to mental health professions as options.
151	-Push professionals to think beyond basic cultural competence education. An attitude of "it don't matter if you're black or white" does not mean someone is culturally competent. -I think the "grandfathering" aspect of MSW licensure for people who are minorities who work with minority groups is a good step. My agency has taken advantage of this option and people are excited about it.

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

152	I think grandfathering in for licensure is helpful, but there needs to be follow up with what is expected as a licensed person. This was not the case with the board of social work.
153	Outreach to minority communities and financial aid or scholarships.
154	Solve the problems of poverty and the dysfunction it begets in people. Most of the 'culturally diverse staff we have had are not with us anymore because their lives are too chaotic and as soon as you hold them accountable some claim discrimination. So there are people coming into the field who lack competence.
155	Peer-to-peer training and support. Use model of Cultural Wellness Center in S Mpls.
156	Hiring people from a diverse background. Having material in more than one language.
157	Active recruitment and possible incentives for professionals who are from a diverse background, or for professionals who are willing and able to obtain competencies for working with culturally diverse populations.
158	Support cultural diversity in all areas of leadership and decision-making.
159	None.
160	reaching out to high school students is essential to cultivating culturally diverse MH professionals 5 years down the road
161	A commitment by agencies to increase hiring of culturally diverse staff
162	Again, more loan repayment options and contracts to recruit people from all different backgrounds.
163	Improved recruiting process.
164	unsure...depends on the workplace
165	Get in the high schools and start talking about these jobs. Many kids and adults know nothing about these types of careers.
166	Mentor-ship programs for students who wish to become a mental health professional to get through school, better school recruitment, better support for students once in grad school.
167	Recruitment efforts that are much more intentional that focus in on those in, or considering graduate programs
168	I would consider this a bit out of my area of expertise. My best thought is to better use interpreters more often. From my work in schools I know that I have assumed someone was following what I was saying and they were not. If I were an immigrant I would stay close to the people I could communicate with. This one simple move could greatly limit mobility in the workforce.
169	Having the flexibility to recruit, despite civil service systems. Utilize allowances made to more easily employ people of a given culture for which there is a client base.
170	Recruit in undergrad and offer money
171	see above
172	High school visits by Social Workers, I would volunteer if asked
173	Funding to offer scholarships to students who desire training in one of the mental health professions.
174	Close the high school achievement gap and adequately address poverty well before graduate school. More grants for education.
175	Payment for the level of eduction is a bad investment. We have to make it worth while for people to get into the mental health field. Too much reliance on people doing it out of the goodness of their heart. Need to be somewhat balanced. Providers who offer services in different languages are not paid at a higher rate, actually paid less than if a provider used a translator.
176	Be less rigid in edcuational requirements.
177	same as #7

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

178	None. I see no obstacles to anyone interested in entering the mental health field from doing so. Individuals tend to go into areas that are of interest to them and for which they have abilities. This is not done in a uniform way in all areas of employment, from mental health professionals to NBA basketball players.
179	be present on college campuses and educate regarding the work field.
180	Increase wages. Start recruitment in junior high.
181	not sure i have a great deal of difficulty with this.
182	Advertise on employment sites targeting various ethnic populations
183	A more culturally diverse workforce would likely be more attainable by first enhance how culturally competent that workforce is (see above).
184	By growing the workforce.
185	Please see response to question #6. But overall, this is a huge systemic issue. Many students are kept out of the field, and out of good colleges because the schools they attend do not offer the courses required to gain entrance into the school. The standardized tests, though proven not to be predictive of future academic performance or success,have been roadblocks for many culturally diverse students. Basically, the system by which one gains entrance into academic institutions shaves off many layers of very competent culturally diverse people. My ideas, look at how culturally diverse people typically use and relate to the educational systems and use this information to modify or add programs, in essence,.meet people where they are at.
186	Figuring out ways to market mental health positions to high school students. Figuring out ways to make bachelor degrees more accessible and reasonable to people of color seeking social service/mental health degrees. Mentoring opportunities in high school, college, and the workplace. Figuring out ways to emphasize other strengths and other ways of doing things in a paperwork and billing driven system.
187	Seek out those interested in the field at colleges and community colleges. Offer information sessions about the work and the career possibilities. Seek out people working in the field who do not have degrees (ex: aides in the schools) who would make excellent mental health workers if given a clear path and support to get there.
188	Pay attention to the recommendations from the Governor's Advisory Council and the Subcommittee for Children's Mental Health who have been working on this issue year after year after year.
189	Support practitioners of color in their licensure process
190	Work should be done at the high school level to educate students around career options in the mental health field. Cultural values and beliefs need to be taken into account when recruiting and integrated into how we educate and train.
191	Many people from other cultures have health provider experience; seek them out and accept their methods that look different from ours. Hire promising people, young adults and up; offer them scholarships and loans for their training.
192	Increase recruitment to include areas where members of a minority populations will be inclined to see the posting.
193	Recruit where the people are, where they shop, where they live, where they gather, where they worship. Do not use online or social media if you want to be effective. People, who have good reasons not to trust, depend on personal relationships. That means ask -and compensate- current bi-lingual bi-cultural persons to reach out to others
194	Our agency has the office decorated with diverse items, photos. It is a directive and requirement not only from the home office, but also licensing.
195	Dont know
196	We need culturally competent early childhood mental health professionals in rural MN.
197	This really needs to start in early childhood, creating more equal opportunities for early education. However, I have heard from practitioners from non-caucasian backgrounds that Minnesota is not a very welcoming place, and the perception is there are not communities that are diverse in race and income level. I think this is improving, but it's made it difficult to recruit and retain diverse staff.

SURVEY QUESTION 10: What ideas do you have to create a more culturally diverse workforce?

198	same as question #9
199	recruiting- but this is a challenging area.
200	Again, teaching children in high school about the field and the need for culturally diverse professionals.
201	lower tuition rates
202	More educational opportunities for nondominant social groups. Education that is more affordable and accessible.
203	Scholarships and mentoring programs
204	(same question as 9)
205	Funding from state and federal dollars to bring programs to reach out to people of diverse backgrounds to help them find educational and career building resources to help them succeed in the workforce.
206	Give more minoritites position of power! Strive for our professional boards/leadership to be more reflective of our communities (and show you care at the state level by financially validating that).
207	When students are failing, student, family, school, therapist of similar color come together at school to address why they are under-performing. Students and parents come to school to hear spokespeople from trades and other businesses talking about careers, income, education, experience, behavior needed etc.
208	Again this comes down to trying to recruit people to want to work in this rural area.
209	Targeted recruitment by colleges and universities. Need to figure out how to "sell" the MH professions so more people of color and people of other culturally diverse backgrounds feel more interested in pursuing MH careers. Peer mentorship can help also.
210	Engage minority providers and community members in discussions regarding how to make the workforce more welcoming and safe for minority clients. This will attract more minority providers to work there.
211	Expand health professional educational grants with a priority for those from a more diverse background and bonuses to all training programs that provide opportunities for these trainees.
212	Same as above
213	continue to allow people the ability to access education inexpensively. it was difficult for me to meet the education and licensure standards because of cost, I can only imagine how daunting it would have been had I been a immigrant
214	recruitment efforts outside of online postings
215	Assist with educational cost for diverse students and set up pathways for students who are first generation by education them on possibilities. Cleanse pathways for them, CHW to CSS to 4 year counseling or psychology.
216	When working in the schools I attended a beyond diversity training that i found to be so helpful .
217	Tuition assistance, loan forgiveness programs for rural areas
218	See #9
219	Provide mentorship and grants for culturally diverse individuals to attend higher education.
220	We invite people to come and talk with staff, share experiences, to challenge how diversity works in each person's live. An idea might be to have the review team for Ombudsmen Children Mental Review group by Culture share perspective from their experience in working with families.
221	see above. The professions need to begin to reshape their practices to fit better with a culturally diverse workforce, or at least provide some bridges.
222	Recognize that many potential providers from diverse communities have families to support and offer flexible training that is a good value for the time and expense.
223	Work with licensing boards to help address cultural issues with licensure testing for Mental Health Professional level testing.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

