DEPARTMENT OF HUMAN SERVICES

Legislative Report

Culturally Informed and Culturally Responsive Mental Health Task Force

Recommendations

Culturally Informed & Culturally Responsive Mental Health Task Force

December 2024

For more information contact:

Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101
651.706.7879

For accessible formats of this information or assistance with additional equal access to human services, write to Jacob.Owens@State.MN.US, call 651-431-2460, or use your preferred relay service. ADA1 (2-18)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $8,662.

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Contents

April 26, 2024

Re: Report from Culturally Informed Culturally Responsive Mental Health Task Force

We are pleased to submit a report prepared per Minnesota Statute section 245.4902 that called for the creation of the Culturally Informed and Culturally Responsive Mental Health Task Force ("Task Force"). The Task Force was established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota.

Consisting of five representatives from state boards and DHS, and seven appointments by Governor Tim Walz, Task Force members represent various professional backgrounds and communities. Preparing these recommendations was a participatory process in which the Task Force offered a wealth of insight based on their professional backgrounds and lived experiences combined with a literature review and engagement of mental health professionals.

This report was written collaboratively with members of the Task Force and DeYoung Consulting Services, the latter of which was charged with facilitating both Task Force meetings and the overall process of this effort. It was important to represent the diverse perspectives gathered throughout the overall effort. We hope that the legislature will find it useful, and we look forward to working together to make progress in this area. We appreciate the opportunity.

I. Executive Summary

Minnesota Statute section 245.4902 called for the creation of the Culturally Informed and Culturally Responsive Mental Health Task Force ("Task Force"). The Task Force was established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota.

Consisting of five representatives from state boards and DHS, and seven appointments by Governor Tim Walz, Task Force members represent various professional backgrounds and communities. This report was prepared collaboratively by the Task Force members and DeYoung Consulting Services, the latter of which was charged with facilitating both Task Force meetings and the overall process of this effort.

Task Force Vision Statement

The Task Force members envision a mental health workforce that is racially and culturally diverse with careers that are accessible to all. They envision mental health care that is equitable, and accessible, fosters the elimination of stigma, and responds to diverse cultural needs. This is done while, as appropriate for each client, honoring and centering cultural practices rooted in traditional forms of healing. Based on historical evidence, they believe the current mental health systems are steeped in white supremacy. They envision systems that continuously assess the current evidence-based approaches with a lens for cultural appropriateness, letting impacted communities define what quality care looks like for them. The Task Force is committed to working collaboratively, communicating honestly, and listening to learn from each other, to develop collective and viable solutions.

Reading This Report

It was determined that the elements that lead to recommendations would be divided into:

- The Current State
- Barriers
- Recommendations

Current State

The Task Force believes that there is minimal emphasis on diversity and cultural responsiveness as a priority in the mental health field. Several factors contribute to this low emphasis, including a lack of shared understanding and shared definitions of important concepts, including a definition of mental health that is inclusive of Black, Indigenous, and People of Color (BIPOC) communities, which have been traditionally marginalized in the field of mental health. Task Force members also perceive systems in the field to be white-centered, emphasizing a one-size-fits-all approach; this can result in inequitable experiences for both BIPOC professionals and clients. The following themes emerged from the Task Force's overall insight into the current state:

- There is a lack of BIPOC representation in the mental health field. The low representation has had a negative impact on community members who need services.
- There is insufficient and ineffective education provided to prepare students and professionals for responding to cultural differences.
- The term "cultural competence" suggests that a provider or an organization can attain true mastery in something as dynamic and fluid as culture. Instead, the Task Force recommends assessing the extent to which mental health organizations embrace diversity and demonstrate proficiency in culturally informed and responsive services. The Task Force acknowledges attempts by some mental health provider organizations to recognize the importance of diversity and cultural responsiveness but perceives that these attempts are often performative and lack depth. The result is a harmful impact on BIPOC communities.
- Some technical assistance is available to increase the number of BIPOC-led organizations, but overall, the Task Force perceives a significant need for more resources and support.

Barriers

The Task Force members believe that, within the field of mental health, the lack of prioritization of diversity and cultural responsiveness and the resulting low rate of investment in BIPOC professionals are barriers to moving forward. They also see a lack of accountability measures as a barrier to making progress. The following themes emerged from the Task Force's overall insight into barriers:

- There are barriers in the pipeline to recruiting and retaining BIPOC professionals in the mental health field. They can be found in the education system, licensing system, and the workplace.
- There is a lack of high-quality learning opportunities related to diversity and cultural responsiveness. In addition, there is a lack of prioritization of further learning in this area, as well as very little accountability.
- A barrier in this area is the overall practice of one-size-fits-all.
- Few resources are accessible to BIPOC professionals in the field, including capital, education, and networks.

Recommendations

The Task Force offers multiple recommendations that align with the four categories of the statute, including:

1. Create and support new ways to enter and grow a mental health career, including routes to licensure, career pathways, and awareness of career possibilities. It recommends providing financial support that attracts and retains BIPOC professionals in the field, including a thorough examination of reimbursement rates and other compensation.
2. Improve the authenticity and quality of training already offered, particularly by inviting culturally proficient experts and community members to lead these changes. Enhance the training offered as well as access to it and elevate cultural responsiveness training as a high priority.

