

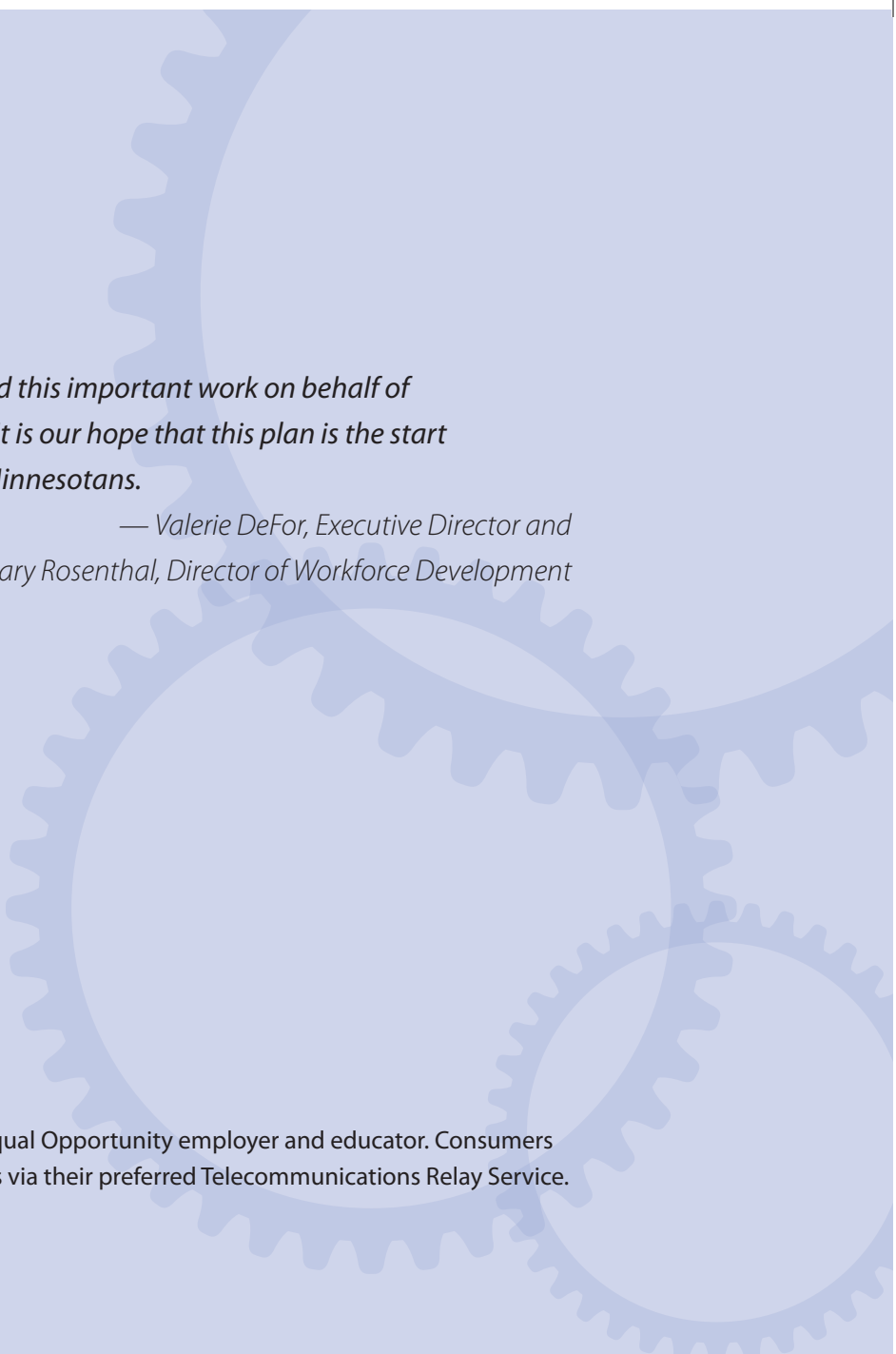
# Gearing Up for Action:

## 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  
Mary Rosenthal, Director of Workforce Development*

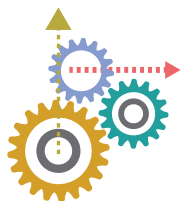
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**APPENDICES CAN BE FOUND AT [www.healthforceminnesota.org](http://www.healthforceminnesota.org)**

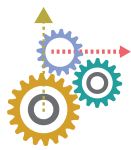
## ACKNOWLEDGMENTS

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.**

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Susan Benolken	Minnesota Department of Education, Special Education
Chris Bray	University of Minnesota, College of Education & Human Development
Greg Clausen	Senator, Minnesota Senate District 57
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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.