1	Incentives New professionals to fill jobs in necessary areas
2	Licensing/supervision requirements for social work at the LICSW level take a crazy amount if time to do as a part time worker. I am currently on my fifth year of supervision and have another 30months! I was paying for supervision and driving an hour to get it for a while. It's discouraging and I feel you may loose a few to these requirements. Seven years of supervision I should have a doctorate!!!
3	Increased flexibility within the delivery of service system. Improving service delivery through a trans-disciplinary approach.
4	I appreciate grant opportunities for evidence-based training that pays for provider time, like the Trauma Focused CBT.
5	Establish consumer operated support services in place of CSP, Support funding WRAP and WRAP training and technical assistance, Move away from the medical model to prevention and recovery. Psychiatry needs to look at a more holistic approach and be more collaborative in the recovery process. Psychiatry needs to be trained in recovery, nutrition, and non-drug approaches.
6	I'm not sure.
7	Need to pay mental health providers commensurate with training and experience. You get what you pay for. Need insurance reform. Too many limitations/barriers that impede effective access and treatment.
8	Make it easier to access mental health resources by consolidating disparate and often difficult to find mental health services. Also more publicity re mental health issues, concerns, & legislation via radio & TV programs. I would recommend Minnesota Public Radio and TPT (Twin Cities Public TV) for their informative and sympathetic programs dealing with various mental health concerns like depression, anxiety, bi-polar, and other issues.
9	Per 9/11/13, USA Today article says "'Peers' may ease mental health worker shortage under Obamacare." I hope that the state of MN will be able to get funding to have more Certified Peer Mental Health Specialist training classes. My goal is to become a Certified Peer Mental Health Specialist. Also, provide more funding to NAMI-MN, so that more people can be trained as "In Our Own Voice" presenters....and/or provide funding for those NAMI-MN "IOOV" speakers to get paid. http://www.usatoday.com/story/news/nation/2013/09/11/stateline-mental-health/2798535/
10	Just want to stress that just having access is not enough. The competency and interpersonal skills of those professionals proving MH treatment and supports is important. Need to focus on professionals developing good person centered skills and "bedside manner".
11	Create the funding for rural areas, and the professionals will follow.
12	Don't let insurance companies run our field. Best practices should be driving our field based on the needs of each individual client, not on what insurance companies deem appropriate. Insurance companies are also offering limited reimbursement for new health practitioners they're affecting the supply and demand chain, pushing many outpatient organizations to have waiting lists of a month and half long before new patient can be seen by provider.
13	We are at a tipping point. We are working hard to reduce stigma and encourage help seeking behavior, yet we have no place to refer patients to that don't have a 6-8 week waiting list. Let's convene various community partners and work to develop a referral model to meet the needs of everyone. Let's train and employ mental health workers who may serve as a support to individuals and families when access to licensed professionals is a challenge.
14	Include more specializations. Spend a little money to save some money. There are many many trained Art, music, Dram etc. therapists unable to get gainful employment yet they are getting request to offer free services on a regular bases. It's really unfair and wasteful. Spend some money to really look at these equivalencies and then hire them
15	Lower fees for services
16	There is a shortage of mental health service providers
17	Screen for possible trauma, abuse, neglect in more comprehensive and family supportive ways. Supportive and fun parenting groups that focus on 'you are not alone' and expression for parents of own past. School based support for the entire school culture and community in each school. Healthy expression through arts and relationship groups, healthy body and integrative nutrition groups and support for parents in interesting and fun community Ed offerings. Why wait until extreme difficulties and life patterns/worldview become trauma based.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

18	Working in a CSP, I have noticed that there is a huge lack of affordable housing for people with SPMI. It seems difficult to connect people to services when they do not have a stable place to live.
19	Ongoing medication management, after stabilization of mental health condition. Covered by the patients' health insurance.
20	Establishing funding- inadequate payment is a big issue.
21	To get MH professionals to come into our community they need to be paid the same salary they receive in the cities to do the same work.
22	Rural areas have a severe shortage. Waiting lists can be long. Many services can't be delivered due to the cost and time for travel. ACT teams can be very helpful, but impossible to implement in rural areas. Reimbursement is insufficient to cover travel/ time costs. The shortage of psychiatrists and prescribing nurses is severe. Reimbursement is again an issue. In one week my children saw a neurologist for 10 minutes and was reimbursed $640. Later that week they saw their psychiatrist for 30 minutes each. the reimbursement was $78. This is not sustainable. Additionally, there are many individuals with neurodevelopmental disorder associated with exposure to alcohol in utero. There are few providers who are trained to recognize, diagnose and intervene. We need more training in this area. Finally, the caregivers are the largest workforce. They need training, support, respite and PCAs to keep children in the home where they are loved and have the best chance of health. We can't afford to have all these children in hospitals, residential centers, group homes. We need access in the homes.
23	Help simplify the insurance process. ie a client can only see a therapist in their network
24	Interns and recent graduates hold jobs working with the highest responsibility/risk, most vulnerable clients. These jobs are the lowest paid and the organizations operate with the least amount of support-supervision...when they need it the most. If they had more support they could provide better care, avoid burnout and give better services back to our communities. It is very problematic to me that only the poorest of the poor and the richest rich have access to mental health services. If you help children-people with milder mental health issues they will not develop into more costly mental health Dxs (BPD, ODD, Addicts) causing more societal problems. Inclusion of art therapy in schools, community centers has had huge positive impact in other cities.
25	More transportation assistance and options. Less paper work for insurance. Less administrative requirements that cost money to for practices to provide.
26	I have worked in public service for many years and in the area of mental health services periodically since 1989, returning again in 2013. I was dismayed at the decline in MH services, lack of accessibility to psychiatry for persons not yet or newly diagnosed, the lack of inpatient hospital beds, limited hospital stays, costs being charged to counties by State Operated Services for services needed by persons w/ limited options or court ordered admissions. Continued collaboration and a willingness by the medical community/psychiatry to consider providing services in new ways, increased PCP participation, competency in treatment of physical and mental health needs of persons w/ a diagnosis of mental illness, use of technology to increase access to services in rural, remote parts of MN, under resourced areas, etc
27	We need to move all levels to the top of their license - psychiatrists/APRN's need to move to more consultation with primary care - move from seeing 400 patients to consulting/overview of 4,000; need to focus on the most difficult patients and Team with other professionals in and out of the clinic setting; leverage internet telepresence for telemental health
28	Train more individuals in this field, support them in their practice, make the training mandatory.
29	Allow license holder to work at the top of their license. Develop this option at the licensure levels.
30	We have many qualified educated 4 year and masters level personnel who are not getting hired due to inappropriate exclusion of their educational credentials. This includes people from other cultures. Task forced to clarify NOT ELIMINATE educational equivalencies. More flexibility not less.
31	It would be great if Minnesota offered some sort of student loan repayment program that starts the day they are out of school.
32	transportation expense provided in rural regions where it can be 30-50 miles each way to access mental health clinical services

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

33	Provide more mental health services in the schools and domestic abuse shelters
34	Early childhood and Infant Mental Health needs to be considered an area of increasing professionals in. When we can impact the family and child at this level so that we can decrease the long term needs for intensive mental health. If we can help resolve and support families when children are young it can decrease the number of people who need intensive mental health programming in the future. Everyone needs to be able to access in-home family skills and therapy. Currently only those on MA or state insurance can access that service. There is a need for families on private insurance to have that in-home option as well
35	The financial qualification of lower cost for people with mental illnesses
36	We need to dramatically increase the number of workers trained to provide effective early intervention treatment for autism given the dramatic increase in ASD diagnoses.
37	Physician Assistants can and are specializing in the field of Psychiatry under the supervision of Psychiatrists. Recruiting and employing a PA can grow a Psychiatrist's practice and can improve patient care by improving access. Currently PAs are being reimbursed by Medical assistance enrollees for inpatient psychiatric services- however- DHS has not agreed to reimburse for PAs serving MA patients in outpatient mental health settings. By allowing PAs to be reimbursed for outpatient mental health services- PAs will be able to recruited by outpatient mental health settings where prescribers are greatly needed.
38	While I realize it's impossible to have representatives from all organizations across the spectrum participate creating in the Mental Health Workforce Development Plan, I believe the committee left out some major players. I was surprised and disappointed to learn that the steering committee for this initiative does not include more representatives from the MN Dept. of Human Services, in particular the Direct Care & Treatment administration (formerly known as State Operated Services). With 5,000 employees and nearly 1,950 clients (1,550 inpatient and 450 residential), it's got to be one of the largest providers of behavioral health and chemical dependency services in the state. In addition, I feel the committee missed an opportunity to lead by example when it didn't include chemical dependency professionals in the discussion. With IDDT such an important aspect of behavioral health care, it would be logical to seek input from the other side of the equation. I'm further amazed that the MN Center for Mental Health is not involved, especially since its part of the University of Minnesota and supported by DHS. Not to mention leadership from the Master's of Professional Studies in Integrated Behavioral Health degree program at the U of MN.
39	Adopt consistent use of "mental health professional" in all laws and rules governing access to and payment for mental health services.
40	Having positive work environments and being treated as a professional Healthy organizational structure
41	require commercial to cover services as MA/MCOs-no real parity when it comes to ARMHS or CTSS
42	I really believe that working with schools - especially social work schools to educate students on the importance of direct practice and case management.
43	Insurance needs to cover open-ended ongoing counseling!!! 6-12 week sessions is nothing when someone has suffered trauma or struggled with severe mental health symptoms.
44	More access to mental health services for the middle class as well as campaign for more acceptance of mental health concerns
45	Cities provide access. In rural areas, access to quality mental health treatment is difficult to locate, if it can be located at all. Example: In our area, when the advanced trained nurse retired, it was 11 months before another was found and hired. Example 2: After hospital - 1st psychiatric appt was 3 months later because of booked schedule and too few psychiatrists in our area.
46	Have clients evaluate their mental health professional.
47	same day appointment when in crisis / affordable meds
48	Make sure MH parity laws are applied. Reduce pre-auth hassles, streamline paperwork and regs