3. Collect data to track, evaluate, and share progress in this area. Support systems change, including a policy analysis and formation of an accrediting body to assess culturally informed practices. Outside perspectives, including community voices, must be engaged in making changes.
4. Enhance funding support to BIPOC-led organizations, including an examination of grantmaking processes, an enhancement of current programs, and increased reimbursement. Intentionally build these organizations' capacity.

Conclusions

The Task Force sees that diversity and cultural responsiveness in the field of mental health are not prioritized. There is a lack of the investment needed to build awareness of the need for cultural responsiveness, to educate practitioners in their skills to effectively serve BIPOC clients, to support and retain BIPOC professionals and leaders in this field, and to build infrastructure, including accountability measures, which can elevate diverse communities' voices and meet their needs. This lack of investment and the resulting low diversity and cultural responsiveness in the field has an inequitable and harmful effect on BIPOC communities.

To pursue the vision that the mental health workforce is diverse, accessible, and responds respectfully to cultural needs, the Task Force makes multiple recommendations that imply action needed on the part of the state legislature, licensing boards, state agencies, and mental health organizations.

II. Legislation

The Cultural Informed and Culturally Responsive Mental Health Task Force was established by Minnesota Statute 245.4902 and was charged with evaluating and making recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota. This report is the first set of the Task Force's recommendations, as required by statute.

Minnesota Statute 245.4902

245.4902 CULTURALLY INFORMED AND CULTURALLY RESPONSIVE MENTAL HEALTH TASK FORCE.

Subdivision 1. **Establishment; duties.** The Culturally Informed and Culturally Responsive Mental Health Task Force is established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota. The task force must make recommendations on:

(1) recruiting mental health providers from diverse racial and ethnic communities;
(2) training all mental health providers on cultural competency and cultural humility;
(3) assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services; and
(4) increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color.

Subd. 2. **Membership.** (a) The task force must consist of the following 16 members:

(1) the commissioner of human services or the commissioner's designee;
(2) one representative from the Board of Psychology;
(3) one representative from the Board of Marriage and Family Therapy;
(4) one representative from the Board of Behavioral Health and Therapy;
(5) one representative from the Board of Social Work;
(6) three members representing undergraduate- and graduate-level mental health professional education programs, one appointed by the governor, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;
(7) three mental health providers who are members of communities of color or underrepresented communities, as defined in section 148E.010, subdivision 20, one appointed by the governor, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;
(8) two members representing mental health advocacy organizations, appointed by the governor;
(9) two mental health providers, appointed by the governor; and
(10) one expert in providing training and education in cultural competency and cultural responsiveness, appointed by the governor.
(b) Appointments to the task force must be made no later than June 1, 2022.
(c) Member compensation and reimbursement for expenses are governed by section 15.059, subdivision

Subd. 3. **Chairs; meetings.** The members of the task force must elect two cochairs of the task force no earlier than July 1, 2022, and the cochairs must convene the first meeting of the task force no later than August 15, 2022. The task force must meet upon the call of the cochairs, sufficiently often to accomplish the duties identified in this section. The task force is subject to the open meeting law under chapter 13D.

Subd. 4. **Administrative support.** The Department of Human Services must provide administrative support and meeting space for the task force.

Subd. 5. **Reports.** No later than January 1, 2023, and by January 1 of each year thereafter, the task force must submit a written report to the members of the legislative committees with jurisdiction over health and human services on the recommendations developed under subdivision 1.

Subd. 6. **Expiration.** The task force expires on January 1, 2025.

III. Introduction

Background and Purpose

Minnesota Statute section 245.4902 called for the creation of the Culturally Informed and Culturally Responsive Mental Health Task Force. The Task Force was established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota. The Task Force must make recommendations on:

> (1) recruiting mental health providers from diverse racial and ethnic communities;
>
> (2) training all mental health providers on cultural competency and cultural humility;
>
> (3) assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services; and
>
> (4) increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color.

Consisting of five representatives from state boards and DHS, and seven appointments by Governor Tim Walz, Task Force members represent diverse professional backgrounds and communities. Members are listed below.

- Alex Espadas, Co-chair
- Talee Vang, Co-chair
- Bharati Acharya
- Jennifer Mohlenhoff
- Sam Sands
- Angie DeLille
- Tera Nelson
- Eric Abu
- Jessica Gourneau
- Hoinu Bunce
- Sue Abderholden
- Neerja Singh
- Sonya Smith
- Tom Howley, Equity Director
- Kaley Kobbervig

This report was prepared collaboratively by the Task Force members and DeYoung Consulting Services, the latter of which was charged with facilitating Task Force meetings and the overall process of this

effort. To prepare the report, the Task Force split into four subgroups, each charged with providing insight, including data and relevant examples, for one category of the statute.

Vision and Definitions

The Task Force collaboratively developed a vision statement that represents the impact that this work will have on the field of mental health.

Task Force Vision Statement

The Task Force members envision a mental health workforce that is racially and culturally diverse, with careers that are accessible to all. They envision mental health care that is equitable, and accessible, fosters the elimination of stigma, and responds to diverse cultural needs. This is done while, as appropriate for each client, honoring and centering cultural practices rooted in traditional forms of healing. Based on historical evidence, they believe the current mental health systems are steeped in white supremacy. They envision systems that continuously assess the current evidence-based approaches with a lens for cultural appropriateness, letting impacted communities define what quality care looks like for them. The Task Force is committed to working collaboratively, communicating honestly, and listening to learn from each other, to develop collective and viable solutions.