### 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

*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.*

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**

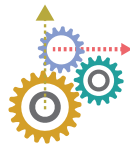
**Recommendation 21:** Identify gaps in the educational, certification, or licensing systems that impede career movement from entry-level, paraprofessional positions to terminal degrees and licensure as an independent professional. Identify the special challenges of and barriers to incorporating persons 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.

## 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.<sup>1</sup>

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.

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11 geographic regions,  
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professional shortage  
areas.*

- **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.<sup>2</sup>

## 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.

### 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."<sup>3</sup> 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.*<sup>4</sup>

*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.*

In 2013, SAMHSA's *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*<sup>5</sup> 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)<sup>6</sup> and The Mental Health Acute Care Needs Workforce Subcommittee Report<sup>7</sup>. 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.

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.

*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.*

## 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 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.

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

## 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<sup>8</sup> (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.

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.<sup>9</sup>*

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.

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

### 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.<sup>10</sup>

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.*<sup>11</sup>

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<sup>12</sup> 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.<sup>13</sup> A decade later, two reports by the Surgeon General on Mental Health and on Children's Mental Health<sup>14</sup> 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.

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.<sup>15</sup> 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.<sup>16</sup> Nationally, Child and Adolescent Psychiatry Fellowship training programs are not being filled for reasons which include staggering medical student debt.<sup>17</sup> At the same time, the mean age of Child and Adolescent Psychiatrists is 53 years, indicating that the shortage may soon grow even worse.<sup>18</sup> 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.<sup>19</sup> 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.<sup>20</sup>

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

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."<sup>21</sup> 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.

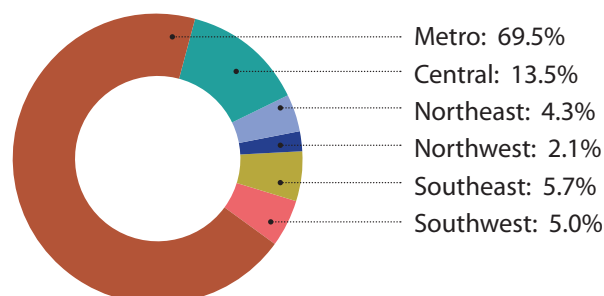
## 2014 MENTAL HEALTH WORKFORCE SUMMIT

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:

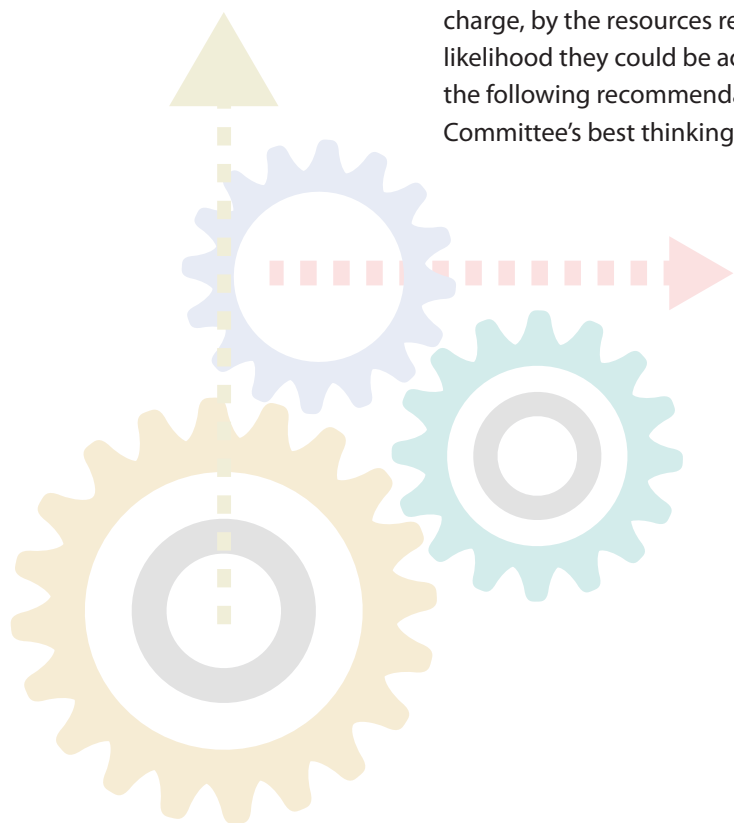
- Develop mental health career promotional campaign that exposes middle and high school students (especially from diverse communities) to mental health careers
- Determine ways that Certified Peer Specialist training can be offered so that it is accessible to the entire state
- Increase funding to Minnesota's 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.