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

49	Just pay people at a rate equal to or better than they were receiving 20 years ago. we are decreasing educational requirements, increasing lower level of competency, increasing licensing across all areas and pretty soon acupuncturists will be licensed medical mental health professionals. We really need to stop the downward trend with him mental health professionalism.
50	Just pay people at a rate equal to or better than they were receiving 20 years ago. We are decreasing educational requirements, increasing lower level of competency, increasing licensing across all areas and pretty soon acupuncturists will be licensed medical mental health professionals. We really need to stop the downward trend with him mental health professionalism.
51	We need more psychiatrists and advanced practice psychiatric nurses more than anything. and we need help working with payers to be more transparent with parity. hopefully affordable care will alter the dramatic issues that payers create with their systems and get something consistent working for psychologists in practice
52	Financially incentivize high quality licensed professionals to offer more training to students and new professionals. It's currently financially unfeasible for many licensed professionals to offer practical training opportunities.
53	Continue to support small, independent practices. Larger is not better!
54	Crisis units should be available in every county. Retired professionals, students, peer support specialists, public health and others may be able to fill some of the gaps that exist. Nami might expand training to rural areas. Persons receiving assistance, who are searching for employment, may volunteer to help in exchange for job skills training.
55	People who see a mental health workers, especially a psychiatrist, often to do come away with a diagnosis. A diagnosis is essential in setting a wellness plan.
56	Increase pay to staff.
57	It's really hard for mental health professionals serving diverse clientele to navigate the institutionalized racism and biases in the system.
58	I recommend considering including Board Certified Behavior Analysts (BCBA) as qualified to become Mental Health Professionals in the state of Minnesota. These individuals have the same (if not more) amount of experience and education as Marriage and Family Therapists and Social Workers and are for some populations more qualified to serve as Mental Health Professionals. With the recent release of the updated CDC prevalence of autism as 1 in 68, we are finding ourselves in dire need of improved access to qualified Mental Health Professionals who can provide the evidence-based treatment most appropriate for this population.
59	Same as answer above re: recruitment and retention
60	For a young adult with a mental illness, the requirements needed are too strict before they can qualify for Adult Case Management with the county. Once a young adult finally accepts help, which is the only way in our mental health system he can get help even though as family members we know there is something wrong, unless they have been hospitalized 2 times and have a sever and persistent mental illness, they don't qualify for any help, financial, social, and vocational wise. The stress that this puts on families that love this person, is extremely difficult and potentially unsafe and life threatening. Sometimes, all the young adult needs is another caring person with access to helpful resources to get them on track to become responsible members of our society. After all, they are young adults and do not want to live with their parents and want to somehow figure out how to be able to be on their own if at all possible.
61	More ability to work with schools/families. Assistance with job training.
62	We need more in-patient beds. When someone becomes very ill and requires inpatient care- they currently often have to wait or be placed far away from their home. This is a major breakdown in our delivery system.
63	The ACA will hopefully result in more people having insurance and being able to afford care and meds.
64	People do much better when they can have frequent appointments if needed.(including more than once/week if needed). Have the same clinic offer coaching and crisis lines 365 days/year. This is actually cost-effective because it is flexible to the person's situation (which can change). It promotes recovery, decreases hospitalization and continued downward spiraling. If we had more community based clinics like the one described; people could access quality care much sooner rather than having to wait until they deteriorate to the point of being committed. People would have a much better quality of life and it would save an enormous amount of money. .

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

65	Maybe have a community resource day or fair to encourage networking, provide information in a non-threatening atmosphere, presentations
66	I think general practitioners and family doctors need to learn more about how mental health treatment and supports are accessed so that when they make a referral, they can also offer insight into the amount of time it will take to get treatment. They should also know where to guide a person to start in their search for treatment and support -- it often isn't clear whether they need to call their insurance company, cold call a psychiatrist, drop in to a walk-in center, call the county, etc.
67	Improve the process for registering complaints. Provide more surveillance regarding basic requirements of provision of services. Attract quality people to the field by reducing stigma and increasing prestige and reimbursement of behavioral health professions.
68	It would be a great help in our Region to be able to utilize those professionals available through the CBHH and assigned to the tribes, but not accessible to all other populations. They have time available - just not the ability to serve beyond the scope of their limited client contact.
69	I see the heart of this problem as a fundamental lack of adequate resources at every level of the mental health treatment system combined with a very inequitable distribution of resources in both fuding and providers. The State of Minnesota has too long neglected the needs of our residents suffering from mental health disorders, especially in rural areas. Whatever solutions may be proposed will need very substantial additional financial investment combined with a more equitable and regional distribution of those resources applied in a more flexible, tailored way to address the diverse needs of specific populations and communities.
70	Improve crisis response by training emergency responders (including 911 operators) and by providing additional training on interacting with families to specific MH response teams. Support use of PBIS in schools and use of MH crisis response rather than police in case of emergency. Stop criminalizing mental health!
71	Ensure they're provided in non-metro areas.
72	Improve transportation in rural areas Allow phone contact to be billable to ARMHS
73	There are areas that are needed that were specific to your list. Child Psychiatrists, neuropsychologists, in home counselors in rural areas to meet the specific and unique needs of families.
74	I am very happy with the CSP workers in International Falls. They do a great deal to support the mental wellness of the mentally ill. They pay is too low so there is a lot of turnover in those positions and that is tough on the populations that they serve.
75	Different counties do things differently. Perhaps making access to programs/funding/how laws are followed more uniform across the state.
76	we are desperately short on placement resources and funding, and this also adds to lack of applicants of quality workforce, rural areas are in need
77	Yes. But you haven't listened. You have only select groups you work with and listen to.,
78	3rd party billing works against poor individuals who face continual crises and challenges. Once individuals miss appointments, 3rd party mental health billers stop giving them appts. This is problematic. Billing is not the "be all and end all" for mental health services...particularly for guaranteeing access to people who face transportation challenges and multi-generational poverty.
79	I think Minnesota needs to work on improving treatment settings that are also long term residential settings (old Rule 36 facilities). It takes a long time to "recover" from an SPMI that is considered to be a chronic illness.
80	Continued and increased funding for community-based supports, Evidence-based practices research.
81	Use of technology that is reimbursed by third party payers. Ensure opportunities for providers to use phone, email, a secure "Skype" type technology as opportunities for payment...not just in-person - for all mental health workers, including county case managers.
82	Pay everyone more. Everyone gets paid below their worth, and this makes everyone feel used and over-extended.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

83	Create an easy friendly access statewide web site, including early sign of symptoms; create a family friendly treatment environment and the need to engage families to support during critical time.
84	Educate colleges/universities that there is a shortage for med mgmt. throughout the state, but especially in rural areas, incentives to enroll in the program, tuition partially waived, etc.
85	See Dr. Matt Miller's presentation about psychotherapy outcomes in the 2013 Evolution of Psychotherapy conference. A YouTube search will find this for you. He makes excellent points about all of these themes. Please contact me for more information: gnorman@co.carver.mn.us (Gary Norman)
86	Actively promote complimentary alternative bodymind medicine.
87	This is not the first time the workforce issues has been studied. Where are your champions at the medical school and in the legislature? How are the health plan payors forcing change through policy and payment? Did you complete another academic exersize that will gather dust?
88	Rural areas have a difficult time paying competitive wages.
89	Better pay, better understanding among people considering mental health careers that persons with mental illnesses can and do get better/ do better and can have control over their lives, so that a career in this area does not have as many negative connotations as it does now.
90	More fluent communication from hospitalization to community care providers to allow for more continuity of care for clients.
91	An unfortunate problem with mental health is the turnover of student practitioners. Instead of assigning someone to one intern or student practitioner, we may as well advocate a "team" of practitioners at the outset. It is traumatic for someone to build an effective rapport with one practitioner, only to have them transferred a couple of months later, and have to begin the process of building a rapport with someone new. The team could meet weekly and discuss clients, in order to be on the same page.
92	more professional staff to allow for more availability in services and programs which will reduce patient wait times, especially if someone is trying to access services for the first time (this is especially true for those seeking psychiatric services)
93	No
94	Agencies and Professionals need to be willing to be wrong and willing to learn from others, including their peers who are having positive results and the individual culture groups without judgment.
95	We need to move our focus off of diagnosis and symptom suppression and onto RECOVERY! I also think that our emphasis on treatment settings needs to be de-centralized away from large institutions and out into the community into a smaller, more comfortable setting such as the clubhouse concept and neighborhood drop-in centers. I also think that some stigma busting and early intervention with proper treatment could go a long way toward reducing our current reliance on intensive care settings. In other words, put out the campfire before the whole damn woods goes up in smoke.
96	Laws pertaining to funding of resources that assist people better manage their illness need to be congruent from the county up to state level. How am I supposed to advocate for supports when a county says "By law, the state must use up their resources first before we chip in!" Then the state says, "By law, the county must exhaust their resources before we chip in!"? Then the client receives no services with which to improve their lives. Frustrating for both the client and mental health workers in the field.
97	Require or allow experience in the field to count towards licensure
98	Consider transportation and distance to services when addressing the rural areas. I have clients that come from 50+ miles away to receive adequate services and anonymity.
99	I would like the individuals we serve to give more feedback on the care they receive and then address those areas of feedback