To ensure a shared understanding of language, the Task Force also agreed on the following definitions of culture, racism, and anti-racism:

Culture

A social system of meaning and custom developed by a group of people to assure its adaptation and survival, resiliency, and healing. These groups are distinguished by a set of unspoken rules that shape values, beliefs, habits, patterns of thinking, behaviors, and styles of communication.

Racism

A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources. *(Adapted from Dr. Camara Jones and* racialequitytools.org*.)*

Anti-racism

The active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices, and attitudes, so that power is redistributed and shared equitably (NAC International Perspectives: Women and Global Solidarity).

Cultural Competence

The term “cultural competence” is used in the statute. The Task Force believes that this term implies a sense of having arrived at a final state of knowing. To that end, in the report below, “cultural

competence" is only used when referencing the statute. In describing its own insight, the Task Force prefers to use other terms such as "cultural responsiveness," which implies a more ongoing, dynamic state of learning.

Reading This Report

It was determined that the elements that lead to recommendations would be divided into:

- The Current State
- Barriers
- Recommendations

The report is organized into the above three sections. Within each section, the Task Force offers insight into each of the four categories of the statute (listed above). Following this insight is a summary of the process to continue this work and fulfill the Task Force's charge.

It should be noted that the focus of the Task Force was solely on culturally informed and culturally appropriate mental health care and services; it did not focus on culturally informed or appropriate research methods or practices. Although the current Task Force did not discuss the topic of culturally informed and appropriate research methods and practices, this is a significant topic that warrants further investigation.

This report builds upon the report that was submitted to the Minnesota Legislature in 2023. It represents the Task Force members' own observations, insights, and suggestions integrated with insights gathered from a literature review and engagement of additional professionals in the mental health field. It should be noted that the content of this report is based on the insight gathered from the Task Force members themselves as well as others, based on their professional and lived experiences. Considering the body of research historically lacking perspectives of BIPOC communities, this insight should be valued as a critical missing piece when reviewing other sources of data. The recommendations are aligned with the four categories of the statute:

(1) recruiting mental health providers from diverse racial and ethnic communities
(2) training all mental health providers on cultural competency and cultural humility
(3) assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services
(4) increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

IV. Current State

The Task Force believes that there is minimal emphasis on diversity and cultural responsiveness as a priority in the mental health field. A lack of shared understanding and shared definitions of important concepts, including a definition of mental health that is inclusive of BIPOC communities, contribute to this low emphasis. Task Force members also perceive systems in the field to be white-centered, emphasizing a one-size-fits-all approach; this can result in inequitable experiences for both BIPOC professionals and clients.

A. Statute Category 1: Recruiting mental health providers from diverse racial and ethnic communities

The Task Force sees a lack of BIPOC representation in the mental health field. The low representation has had a negative impact on community members who need services.

- There is a severe lack of representation of BIPOC mental health professionals/practitioners in most areas of mental health.
- There are too few BIPOC mentors/supervisors in the field. The Mental Health Cultural Community Continuing Education Grant Program (MHCCC), authorized by Minnesota Sessions Law, 2021, Chapter 7, section 44, was established to assist mental health professionals from communities of color or underrepresented communities to become qualified to serve as supervisors for mental health practitioners pursuing licensure.
- Compared to other medical professions, mental health professionals are compensated less and reimbursed at lower rates.
- The lack of BIPOC mental health professionals has adversely affected access to culturally responsive service provision from historically marginalized patients/clients. When people cannot access culturally informed services in a timely way, it can lead to individuals needing higher-intensity services, which cost more.
- There is not enough information provided at the high school level to educate and expose students to topics on mental health, much less to careers in mental health.

B. Statute Category 2: Training all mental health providers on cultural competency and cultural humility

The Task Force believes there to be insufficient and ineffective education provided to prepare students and professionals for responding to cultural differences.

Undergraduate and graduate education requires very little coursework related to cultural differences

- Very little is required regarding cultural education at the undergraduate and graduate levels. While accrediting bodies in general are beginning to place more emphasis on cultural education (e.g., equity, decolonization, diversity), more could be done to support and incentivize this content, as well as to integrate policy-level guidelines. As an example, in the 2022 "Educational Policy and Accreditation Standards for Baccalaureate and Master's Social Work Programs," one policy directs programs to "recognize the pervasive impact of white supremacy and privilege and prepare students to have the knowledge, awareness, and skills necessary to engage in anti-racist practice."[1]
- Regarding graduate programs, outside of the minimum requirements of diversity credits set by accrediting bodies, the students themselves determine whether they want to learn further in this area, and it is often BIPOC students who decide to expand their education in this way.

The School of Education staff at the University of Redlands appealed to students to grow their own multicultural competence:

*"*Courageously opening yourself to step aside from your worldviews allows you to become a stronger ally to the client, building a more authentic, trusting relationship. This takes extensive honest self-reflection to understand where you may differ from your client and how those differences could impact your ability to provide services."

Continuing education requirements related to cultural understanding are cursory, lack depth, and are ineffective.