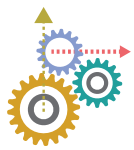
## CALL TO ACTION

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

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**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.

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**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**

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**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.<sup>22</sup>*

*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.

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**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)

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**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.

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**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



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**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.<sup>23</sup> 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.

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**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

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**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.

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**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

- <sup>1</sup> 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.
- <sup>2</sup> 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](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058037)
- <sup>3</sup> Substance Abuse And Mental Health Administration, *Transforming Mental Health Care In America: The Federal Action Agenda: First Steps*, 2005.
- <sup>4</sup> Annapolis Coalition, *Action Plan on the Behavioral Health Workforce Development*, Substance Abuse And Mental Health Services Administration, 2007.
- <sup>5</sup> U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, January 24, 2013.
- <sup>6</sup> Minnesota Mental Health Action Group, *Road Map for Mental Health System Reform in Minnesota*, June 2005
- <sup>7</sup> Children and Adult Mental Health Divisions- Chemical and Mental Health Services Administration, Minnesota Dept. of Human Services, *Mental Health Acute Care Needs Report*, March 2009.
- <sup>8</sup> Some programs listed are online only. Not all enrolled students are in Minnesota or plan to work in Minnesota upon program completion.
- <sup>9</sup> Annapolis Coalition, *op. cit.*
- <sup>10</sup> Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, 2004.
- <sup>11</sup> Michael A. Hoge, Gail W. Stuart, John Morris, Michael T. Flaherty, Manuel Paris, Jr. and Eric Goplerud, "Mental Health And Addiction Workforce Development: Federal Leadership Is Needed to Address the Growing Crisis", *Health Affairs*, 32, no.11 (2013):2005-2012.
- <sup>12</sup> Mental Health Summit, "Setting the Stage", Survey Results.
- <sup>13</sup> Council on Graduate Medical Education, Third Report, *Improving Access to Health Care through Physician Workforce Reform*, 1990.
- <sup>14</sup> US Public Health Service Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC, Department of Health and Human Services 2000.
- <sup>15</sup> The American Academy of Child & Adolescent Psychiatry, *Children's Mental Health Workforce Shortage - A Call for Immediate Relief*, 2012.
- <sup>16</sup> Conversation with Minnesota Association of Community Mental Health Programs.
- <sup>17</sup> American Academy of Child & Adolescent Psychiatry, *op. cit.*
- <sup>18</sup> *Ibid.*
- <sup>19</sup> Minnesota Department of Human Services, Children's Mental Health Services, *2013 County Long-Term Services and Supports Gaps Analysis Survey*, August 2013.
- <sup>20</sup> Annapolis Coalition, *op. cit.*
- <sup>21</sup> Huang, Jarke, Macbeth, Gary, Dodge, Joan et.al., "Transforming the Workforce in Children's Mental Health" *Administration and Policy in Mental Health*, 32(2). 167-187, November 2004.
- <sup>22</sup> National Center for Health Workforce Analysis, *Projecting the Supply of Non-primary Care Specialty and Subspecialty Clinicians: 2010-2025*, 2014.
- <sup>23</sup> Fixsen, Dean L. et. al., *Implementation Research: A Synthesis of the Literature*, University of South Florida, 2005.