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

100	Please read this - you have one of the more accomplished rural mental health workforce researchers right here in MN at MSU Mankato - Dr. Paul Mackie. I've known this person for some time, and know that he has been carefully dissecting the problem, publishing papers, presenting his data at state and national conferences, and has served on boards that seriously consider rural MH workforce issues. He has even been consulted by federal agencies and might possibility have the most solid understanding of the problem as anyone currently in the field. I asked him if he had been contacted by anyone at the state level or NAMI, and the answer was "no." He hadn't been informed of this survey or this inquiry. I'm not trying to chastise but make aware that you have this resource and you are not using it. My fear is that you are also missing out on a considerable amount of quality research on this topic that really tells the story to those interested. He's easy to find - Dr. Paul Mackie, Department of Social Work, Minnesota State University Mankato. Until you talk to this person, you've not talked to the person who has a lot of information on this very topic.
101	It is crucial that the state of Minnesota work to increase the community services needed so the forensic hospitals can discharge difficult patients back to the community so the access for new patients needing the care can be admitted. Until this is done there is a need for additional acute beds for the most difficult patients.
102	Hope to see actual people doing the work in the field at the upcoming meeting- seemed like only ones invited were key stakeholders from the people at the top of those organizations- are they really the ones that you need to focus on to get info?
103	create a school-based therapist position (like school psychologist or counselor or social worker)
104	Currently there doesn't seem to be any or much follow-up when someone is discharged from a mental health unit. There should be a seamless transition to providing peer specialists and family support upon discharge. Also beds need to be made available in the area where the person w/mental illness lives. It's somewhat useless to hospitalize them in area far from their home.
105	The overall health system has to place a higher value on behavioral healthcare professions by improving reimbursement rates so employers can afford to pay better salaries. If you simply do the math-- reimbursement rates times reasonable productivity, you get a number that doesn't match up to the level of education and experience required to do the work.
106	Don't forget rural.
107	Broaden the array of possible funding sources to reduce the reliance on MA as a source of payment for mental health services.
108	more accessibility for licensed providers, particularly LPC and LPCC to insurance panels so the community can benefit from their skills
109	The lack of beds at the state systems is appalling. There needs to be long term safe treatment options for staff and patients. Violence has to be addressed in acute care across the continuum. Families should be a standard voice in treatment. I see plans made based on what a patient says with no realistic base of what is really going on because of HIPPA. There should be case coordinators across the mental health and CD systems (same one) who can actually coordinate and have access to beds, appointments, medications. There should be chronic addiction case coordinators. Focus on children. Special education is the beginning. The pressure on the schools hurts education and the community as a whole.
110	Better pay so that more people go into the profession. Focusing on prevention. More providers that are accessible to people who are struggling with their mental health.
111	Have a clearing house for resources that is staffed by people who really know the systems
112	There needs to be more services in rural Minnesota and outreach to these communities. Counties are not the best in providing these services because of the stigma attached. You need to partner with schools, hospitals, clinics, community centers to help develop and provide services.
113	Make it more available, manageable case loads
114	I would support more DBT treatment options, there is a need for more programs to treat dual- diagnosed individuals, there is a greater need for more treatment options for aggressive individuals

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

115	Again, this whole system is getting bogged down in paperwork (SDQ's, plans, CASII's, reports, signing off on practitioner notes, quantitative progress notes that do not address client needs yet take up time, etc....
116	more urgent mental health centers are needed, community activity drop in centers are needed, funding needs to be advocated for for housing i.e. monetarily accessible housing for low income/mentally ill people
117	Switching to a single-payer system so that everyone had coverage, then increase reimbursement rates for mental health providers.
118	Provide more accessible psychiatric services. Increase the bed availability in the State Regional Treatment Centers. Increase the length of time for IRTS from 90 days to a year to ensure stability. Provide apartments with security at the front to act as a gate keeper.
119	For employers to offer incentives for employees to stay rather than leave after life circumstances changes. At this agency, there is frequent turnover of mental health social workers due to lack of pay structure and benefits that adjust to an individuals changing life circumstances for example a new graduate social worker. This is a great place to start but once a person gets married or has children the pay scale and benefits are such, it's difficult to stay in this high stress job and get very little pay or recognition.
120	I think breaking down the stigma is a big first step. NAMI-MN and other related agencies do great work, and we should all be partnering with them in these efforts on the ground.
121	Having moved to MN only 18 months ago, I have had the opportunity to compare mental health services in this state with those of other states. I have been disappointed to find that the quality of services here is much lower than in other states. This appears to be directly related to the fact that much of what is offered here is offered by bachelor's level providers who lack professional competence. To compound the problem, these providers are frequently inadequately supervised (which includes both not enough supervision and supervisors who are not adequately trained).
122	There are no specialist in RAD in most areas. Attachment therapist are in great need in most areas.
123	If you pay people more, they will enjoy their work more and provide better services.
124	The whole "medical" system/model and gatekeepers of the financial resources which might support mental health-related issues needs to change payment/funding sources to create more parity among all of the otherwise "medical" identified areas of focus, for example, cardiovascular, orthopedic, internal medicine, etc. so that mental health-related treatments and support services are funded and given as much importance as any other area.
125	Make it easier for clients to get Mental health CM. have a team that is an outreach team that can go out to clts houses to sign them up to work with a MHCM. Most people with SPMI don't want to go to a clinic that has a waiting period of an entire day to be told that they have to take medication etc.. Have a team that meets with a clt in their home, in a program and set up MHCM there on the spot. I think more people would be reached this way than asking them to show up to a clinic. IE: I have a friend that wants a MHCM but I cant encourage him to go to the clinic. Great give me his nbr and I will have a MHCM meet him for an intake. Look at reducing the amount of paperwork that is required by CM so that its minimal paperwork, so that more time is dedicated to the clients. I wish there were more in home programs ie: therapist that go to clients home, psychiatrists that go to clients home. We aren't reaching the clts that have a hard time leaving their house, that are off medications for a period and cant organize their thoughts or aren't good with keeping appointments. The new state forms for the new rate setting is limiting access to clients to work. First the CADI Cm has to request from the CAFC a rate form for the current hours for the client at the CAFC then another form from the CAFC to show what it would look like when the clt starts working. Then the CADI Cm has to request from the Work program a form for the clt to start their program. Then the CADI Cm has to turn in the new service agreement with all the forms and have an account clerk enter them for the services to start. I am finding out that the Foster care programs aren't wanting to give the form to me bc that means a decrease in rate for them. So, collecting forms is delaying services. I have currently been waiting 2 1/2 weeks on one CAFC to provide me the form. Before the rate forms started here is how it went. Clt said I want to work at this program, CADI Cm contacts work program, clt tours, all agree its a good fit. CM enters contracted rate onto service agreement for agreed amount of days. Clt starts working within 3-4 days. Again talking to Cm before a new plan is rolled out to see how the work would get done I think is very BENEFICIAL! Currently, all I am doing is collecting these rate forms and waiting on them so that I can set up services.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

126	Ramsey County has no place for people with SPMI to connect with other people with SPMI, except the mental health center. I know consumers who don't want to go there because they feel like it is where they get therapy and psychiatry services and not where they want to meet peers and get other services such as supported employment, support groups, etc.
127	1.) We need more Mental Health Professionals who speak more than one language and who are more culturally competent.
128	Make social service work more lucrative. Raise awareness of mental health in the community, reduce barriers to receiving mental health care (right now the county mental health center is not accepting new clients.)
129	More dually trained mental health professionals and psychiatrist re: SUD MA grads are leaving programs with one maybe two classes on SUD. Given the stats on dual disorder this is shocking
130	Encouraged care coordination of providers.
131	Accept that some kids need help at a very young age. Ournkw 6 yr old had to wait until 4 and required being hospitalized
132	Inform those seeking help for their loved ones about the differences between the types of mental health professionals to enable them to seek the proper treatment. It's almost impossible to get an appointment with a psychiatric doctor. Family counselors are not enough when someone has bigger issues.
133	Insurance denials, and pre-auths denied on whims, are big problems for providers.
134	Improve sliding fees, accept all insurance.
135	Kids in the Juvenile Justice system often are not given the type of mental health services that would be provided if they were in a residential facility. Much of this is due to lack of financial support, lack of good education around the need to mental health services in locked facilities, and the traditional belief of consequences -v-rehabilitation. Many probation officers struggle with the lack of services provided/required of families prior to a kid becoming a "criminal". Something is wrong when a county social worker wants a probation officer involved so the kid will get some mental health services.
136	None
137	decrease cost barriers, reduce stigma, increase MA reimbursement so the MH professional field is more attractive (we can increase salaries), continued increase of intensive OP programing to reduce hospitalizations
138	Quit allowing red tape from allowing the services to the consumer to happen. Meaning be creative on how it can be billed and document the material accurately with explanations if necessary on the reasoning for the service and the impact it has on the client, family, community and society as a whole.
139	leaders need to know access to providers and family
140	If people could have an easier way of maintaining MA and SNAP, that would be a good start. Housing with paid utilities, including a phone, would also improve access. People who have MA but no stable address can't schedule medical transportation effectively, and without a phone they can't confirm the ride. Services for people with any criminal background are even harder to find. Since clients of color are disproportionately involved with criminal justice, this makes it even harder for them to break out of this cycle of racism and poverty. Finally, a lot of people want to work but can't without supports, and employment programs are really scarce for people who do not have a CADI waiver. Also, when people work, reporting income can be very confusing. People find themselves in the position of having to maintain their disability rather than developing their abilities. If these services could be available, all together, but in several locations (like in the health care home model), it might help.
141	More trained interpreters
142	There are very little to none mental health providers in rural counties. This means that the families have to travel 30-50 miles for any appointments. These counties need to somehow have the mental health professionals come to them, or set up an office in the county. Also, increasing the reimbursement rates for an in-home diagnostic assessment would help with access to services, but also give a more accurate and complete diagnosis and recommendations for services.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