- Effective July 1, 2023, Minnesota statute requires continuing education for psychologists, Licensed Marriage and Family Therapists (LMFTs), social workers, and Licensed Professional Clinical Counselors (LPCCs) to include at least four hours on addressing the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. Topics include understanding culture, its functions, and strengths that exist in varied cultures; understanding clients' cultures and differences among and between cultural groups; understanding the nature of social diversity and oppression; and understanding cultural humility. (SS Chapter 7, Article 4, Sec. 12)
- Once individuals have completed their graduate education and attained licensure, continuing education is required to maintain the license to practice. All licensees of the four behavioral health licensing boards are required to complete Ethics and Cultural Competency continuing education for each reporting period. However, there are no accountability measures to ensure the quality or appropriateness of the proposed cultural or diversity training.
    - Within the continuing education curriculum, diversity, equity, and inclusion (DEI) training is cursory and may prove to be more performative than substantive.

[1] 2022 EPAS Educational Policy and Accreditation Standards

    - Without any mechanisms for employers to hold learners accountable, the effectiveness of training is limited.
    - Culture and diversity are not commonly defined across licensing boards, and there is no clear expectation that mental health providers must include in their continuing education at least one activity related to culturally appropriate or informed mental healthcare, specific to BIPOC communities. This can result in licensees obtaining diversity continuing education credits by taking classes on topics such as working with ADHD, learning disabilities, or polyamorous relationships, rather than any racial or ethnic-specific diversity training.
    - Other than continuing education requirements, there is no formal tracking of culture-specific training offered.
    - There is a requirement for continuing education hours. For example, for a licensed social worker, the requirement is: "72 clock hours (20 percent) in social work values and ethics, including cultural context, diversity, and social policy; and 18 clock hours (5 percent) in culturally specific clinical assessment and intervention."
- Not enough training is happening in the workplace. Training in this area is often online, cursory, lacking depth, and white-centered.

New state law includes new requirements. The following applies to psychologists and is offered as an example (the other boards have similar requirements):

At least four of the required continuing education hours must be on increasing the knowledge, understanding, self-awareness, and practice skills to competently address the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, its functions, and strengths that exist in varied cultures

(2) understanding clients' cultures and differences among and between cultural groups

(3) understanding the nature of social diversity and oppression

(4) understanding cultural humility

(5) understanding human diversity, meaning individual client differences that are associated with the client's cultural group, including race, ethnicity, national origin, religious affiliation, language, age, gender, gender identity, physical and mental capabilities, sexual orientation, and socioeconomic status.

The current training and education have a harmful impact on communities.

- Because there is no common definition of “cultural diversity” across licensing boards, these training programs do not necessarily touch on racial or ethnic diversity. This does not create an inclusive mental health field for BIPOC people or communities.
- Impactful culturally responsive work with BIPOC communities (e.g., mezzo- and macro-level work) may not be considered “clinical” and therefore will not be credited toward clinical

licensure. Issues that may be considered are kinship, collective, and community-based mental health interventions.

- People whose perspectives and worldviews align with Western medicine viewpoints and who are not affected negatively are less likely to prioritize learning about other perspectives. Therefore, if a client with a different worldview relates to a therapist who has not taken the time to continue to learn about other viewpoints, there is a risk of harm.

C. Category 3: Assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services

The term "cultural competence" suggests that a provider or an organization can attain true mastery in something as dynamic and fluid as culture. Instead, the Task Force recommends assessing the extent to which mental health organizations embrace diversity and demonstrate proficiency in culturally informed and responsive services. The Task Force acknowledges attempts by some mental health provider organizations to recognize the importance of diversity and cultural responsiveness but perceives that these attempts are often performative and lack depth. The result is a harmful impact on BIPOC communities.

Some structural support exists to embrace cultural responsiveness (examples given below), but these supports are not adequately implemented.

- The World Health Organization Assessment Instrument for Mental Health Systems (2005) recommends 10 components of mental health system development. One component is: "Involve communities, families and consumers" but there is no discussion of culture.
- Minnesota law requires supervisors to consider the impact of the client's culture on providing treatment; supervisors are responsible for assessment. The extent to which supervisors are held accountable for implementing this, and the degree to which client voices are sought and represented when planning treatment, are unknown.
- There are currently no standards to assess the extent to which organizations embrace diversity, equity, and inclusion. Practitioners subjectively define their own familiarity and skills in this area.
- State law addresses expectations of clinical supervision. Supervisors are to educate potential mental health professionals on the cultural norms or values of the clients and communities that the provider serves, as well as the impact that a member's culture has on providing treatment. The clinical supervisor is charged with reviewing each of their assessments, treatment plans, and progress notes for accuracy and appropriateness. However, the extent to which clinical supervisors can use an appropriate cultural lens, and the degree to which clients are engaged in developing their own culturally responsive treatment plan, are unknown.

- National CLAS Standards provide 15 standards related to culturally and linguistically appropriate services. They describe the staff and other supports that are needed to make sure a provider organization is culturally responsive, including language support services. For example, clients should be asked if they prefer services or materials to be provided in an alternative language of their choice even if they speak English.

The Mental Health Uniform Services Standards Act (2451) says little about culture. It mentions "(4) culturally responsive treatment practices" but does not refer to a number of hours or other expectations.

CHAPTER 245I. Mental Health Uniform Service Standards Act Webpage

Some organizations attempt to be culturally responsive, but follow-through and commitment are lacking.

- Sometimes organizations make assumptions about what is a culturally informed practice, and they overgeneralize.
- Some mental health programs close or are ended because they reportedly didn't work; however, the community may not have known that the program was available to them.

Often, when larger, white-led organizations compete for grant funds, they propose partnering with smaller, culturally focused organizations. However, when they are awarded the grant, the smaller organizations often don't receive any of the funds. This leaves the sense that these organizations are "checking a box" but are not committed to a deep partnership with cultural communities.