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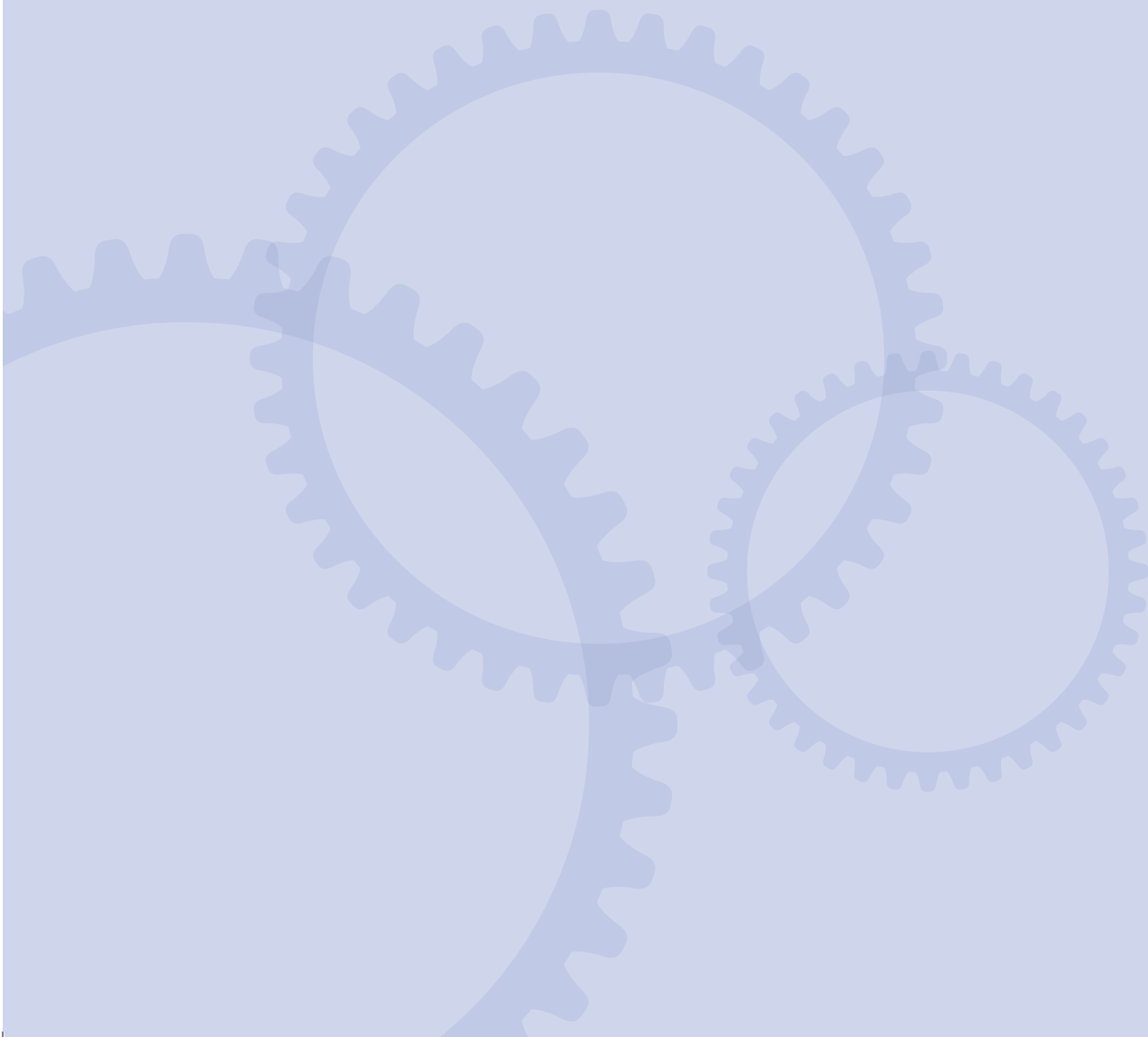
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# Gearing Up for Action: Mental Health Workforce Plan for Minnesota