143	Hopefully the health care exchange will give the working poor greater access to mental health treatment as this population is currently the most underserved.
144	Ways of motivating people in more rural communities
145	Allocate more funds to mental health care.
146	Currently there is a grandfathering for LICSW for people of color to apply. The theory sounds good but many County employees who have worked in the areas of Mental Health for several years are unable to be grandfathered in due to the county not being a part of this process. In addition, several nonprofits are not hiring people of color to fulfill the requirement of working at a nonprofit in order to get grandfathered. I know several people who have had no success in locating employment in a nonprofit the entire year 2013-2014. This type of gate keeping is making it difficult to allow access to people of color in the field. If the goal is for the client to reach a sense of wellness by managing mental health symptoms, It should not be a difficult task to have people of color represented in the population of service providers. Non-minority clients have the luxury of receiving service from people they identify with based on race, color, religion and social economics. That same option should be given to people of color.
147	Change the insurance system so that all are insured at a cost people can do.
148	It is important for Universities to produce qualified applicants, who have the training and experiences to be prepared to practice in multiple settings and competent to meet the needs of our populations.
149	The model of mental health service delivery has gotten fragmented, in part because the service delivery model is dominated by private practice. Although I am in private practice, I do not find it to be a good way to deliver service to any but patients with the fewest needs. For high-needs patients (chronic mental illness, dual diagnosis, mentally ill children and adolescents), service should be delivered where there is psychiatry or psychiatric nursing on site, where there are both degreed professionals and BA-level mental health workers. As mental health becomes increasingly housed in medical clinics, those clinics need to show a commitment to integrated care. As of now, mental health is seen by medical clinics as a sometimes-necessary adjunct to their "real" mission of medical care, so they have one or two entry-level psychologists or clinical social workers. Mental health will never be a good profit center for these corporate clinics compared to medical service delivery, so there must be other sources of income that subsidize the Allinas of the world for delivering mental health services. Fee-for-service for a psychologist will never measure up to what they can bill for a Family Medicine doc, much less a surgeon.
150	Make it easier for providers in private practice to connect with county agencies as another option for services.
151	A. Misunderstanding mental illness and stigma are two barriers to WANTING TO ACCESS tx. 2. It is going to get harder to access services as it becomes harder to practice as individ. or in small groups due to requirements of electr. health records and health care homes, and the continual downward slide of insurance reimbursement rates. Some practitioners are going to just give up and quit--early retirement, etc.
152	Pass a law in MN providing prescription privileges to appropriately-trained psychologists.
153	Often mental health services are just a piece of the treatment picture, especially with children. Mental health practitioners need to be able to work WITH other professionals (e.g., speech-language pathologists, occupational therapists, physical therapists, skills workers, etc.) to better understand and treat the person from coordinated perspective. Professionals treating in isolation miss the full picture much of the time.
154	Psychiatrists are the most difficult group of mental health professionals to recruit and for patients to access. What makes them particularly valuable is their ability to prescribe. APRNs help with access because they prescribe, too. Adding prescribing ability to other mental professionals with appropriate training in clinical psychopharmacology would help both access and the effectiveness of integrated care. Appropriate education and training probably includes a master's degree in clinical psychopharmacology plus several hundred hours of supervised experience. This would all be on top of the education and training requirements that already exist for the mental health professional.
155	Transportation is a HUGE barrier for many of my clients, along with bilingual/bicultural services.
156	Reducing stigma and increased funding.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

157	We need to change the criteria/definition of mental health practitioner and drop the required hours of experience. A bachelor's degree in psych or social work etc should be good enough-maybe hours required for other majors. Same goes for post degree licensure. What happened to the idea that you could get a job with a BA or that you should be able to do therapy with a master's. We have degraded the meaning of these degrees by adding all this 'experience and supervision' post degree.
158	Promote and advocate for screening for depression and anxiety during pregnancy and postpartum. Create more support groups (peer-led or professionally-led) all over the state to address stress of parents -- daytime and evening and weekends.
159	Be able to provide transportation to the office if needed.
160	I think the LPC/LPCC licenses go unrecognized in many arenas. It is a fairly new license (about 10 years) and there needs to be more education around the training, competencies, requirements and scope of practice of a professional and clinical professional counselor. This license is among the most well-trained to diagnose and treat mental illness across many situations. There are counselors willing and able to serve in underserved areas and working with underserved populations, but the insurance industry, legislators and other agencies have yet to recognize the value of the license in this state.
161	Offer returning veterans grants for graduate level schools to work in the mental health field
162	Concern is obtaining "easy" access and then finding a way to pay for mental health treatment. Often the people who need it, cannot afford to have it...or to continue it for any length of time. Also, consider having mental health counselors (clinical social workers) on staff in more school systems to assess and help children beginning at a young age.
163	Make connections within the schools. Teachers/educators know a lot about their communities.
164	It is very hard to hire qualified Mental Health Practitioners, which as the first line of service. Decrease the amount of paperwork requirements.
165	To make locations people can receive services flexible.....ie, schools, family home, community, etc.....instead of people having to always receive counseling in the typical "office" setting.
166	Engage those communities in which access to cultural match of MH professionals is problematic. Asking those communities the arenas and opportunities may be available
167	I am a psychiatrist and I moved here from another state last year to start working in a rural psychiatric clinic and hospital. The following may be longer than you want, but it pertains directly to recruitment and retention of psychiatrists. Already I am thinking of leaving my job here because of the dire problems in this state related to mental health services. If Minnesota is serious about wanting to recruit and retain mental health professionals, then it is essential that the bed shortage crisis and the crisis affecting State Operated Services be resolved. Currently, because of bed shortages in the state system, and backups of mental health patients in ERs, aggressive and persistently mentally ill patients are being shunted into private community hospitals that are ill-equipped to care for them. One of my colleagues has written to Governor Dayton about this problem and it is hardly news. There is a reason we need state facilities for some patients. It is to protect the public and the patients themselves. These facilities must be properly designed. For example, my hospital uses a converted medical ward as its psych unit. We do not have a well-designed seclusion room, we have no psych techs, and an aggressive patient could easily harm or kill staff, other patients, or themselves. No hospital licensing agency would look at our unit and say we are "equipped" to treat dangerous patients, despite what many county attorneys, judges and ER docs seem to think. These critically ill patients SHOULD be going to STATE facilities, but invariably all state facilities, from Anoka to the smallest CBHH, claim they are "full," or the patient is "too aggressive." (These are the hospitals FOR aggressive patients!!!) THIS IS SOMETHING THE STATE SHOULD INVESTIGATE. There should be an audit of the state system to make sure the facilities are operating at capacity. To me and my colleagues it appears that some of them are not. Emergency rooms are affected by the bed shortages, and the patients pile up there, so emergency room doctors LIE to psychiatrists, concealing patients' aggressive tendencies to get them in the doors of any hospital that will take them. Patients we are assured are "not aggressive" often turn out to be highly aggressive. This is no different from sending a patient who has diabetes and also needs a liver transplant to a hospital that has no liver

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

	transplant service, and getting them in by only mentioning that the patient needs treatment of "diabetes." Patients die when that happens. They will die in psych hospital too. These inappropriately admitted patients then go to commitment hearings, and after being committed by the judge, the judge will tell us we "have to take patient back because the state beds are full" even though we DON'T treat committed patients. (For one thing we often don't get paid.) It is a medical decision to admit a patient to a hospital, not a legal one! Yet I would be in contempt of court if I didn't allow these inappropriate admissions made by judges and attorneys. Although I'm told that by state law, the Commissioner of Health is supposed to find beds for patients, I have never once been contacted by the Commissioner regarding a patient in need of a bed. Would a judge force a victim of a serious motor vehicle accident to be helicoptered back and "readmitted" to some small local hospital that doesn't provide trauma care just because "HCMC is full?" Of course not. Would a judge send a patient needing emergency coronary bypass surgery to a hospital that doesn't have a cardiac surgeon because "Abbott Northwestern is too busy today?" Of course not. But in psychiatry, judges make medical decisions, and these patients bounce back to us. As a result, they present a great risk to themselves, other patients and staff, as well as to my own career – and there you have the link to recruitment and retention. I fear the day when I am on call and a patient in our hospital kills another patient or a staff member and then I end up on the front page of the Star Tribune. A death occurred at St. Peter recently and I'm not surprised. Careers are ruined over incidents like that. I actually interviewed for a job at St. Peter, but decided for precisely that reason not to take the job. I was actually interested, but an event like that is exactly what I feared. And it happened. I don't plan to put my career at risk on an ongoing basis or take the fall for the State of Minnesota by having my entire life ruined over an incident that ought to be prevented, and I can't imagine other sane physicians want to take this risk for very long either. If you really want to recruit psychiatric providers, the system needs to be fixed. Either that or you need to pay A WHOLE LOT MORE. The same thing is true and only worse in child psychiatry. Recruiting nurse practitioners to fill the gaps will not solve the problem. It will make it worse. NPs have a role and are important, but they don't have the same training or knowledge. They may not always recognize serious medical situations. Are they required to carry malpractice insurance? You can't drive a car without insurance – you better not be able to care for the most dangerous people in the state of Minnesota without it! (Unless the state doesn't mind being sued, I would guess, by the family of some future victim who was treated by a provider that had no liability.) No amount of experience as a nurse is enough to make one into a doctor. What doctors are trained to realize is how LITTLE we know, and to act accordingly. If legislators are ok with letting nurses manage the most dangerous people in the state, then go ahead. If Minnesota doesn't fix the system itself, then given enough time, the federal courts will. When patients are shunted into the WRONG facilities, they are often not treated properly, because those facilities can't manage their needs. For example, we do not have psych techs at our hospital. We cannot really be Jarvising patients and forcing medications safely without psych techs. And patients have a constitutional right to be TREATED when they are committed involuntarily to mental hospitals. If they sit in our hospital being unJarvised and untreated, and just imprisoned while we all await a bed for them at some non-existent state facility, then Minnesota will make the news in a different way. The Supreme Court has previously ruled that commitment without treatment is a violation of patients' constitutional right to liberty. You don't think anyone will ever notice? We have already drawn attention to ourselves with the dubious sex offender treatment program this state is running. If legislators want an easy and cheap solution, they can overturn the laws that allow for commitment of the mentally ill. Then we will all see how that turns out in terms of public safety. (Remember this case? http://www.mprnews.org/story/2007/10/16/sjodinsettle) Instituting caps on malpractice lawsuits might help with recruitment, but will only go so far. If our state wants to keep these laws in place, then doctors are needed, as well as appropriate facilities for them to work in. Those facilities must have beds.
168	As an LMFT supervisor, if graduates seeking licensure could bill a partial payment under my supervision and licensure we could put well educated people into the mental health workforce immediately. This is the same for LPCC and LICSW licensure. The reason that the insurance companies stopped doing this was to "market" /compete for employers by saying they guaranteed providers with only the highest licensure. The healthcare field is inconsistent in reimbursement. Medical residents, radiology technicians, etc. receive reimbursement during training
169	Don't risk overloading productive and competent staff.
170	Extend the length of years a parent can be involved in their offspring's care. Automatically cutting it off at 18 (especially if the patient is in a bad space and won't sign an ROI) diminishes a great deal of information available to help treatment.