The lack of proficiency in culturally responsive mental health care results in harmful client experiences.

- Minnesota has among the highest rates nationally of racial disparities related to the social determinants of health.[2]
- Many BIPOC clients have relatively more negative experiences with mental health care than white clients. They are misdiagnosed or undiagnosed more often, many do not feel welcome, and some are accused of seeking care solely to receive pain medication. This results in more harm than help being done.

Racial disparities in Minnesota (Sourced from "Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans" (DHS):

- The state of Minnesota has the second biggest income inequality gap between Black and white people in the entire nation. Compared to white Minnesotans, Asian people earn 94 cents on the dollar, Black people earn 71 cents, Latino people earn 70 cents and Indigenous people earn 68 cents.

[2] Https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG

- Minnesota has one of the widest homeownership gaps in the nation. While 77 percent of white households own their home, 57 percent of Asian, 46 percent of Native American, 45 percent of Latino, and just 24 percent of Black households own their home (Minnesota House of Representatives, 2020).
- In Minnesota, Indigenous students are ten times more likely to be expelled or suspended than their white peers. Black students are eight times more likely to be expelled or suspended than their white peers (Minnesota House of Representatives, 2020).
- Black and Latino Minnesotans have reported food insecurity at more than double the rate of white Minnesotans (Wilder Foundation, 2020).
- Black Minnesotans have been disproportionately affected by a loss of employment during the COVID-19 pandemic (MN Gov, 2021)
- Black, Indigenous, and Latino Minnesotans have lower COVID-19 vaccination rates statewide (Minnesota Department of Health, 2021a) and among age-eligible Minnesota Medicaid enrollees (Infogram, 2021)
- Total mortality increased in 2020 by 14 percent for non-Hispanic white Minnesotans and 41 percent for BIPOC (Black, Indigenous, and people of color) Minnesotans (Wrigley-Field et al., 2021).

D. Category 4: Increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

Some technical assistance is available to increase the number of BIPOC-led organizations, but overall, the Task Force perceives a significant need for more resources and support.

- There are no programs that specifically support BIPOC professionals in building their business skills within the profession. Few mentorship programs exist to guide professionals. Overall, there is a lack of knowledge about business practices.
- To the knowledge of this Task Force, there are no graduate courses available to educate professionals about opening private practices or cultivating BIPOC-led organizations.
- Overall, there is low generational knowledge, generational wealth, and a lack of support networks to support opening a business and provide resources when it faces challenges.
- It is unknown how many programs offer courses about addressing family trauma.
- The Office of Equity in Procurement serves as a resource, providing technical assistance to small organizations.
- Disparities exist between BIPOC and dominant culture practitioners regarding their existing networks and generational wealth (financial knowledge, access to capital). To that end, fewer BIPOC practitioners are willing to strike out on their own into private practice.
- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) include three standards related to governance, leadership, and the workforce:[3]

[3] National Standards for Culturally and Linguistically

    - "Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
    - Recruit, promote, and support culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
    - Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis."
- The Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program was established to "(provide) culturally-specific, trauma-informed mental health and substance use disorder services within targeted cultural and minority communities in Minnesota" and to "(expand) these services by increasing the number of licensed mental health professionals and licensed alcohol and drug counselors, as well as other behavioral health supports such as Peer/Family Specialists and Recovery Peer Specialists, from ethnic and cultural minority communities."[4] As of 2023 this program is in state statute and is s funded through general fund appropriations with additional federal funding available at the discretion of DHS.

V. Barriers

The Task Force members believe that, within the field of mental health, the lack of prioritization of diversity and cultural responsiveness and the resulting low rate of investment in BIPOC professionals are barriers to moving forward. They also see a lack of accountability measures as a barrier to making progress.

A. Category 1: Recruiting mental health providers from diverse racial and ethnic communities

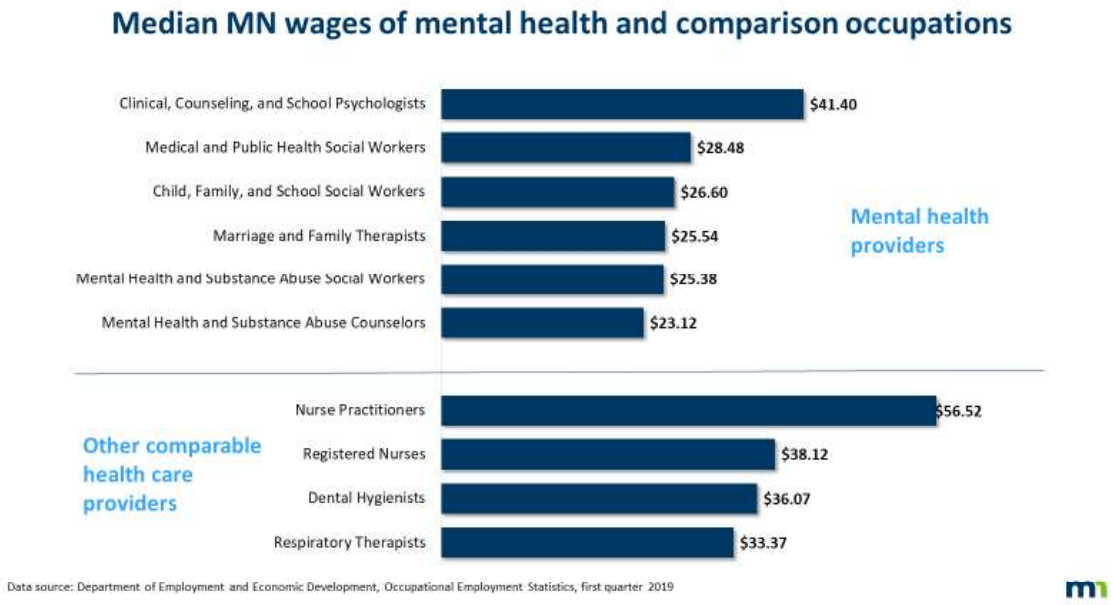
The Task Force sees barriers in the pipeline to recruiting and retaining BIPOC professionals in the mental health field. They can be found in the education system, licensing system, and the workplace.

There are barriers to entry into the field beginning in high school and continuing throughout the education system.

- "High school students rarely see career options in mental health fields."
- BIPOC students see very few professors in the mental health field whose cultural or racial identities match their own.
- Jobs are low paying. Salary rates/reimbursement rates for behavioral health providers can affect whether individuals seek to become mental health professionals (all individuals, not just BIPOC individuals). The historical undervaluing of mental health services and the profession, as evidenced by the lower compensation and high student loan costs, discourages BIPOC

[4] Culturally Specific Mental Health and Substance Use Disorder Services

individuals from pursuing a career in mental health even if they are interested and positioned to seek out a career in the medical field. The graph entitled "Median MN wages of mental health and comparison occupations" compares mental health professionals' median wages with those of other jobs.[5]



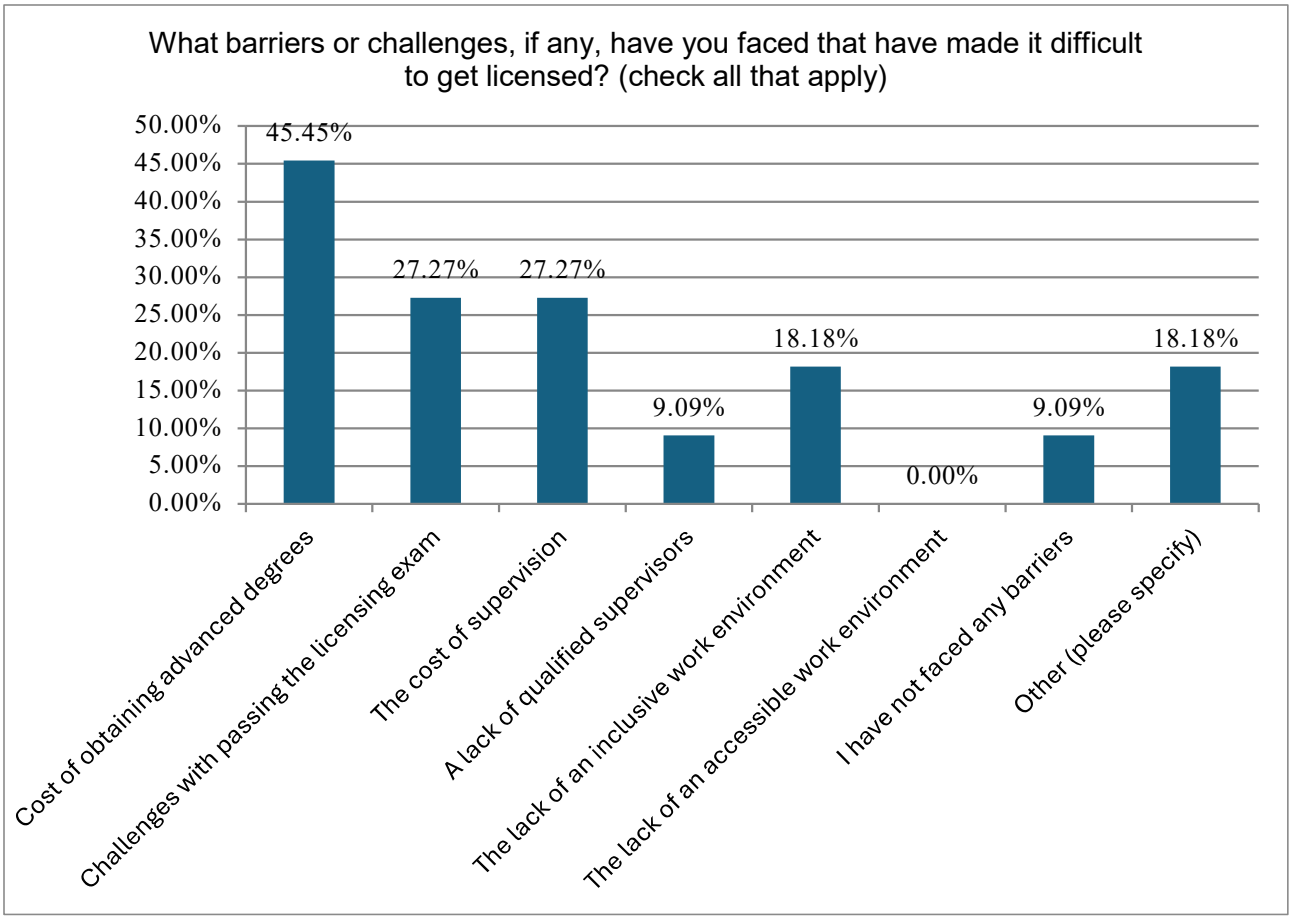
- Cost makes the pursuit of mental health education prohibitive. According to findings published in the report "The Social Work Profession:"[6]

  "Debt from their social work education was substantially higher for Black/African Americans than for whites (mean debt $66,000 vs. $45,000) and for Hispanics compared with non-Hispanics ($53,000 vs. $48,000). The mean total debt for all education was $92,000 for Black/African Americans and $79,000 for Hispanics. This is quite high given that the mean starting salary for new MSWs was only $47,100."