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171	Money, reimbursement needs to be higher. The mental health field has changed and we spend more time on paperwork and "required" documentation that less time is spent face to face with a client. Compensation is out of balance with the amount of work, hours and responsibilities that are placed on Mental Health Professionals and practitioners. The Mental Health field requires commitment and 45+ hours a week. There's a lot of burn out and exhaustion. Our own families pay the price for us Mental Health Professionals helping others. The medical field has higher reimbursement, but people helping those with severe and persistent mental illnesses get little compensation for the demands of their jobs. Hence, quality of work is down. You get what you pay for and when you can't afford educated people.
172	Include legislation that makes it harder for payer groups to deny psychological measurement (e.g., psych testing for ADHD)
173	Increase reimbursement rates for governmental insurance programs. They are the lowest in the profession. Decrease paperwork and red tape to make taking on government insured clients less painful administratively. Pay mental health professionals when government insured clients cancel late or don't show, just as in private practice.
174	very difficult to find mental health practitioners due to limited acceptable degrees and number of worked hours required by DHS.
175	I think this survey needed to be addressed to the specific stakeholders. My ideas/ comments are not the same as those of the "corporate" level of people in my organization. The tone of the survey is decided bent toward those levels starting w/ the second question. How about, " If you are an employee.." If you are a parent, client, etc.? That said, thanks for looking into this. Recommendations: 1) Payment for collateral contact when working with children. 2) Review of efficacy of pay-for-performance models in community mental health. What are the CLIENT outcome measures. I'd love a year long experiment w/in my agency of so-call "productivity" of clinicians who must schedule upwards of 30 clients/week in order to meet a required caseload of 25+ per week. VS. someone who gets paid the same amount for, say minimum 20 clients per week, depending on difficulty of the case. 3) Research is available on what it takes to create a master therapist, and these clinicians are best for clients.
176	Highlight the importance of preventive mental health services in children, youth and adolescents in schools. Educate school district administrators on the importance of mental and behavioral health services. Move agencies away from preferring LICSWs for positions that can be equally discharged by LMFTS or LPCS
177	More funding, so mental health professionals are not so overextended, and therefore often distracted by workload (i.e. - more resources so one person isn't doing the job of 3 people.)
178	We need psychiatry and we need MH practitioners!!! We also need staff trained in supervision. The rules on supervision have grown to be expensive and difficult to maintain. So to find people to head up day treatment services can be difficult.
179	The system has to find a way to engage families and individuals with generational trauma...those who struggle to make it to appointments and access services.
180	Work towards having rates of reimbursement/payment for mental health treatment and supports equivalent to other medical treatments and supports.
181	State regulations and rules can be overwhelming and daunting for professionals delivering services. It can be incredibly difficult to navigate and complete required documentation. This can be a barrier to providing quality care, due to the cumbersome nature of understanding and abiding rules as well as a set up for burnout and turnover. The state needs to look to streamline systems and have a better system of communication to providers. There must be some way to ensure quality care without creating so many hurdles and layers for professionals to sort through.
182	Increase reimbursement! Increase reimbursement! Increase reimbursement! Allow graduates who are working toward licensing to be paid for their work -- combat the discrimination by insurance companies against reimbursing new graduates. Pass legislation requiring insurance companies to have in-network providers within 30 minutes or 30 miles of patients' homes. Pass legislation requiring adequate reimbursement for a full spectrum of services: inpatient, day treatment, group, family, individual therapy, and classes. Make insurance companies respond to efforts by practitioners to practice in a way that reaches more people and that evidence shows is effective. Recognize that mental illness is a chronic disease that requires multiple strategies to effectively combat -- For example,

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

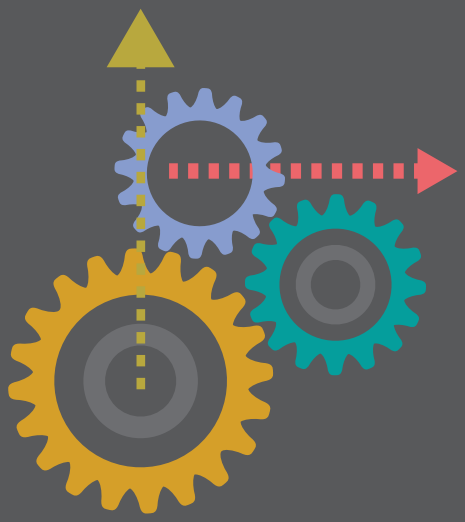
	when working with children, it is often more effective to train parents than to do individual therapy with the child. Parents are best trained in groups, but to be reimbursed, one of the parents has to be identified as a "therapy" patient and the group has to be "therapy." Group therapy is very effective, but difficult to put together because a minimum number of participants must be present each time in order for the facilitator to be adequately reimbursed. Change the documentation requirements so that every new professional doesn't have to spend 4 hours generating a new, complete, diagnostic report. We should be able to build on previous reports that are adequate and accurate. Reimburse psychologists (and others) adequately for report-writing. Recognize that attending school conferences for children with serious mental illness is a legitimate function of a mental health professional.
183	More providers and not allowing for duplication of service by one provider.
184	Some of us have been working in "hard-to-reach" areas of the state for many years. Areas with high poverty, high trauma, and too few mental health professionals. This burns out some people, but some of us thrive here. It would be nice if MA would pay a little more so my employer could give me a raise. Also, the paperwork demands are getting more and more and honestly, are a good incentive to get out of this line of work. Is there some way the paperwork could be simplified so that we can spend less time typing and more time seeing clients?
185	Reach out specifically to youth in schools. Allocate more staff resources such as social workers in high schools to prevent criminalization of marginalized youth.
186	The legislature taking some of the budget surplus and reinvesting in the mental health system in the state of mn, so that providers can pay reasonable wages to develop and recruit a culturally diverse workforce.
187	You didn't even have the option of early childhood in this survey and there is a huge need and shortage of early childhood mental health professional in rural MN.
188	This needs to start at the legislature, providing adequate funding to treat and care for individuals with mental health needs. We need the funding.
189	Increase the number of providers. Use groups more effectively. Add on-line resources and scheduling.
190	* What can be done to improve the mental health workforce/delivery system? • Make paperwork more streamlined-less documentation and more time with patients. • Small community based practices. We have to give new practitioners good training. Have a treatment team approach. THIRD-PARTY PAYERS need to sponsor and reward innovations in practice that improve service delivery and reduce barriers THIRD-PARTY PAYERS need to recognize that most mental health problems are chronic, recurring conditions Third party payers need to recognize that working with the family is essential to getting patients well and this work should be adequately reimbursed. Third party payers need to recognize that psychological testing is an essential tool for diagnosing and treating mental illness and need to reimburse adequately for testing time, scoring, analysis and reporting of results.
191	School districts to hire more school social workers - having the mental health professionals be employees of the district and understanding school procedures.
192	Availability for young children in high risk family situations to receive treatment and care quickly
193	We could probably double the number of metal health case managers in some of our counties and still not have enough; same with psychiatrists, especially ones who work with children and adolescents.
194	*School based mental health is the single most effective way we can reach more people with mental health issues and intervene earlier. The reduced suspension rate also suggests that academic outcomes would be improved (and potentially would reduce our achievement gap). *Families and individuals need an information clearinghouse to help them navigate an extremely obtuse and complicated system. Any information that case managers or providers can access to guide families should also be available more broadly to families, so that those who are capable can do more self-help. *In developing policies, pay special attention to families and individuals that fall in the "grey area" -- those who are lower middle class, have insurance, but face such high deductibles that accessing services is unaffordable. Also grey area are children, youth and adults who have mental illness, but are not in the "red zone" but still need lots of help. Many grants, county programs, etc. tend to be focused only on the most extreme cases and don't help these "grey area" families. The result? Things spiral downward and we have more extreme and costly cases.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