The graph below represents responses from the survey distributed by the task force to mental health professionals. Results indicate that the cost of obtaining a degree was a top challenge to entering the field. (See full survey results in appendix.)

[5] Teri Fritsma, Ph. D, "An overview of Minnesota's mental health workforce" PowerPoint presentation, 2019.

[6] Workforce Studies[1]



- The perception of the mental health professional as low status is a "turn-off" to some immigrant or BIPOC families.
- Power differentials exist in the field, making it difficult to navigate for those lacking in power.
- Access to data (for example, information about current students in mental health undergraduate and graduate programs) is a barrier to understanding the level of diversity in the field.
- Racial disparities exist throughout childhood education and are important factors that negatively impact the workforce pipeline, e.g., quality of childcare, school suspension rates, high school graduation rates, college completion, etc. Disparities in high school graduation rates are an important factor (that is, there are lower rates of BIPOC students who are prepared to go to college).
- Holding an undergraduate degree in a mental health field does not guarantee job security in the mental health profession; a master's or a doctorate is necessary to provide mental health care. Thus, potential students require enough assurance that they will be admitted into accredited graduate programs and that they can complete the unpaid practicums required and pass licensing exams before committing to pursue this career path. The many points at which systemic barriers can block progress deter BIPOC people from embarking on or completing the long journey to licensure.

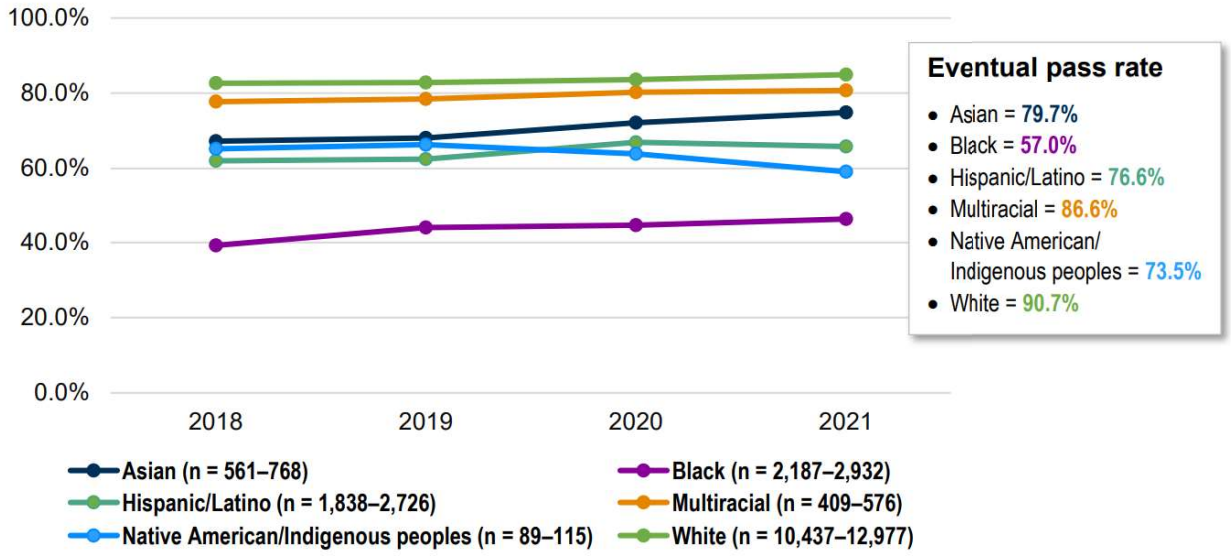
There is a perception that attending to one's mental health is a "white thing." This is reinforced by the lack of BIPOC people in the mental health field, as well as by the way the dominant culture defines what attending to "mental health" is. Issues to consider include cultural norms, providing mentors, and BIPOC supervision (paid).

Barriers exist to satisfying requirements for licensure and passing the licensing exams.

- Multiple costs associated with licensure pose a significant barrier, including the cost of supervision to get licensed, the cost of the licensure exams, and the cost of required graduate education. The cost of supervision, when compared to salary or reimbursement rates for behavioral health professionals, could be perceived as too high for everyone, not just BIPOC communities.
- People who do not pass the licensure exams end up paying more to get licensed than those who tend to pass the first time.
- It should be noted that criminal convictions are not often a barrier to licensure.
- Licensing exams written in English are a barrier to English Language Learners (ELL), though the Board of Marriage and Family Therapy does allow extra time for ELL/English as a Second Language candidates to take licensing exams.
- There are persistent racial disparities among clinic exam pass rates, as shown in the figure below.[7]
- There is a question of the tests' validity, including improper test structure, constructs that do not reflect day-to-day knowledge and questions that do not accurately reflect cultural perspectives. Some exam developers don't collect demographic information to be able to evaluate potential bias.