195	We need to make it easier for families to get help for their family members who are suffering from mental health disorders. Family members should be able to get their loved ones court ordered treatment when the loved one cannot make the decision on their own. Risk of homelessness, suicide, overdose, child endangerment of children living with a mentally ill parent or sibling, and other issues need to be seen as a priority. Currently many folks cannot get help unless they are immediately suicidal or homicidal. These illnesses need to be seen as not just choice, but as a serious neurological problem in which the individual with the disorder is unable to make competent decisions to protect themselves and others. Early intervention is essential. We must recognize that families cry out for help because there are very real threats to the lives of their loved ones, not because they want to manipulate the loved one.
196	Reimbursement rates are low for mental health services - it is difficult to make programs work, do what is in the best interest of the client, pay people a fair wage and make the agency financially viable without overloading workers and creating burnout. If we were able to pay better and allow workers to have "healthy" client load we could retain workers and truly do what is helpful and right for our clients.
197	Smaller caseloads for school counselors. Increased access to mental health services ie therapy in schools. Families coming to schools after hours for family therapy.
198	Improve the benefits to veterans. There gov't benefits are so poor that many clinicians choose not to work with them.
199	It is nearly impossible to find a mental health provider who understands the complexities of FASD and the overlapping behavioral characteristics. It is so often misdiagnosed. We need to get providers trained in FASD
200	I think we have come a long way and we still have a long way to go.
201	Again - making it more attractive for mental health professionals to work in rural areas with some sort of incentives or help with financial aid.
202	Private insurance recognizing skills training for both adults and children so they can learn and practice the skill necessary to manage their mental health more effectively in the home, school, and community settings.
203	Private insurance recognizing skills training for both adults and children so they can learn and practice the skill necessary to manage their mental health more effectively in the home, school, and community settings.
204	How on earth did it happen that the large MH agency serving east central MN (I forget the name) just suddenly shut with essentially no warning??? That kind of thing can't be allowed to happen. There is already much too limited MH services for greater MN (not to mention in the metro), and to close with essentially no backup plan for clients is unconscionable. How can the MH professions work better together? How can they communicate better, and be less siloed, to better support clients? What alternatives to hospitalization can be developed - crisis bed networks, adult foster homes, etc. More access to ACT teams and other intensive MH services.
205	less red tape to access high end services, insurance that supports longer-term treatment to stabilize and heal
206	Purposefully construct and organize teams to include sibling disciplines. Psychology is not better than Marriage and Family Therapy, Social Work, Addictions Counselors, etc. -- nor are any of these better than Psychology. To presume so is arrogant. All disciplines overlap, and all disciplines offer something that others do not. Interdisciplinary teams serve to role-model this for students (so that they do not become disciples to their own disciplinary choice), and provides patients with a diverse skill set that is better equipped to offer top-notch care.
207	Add a bonus to those health care homes in MN that provide integrated care and add another added bonus to such sites that offer training in integrated care to both behavioral health and medical providers.
208	More psychiatrists willing to listen to patients and work with them to achieve their personal goals. Better scheduling systems which are not as automated and inflexible. More emergency assistance settings at levels between the medical office and locked hospitals.

SURVEY QUESTION 11: Do you have any other ideas or comments that you want to share about improving access to quality mental health treatment and supports?

209	I suggest that persons who provide CTSS or other related MA supported services see some perk in doing the work that would increase professionals and practioners and clinical trainees' commitment and longevity to this service area and with this population. Some ideas include: prestige--seeing this work as important and highly valued versus sort of a starting point that new professionals have to get thru to get to their desired work. Compensation---making this work valued in financial terms. MA dollars are often very limited dollars.....so perhaps the answer is really in : security---could the Legislature set up a special retirement type benefit that CTSS service providers could be vetted into? That other service providers are not (ie the private practice therapist who does insurance and private pay service only) IF this work were more appealing and we invested in the workforce providing these important services; we would improve access to quality mental health treatment. which would be a smart investment. and cost effective in the long run.
210	Improve better care coordination with mental health teams, and related people involved with clients.
211	Greater compensation for care coordination and in home services.

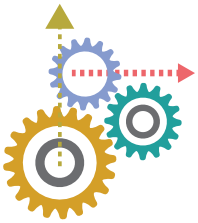


Appendix D:

Mental Health Workforce Summit Agenda

Mental Health Workforce Summit Recommendations

Appendix D:
Mental Health Workforce Summit Agenda



Challenges & Solutions:
Minnesota's Mental Health Workforce Summit
May 28, 2014 • 8:00 A.M. - 4:00 P.M.
Hennepin Technical College - Brooklyn Park

Goal of the Summit: To generate ideas and solutions for Minnesota's mental health workforce state plan that:

- ✓ Increases the number of people working at all levels of the mental health system
- ✓ Ensures appropriate education, training and coursework
- ✓ Creates a more culturally diverse workforce

Requirements: A. Read assigned articles to be sent with registration materials
B. Complete "Challenges & Solutions" form

Registration

Welcome & Kickoff

Overview of Previous Efforts

Overview of Data: Supply & Demand

Overview of Community Forum Input

Small Group Breakouts

1. Education/Recruitment/Retention—Early Childhood
2. Education/Recruitment/Retention—Children
3. Education/Recruitment/Retention—Adults (Acute & Residential)
4. Education/Recruitment/Retention—Older Adults
5. Education/Recruitment/Retention—Culturally diverse workforce

Lunch

Small Group Breakouts second session

1. Education/Recruitment/Retention—Culturally diverse workforce
2. Education/Recruitment/Retention—Special Education
3. Education/Recruitment/Retention—Adults (Community)
4. Addressing shortages in rural areas
5. Building career ladders for entry level MH workers.

Moving Forward/Next Steps

Adjourn

HealthForce Minnesota
Transforming education. Advancing practice.

Appendix D:
Mental Health Workforce Summit Recommendations

Accreditation	Make sure that training is occurring through accredited programs
Benchmarks	Set goals, timelines, accountability for making those goals
Benchmarks	Key stakeholders take lead on implementing and measuring results of increased funding and recruitment of people of color into mental health fields.
Benchmarks	Establish and publicize benchmarks
Benchmarks	In two years provide this summit again to see where we are
Benchmarks	Inventory current practices to determine what works well, what should be scaled up
Career Ladders	Recruit from minority community through adult ed and offer para certification program
Career Ladders	Recruit interpreters using ladders
Career Ladders	Develop certificate program for entry level MH position , credit for peer specialists, leverage prior experience for credit
Career Ladders	Supported pipeline - behavioral aide to mental health practitioner to professional to clinical supervisor; support from high school through licensure with mentoring and financial support
Career Ladders	Create certificate programs at community colleges to train people in basic mental health practice skills, IDDT, IMR, etc.
Career Ladders	In community health center, steps on "career ladder" are few. Best practitioners become supervisors—we take them out of what they are best at and make them managers. The way the system is funded—how we are paid—makes this a reality.
Communication	Create a forum where communities of color can present
Competencies	Define key core competencies--community, professional group
Competencies	Is there a way to develop more robust undergraduate training that could help bachelor's level providers be more prepared for inpatient/residential settings? More useful job skills?
Competencies	Campuses are uneven in their use of Credit for Prior Learning. Systematize process statewide for mental health workforce.
Competencies	Can we create a competency-based set of qualifications—not dependent on the individual's undergraduate major but rather based on focused skill development? Graduates in psychology don't differ that much from graduates in other undergrad majors in their readiness for entry-level practice.
Competencies	Students coming out of grad programs hear a lot about being "culturally competent", but what they often don't seem to get is what it means to be poor. Being "broke" as a grad student is not the same thing as living in poverty. We have to talk about "class" and culture.
Competencies	Provide risk assessment training
Competencies	Provide inter agency skill training, i.e. working across agencies and their cultures
Cultural Competence	Require core cultural competency in training and as part of licensure/renewal
Cultural Competence	All professionals must be required to demonstrate knowledge of diversity and diversity education for licensure at all levels

Cultural Competence	State wide initiative to "integrate" diversity into all human systems, including families, schools, workplace, corrections and professional training programs
Cultural Competence	Help foreign born professionals get licensed as MH professionals/ Investigate DEED program to learn its outcomes
Cultural Competence	Require core cultural competency in training and as part of licensure/renewal
Cultural Competence	Ensure a critical mass of diversity in hiring practices
Cultural Competence	Provide and support ongoing training and supervision of all staff in culturally competent practice
Cultural Competence	Providing consultation to improve cultural competency
Curriculum	Build 2000 required hours to meet criteria for MH practitioner into college/university experience (field training, extended internships) so that when they come out of college they are ready and meet criteria as MH practitioner and can get hired
Curriculum	Concern: There is a disconnection in expectations from student's training experience in school and what their expectation of real-life experience will be. Solution: Offering elective mental health classes that focus on specific interventions
Curriculum	Curriculum and training should include resiliency and recovery, wellness, not just for client but also for provider. Training in resiliency and "hat works" is more holistic and may attract more diverse potential providers rather than focus on "medical necessity" determinations alone
Curriculum	How to ensure that LICSW social workers receive personnel management and supervision skills and training for new managers? Colleges and universities are not offering really good management training either in graduate curricula or CEU offerings.
Curriculum	Need to prepare students for the changing work of mental health careers and the amount of paperwork involved
Curriculum	Currently, there are no requirements for care coordinator in health care homes. Create more standards around who's doing the care coordination at clinics. (Mental health training for care coordinators?)
Curriculum	More discussion between community providers who and the graduate programs at the colleges and universities.
Curriculum	Hire family members as co-teachers in university training programs
Curriculum	Ask universities to clean up their programs and align them more with statute definitions
Curriculum	Create a certificate that licensing and universities agree on that will produce
Curriculum	Determine whether natural healing skills used among other cultures might be reimbursable
Data	Charge DEED and licensing boards to collect better and more standard data
Diversity	Coordinate training efforts between mental health providers, higher education professionals, and leaders in local/regional communities from cultural minorities. Establish regional networks and training centers to facilitate these efforts, make the training more affordable and accessible, and more sustained and consistent.
Diversity	Practicum opportunities to fit students with diverse backgrounds
Diversity	Offer programs through tribal colleges
Dual Diagnosis	Increase dual diagnosis training for mental health workers and substance-use provider
Dual Diagnosis	Cross train chemical dependency and mental health workers

Evidence Based Practices	Ensure that evidence based practice includes experiences of people of color
Expansion	Expand and scale up existing programs that work, for example, Diversity Social Work Advancement Program (DSWAP)—social work diversity initiative
Fellowships	Faculty fellowships so that faculty are teaching relevant concepts/interventions/evidence based practices
Fellowships	Having a fellowship for faculty to get them reacquainted with what the field is like nowadays.
Funding	Build diversity training and recruitment efforts into long-term budgets rather than as "pilot" projects
Funding	Resurrect 2007 bill that was designed to fund the connection of experts in particular cultures/populations with mental health (MH) workers to provide consultation
Funding	Payment for supervising trainees and or interns.
Funding	Structure administrative barriers around who can supervise, and restructure reimbursement for down time and travel time. Medical Education and Research Costs (MERC) is a model.
Funding	It's hard to find qualified supervisors—supervisors don't get paid for their supervisor roles. There are strict accreditation requirements but not much recognition of the importance of that role. If we could find ways to pay or recognize this work, it might be more attractive for people who might be considering becoming supervisors.
Funding	DHS provide training funds to support providers teaching if education programs cannot pay
Funding	Explore the idea of performance bonding, where an initial infusion of money is paid back with long term savings in state programs.
Grow Own	Grow your own — integration of county/tribal/community providers
Grow Own	Grow clinicians from people who already live in rural areas
Grow Own	Bring programs to rural areas rather than rural students to metro programs
Grow Own	Expand UMN infant and early childhood mental health certificate program to greater MN (MNSCU role??)
Grow Own	Could we create funding for an advance practice nursing program in psychiatric nursing to be offered in a more rural area?
Grow Own	Develop distance learning options
Grow Own	Create masters programs through rural MnSCU sites
High Schools	Recruit in high schools—expose them to mental health careers
High Schools	Recruit at junior high and senior high schools with populations of color so they know early on about career options in mental health
High Schools	Partner with diverse school districts to teach/introduce students to MH, bring MH providers who reflect the community
High Schools	Scale up scrubs camps around the state
High Schools	Investigate whether mental health workers in public schools could do a career day to expose students to MH careers
High Schools	Recruit at junior high and senior high schools with populations of color so they know early on about career options in mental health
Incentives	Can housing be offered as an incentive to bring workers to shortage areas

Incentives	Reimburse for moving expenses for people moving from metro to rural areas to work in MH field
Incentives	5-year loan forgiveness in rural areas, reimbursement in increments of 25K
Incentives	Grants, stipends, scholarships for students from underrepresented cultures in the field
Incentives	Provide tax incentives for sites that establish paid apprenticeship programs
Incentives	Creating scholarship funding for career ladders for people working in residential mental health care can help encourage people to stay in the system
Incentives	Develop incentives to encourage people to pursue MH careers with underserved populations, i.e. geriatric communities and children
Incentives	Trainees could benefit from financial support during internships, adequately paid apprenticeships post-graduation and increased access to well trained supervisors. Mentors would be great help too.
Incentives	Hospital Fellowships based on a structure like Regions (who developed a fellowship for PA's and RN Practitioners)/post grad fellowship in community mental health patterned after Regions physical assistant fellowship
Incentives	Diversity - think about male involvement in field 82% women entering psychology as an example
Incentives	Have MNSCU schools offer alternative of a senior capstone project focused on mental health and tied to loan forgiveness if person goes into mental health career
Incentives	Grants, stipends, scholarships for students from underrepresented cultures in the field.
Information	State plan needs to reflect clarity on competencies, licensing and reimbursement requirements
Internships	Better connect internships between educational facility and training site. Allow for providers to teach module or class on community mental health providers
Internships	Every student needs to have a significant amount of time working face to face with people who have mental illness and/or addiction. This should be an internship - something built into their education.
Licensure	Make sure licensing boards are culturally diverse
Licensure	Work with licensure boards to support "cross certification"
Licensure	Approach licensure boards to ask if they could create equivalencies for supervision among disciplines for masters licensed professionals to open up possibilities for employment and supervision across the board
Nursing	Designate a current nursing school to be pilot for specific psychiatric nurse training.
Peer Specialist	Get users of mental health care services into classes to talk with students as part of their education/training
Peer Specialist	Encourage clients who are of a different culture and doing well in recovery to train to become peer support specialists.
Peer Specialist	Utilize local Peer Support Specialists for practice drills in de-escalation techniques, cultural competence with diverse populations.
Peer Specialist	Have schools take over the training of Peer Specialists – a person with lived experience goes through a training program.

Peer Specialist	Develop a Peer Specialist Health Coach program
Peer Specialist	Can we make a way for services of Certified Peer Specialists to be reimbursed, to make it more feasible for agencies/health care settings to offer these services?
Physicians	Much more mental health education in medical school for family physicians. Require a mental health rotation.
Promotion	Media campaigns on TV, ratio, internet that a target population would see. Ads are designed to reduce stigma, teach about mental health topics and mental health services—interest people of that population to enter mental health field
Promotion	More effort at the state level to market mental health careers
Promotion	Add info on MH roles, salaries, skills training to ISEEK. org
Promotion	Clarify social work titles
Promotion	Develop a clearing house that is a repository of information to find out who are supervisors, agencies, training site, providers, consultants, speakers, etc. for specific populations. Base it at the state (DHS?) or college (MNSCU??) and everyone in the state would know to contact the clearinghouse for information. The clearinghouse has an application process to screen who is on the list
Rates	Reimbursement for entry level positions
Rates	Rate structures realigned to reflect education and experience
Rates	Increase flexibility in county based rates; when counties freeze rates they can't offer competitive salaries
Rates	Require insurance companies to reimburse trainees performing clinical work under appropriate supervision
Rates	Increase reimbursement rates
Recruit & Retention	Cohort support models to create networks
Recruit & Retention	Develop an outreach campaign to immigrant and refugee communities about the benefits of "counseling", the value of "counseling" as a profession to foster interest in a career in mental health and recovery. Many immigrants and refugees don't have the concept or language of mental health or counseling from their cultural perspective
Recruit & Retention	What is status of helping-foreign born professionals get licensed as MH professionals
Recruitment	Expand the model of the Reservation Summer Institute
Recruitment	Have MnSCU meet with their students of color and survey them as to what would help them enter and stay in the MH field
Recruitment	To what extent are entrance tests barriers to recruitment of communities of color
Regulations	Could the legislature change regulations around "mental health practitioner" credentialing and supervision? What does a person really need to do this kind of entry-level job? How to provide bachelor's level people with necessary training and experience to really be competent in mental health?
Regulations	Create a workgroup (composed of those in hiring positions) to review statute language and provide recommendations on changing the language
Regulations	Connect DHS licensing and Universities to obtain program verification to minimize/eliminate the barriers [that] Rule 36 providers are experiencing.

Requirements	Expand MH practitioner requirements to recognize prior experience and education
Residencies	DHS funds more psychiatric residencies and/or continuing education
Residencies	If each residency program expanded by 1 or 2 residents per year, we would have many more qualified physicians. This would require some creative funding mechanisms and pathways.
Residencies	Create a system of collaboration between Community Mental Health Center –and Psychiatric Residency
Retention	Develop supports during programs that address vulnerable "drop out" times for particular populations
Retention	Develop mentoring programs
Retention	Provide supports for all licensure exams as people move up career ladders
Retention	Recruit larger cohorts from cultural groups for workplace to enhance supportive environment
Retirees	Recruit retired psychiatrists to consult with providers in shortage areas
Retirees	Develop a limited-practice license for mental health professionals who are qualified, skilled and wise and who may be leaving the field for retirement. This limited scope would allow for provision of clinical supervision, training and part-time clinical practice
Retirees	Develop resource of retired mental health professionals and coordinate them into volunteer program
RNs	Psych rotations need to be a mandatory part of nurse education
Scale Up	3000 certified peer specialists needed, partner with MnSCU to train them around the state
Scale Up	Challenge- lack of placement options results in grad schools not expanding admissions—solution, united kingdom model of compensating field instructors in agencies for placement of students, incentive for agencies, expands education slots
Supervision	Incorporate licensure supervision into programs that already require supervision
Teams	Integrated teams—workforce needs to be geared towards care of the future, which is delivered through team model and includes professionals not normally though of as mental health providers, i.e. occupational therapists, peer support specialists, art therapists, etc. education of providers needs to include understanding of what other professionals provide in treatment of individual
Technology	Promotion of technology for continuing ed. training, telemedicine. Ideally supervision could occur electronically
Technology	Increase the mobile crisis outreach slot programs on teleconferencing with MH specialist statewide. May be staffing issues so increase in education.
Technology	Develop virtual training cohorts to build support for distance learners
Technology	Challenge—lack of support and access for school, training—solution technology—cross training/multi disciplinary creating virtual support groups or training cohorts for staff, expanding certification options
Training	Regional training centers to make affordable supervision available and to train supervisors
Training	Develop a training institute for clinical supervisor to continue to train and build mentors in the field and across the state. Provide training, mentorship, support for clinical supervisors. Develop and maintain a large pool of clinical supervisors connected to one another
Work Requirements	Reduce duplicative paperwork

	Target providers, that already do training well, as centers for getting supervisory hours for practitioners and provide extra payment to support this
	Give credit for prior learning to family members/peer specialists who want to enroll in MH programs
	Marriage and Family Therapy (MFT) training could be stronger in community mental health... how could other programs benefit from community mental health training that social work does better
	Develop outreach to immigrant and refugee committees - WSU has grant in Rochester area around health literacy...process to establish trust...using health literacy volunteers