[7] Association of Social Work Boards report "2022 ASWB Exam Pass Rate Analysis."

Figure 2. 2018–2021 Clinical exam first-time pass rates by year and eventual pass rates by race/ethnicity



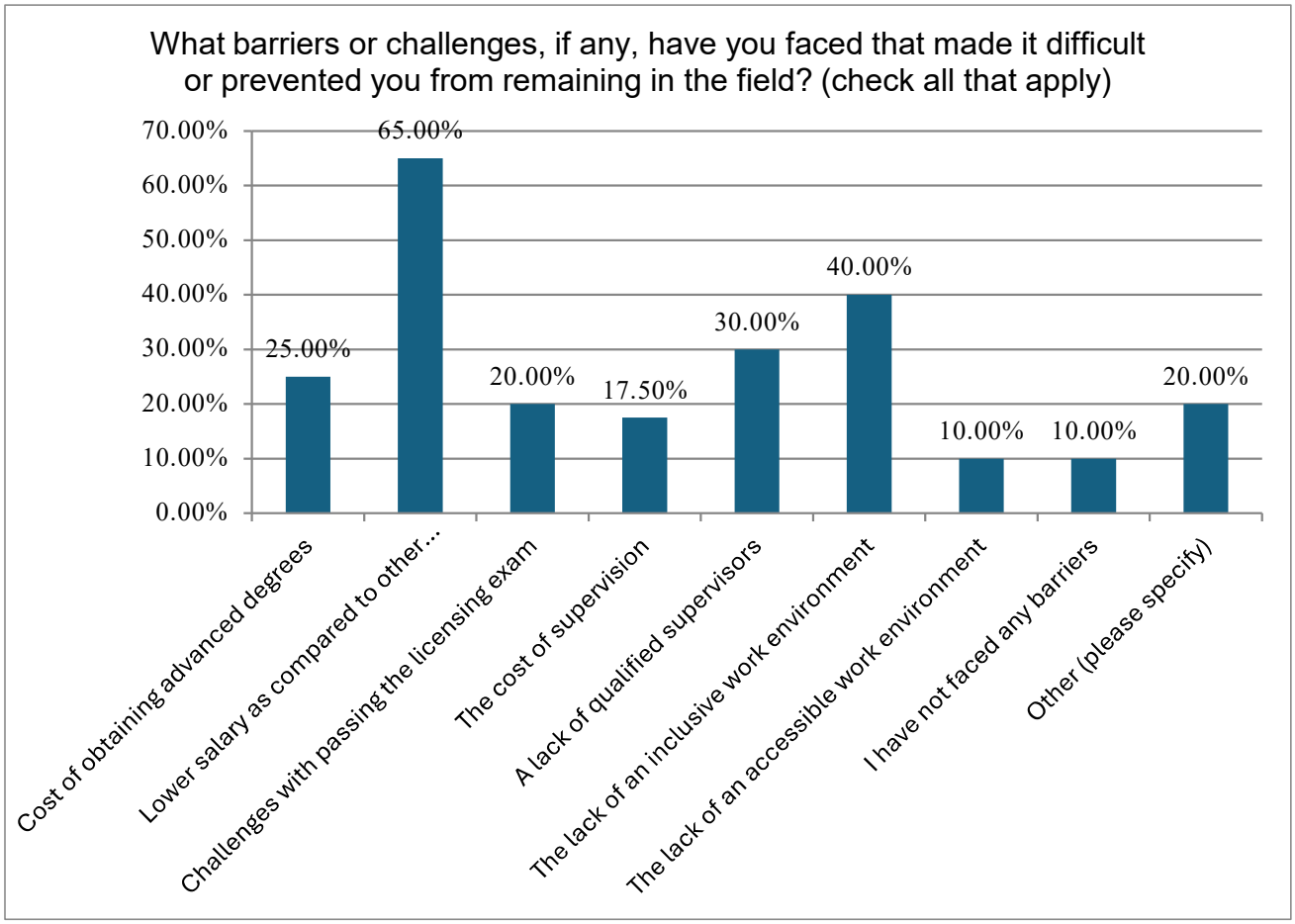
Professionals who may be interested or ready to rise to leadership positions face barriers. Retention of BIPOC professionals overall is a challenge.

- It is challenging to develop a definition that fully captures what is considered leadership within BIPOC communities, and how these leadership qualities are, or are not, represented in mental health settings.
- The MN Board of Marriage and Family Therapy does not have racial/ethnic data for Licensed Marriage and Family Therapists who are approved supervisors, making it difficult to determine representation.
- Barriers to becoming supervisors or mentors include lack of time and remuneration. The financial burden is a combination of costs and low pay.
- BIPOC practitioners may experience cognitive dissonance related to the pressure to exclusively espouse mental health interventions that have their roots in white, dominant culture. They may be aware of other practices/interventions that are life-giving and mental health-affirming. Feeling this disconnect may lead some away from supervision, as there is a sense that this reality is not affirmed in graduate programs, and therefore mentees are looking for something more "mainstream." In essence, it is a challenge to be a proponent of a system that pathologizes people's responses to experiences of injustice and oppression. This dynamic causes some to feel isolated and stressed, in part due to a lack of their own cultural belonging and the sense that a white-dominant culture doesn't prioritize the care they want to provide.

- Leaders of color encounter micro-invalidations and micro-aggressions from white colleagues regularly.

- Retention of BIPOC professionals can be hindered in part because BIPOC employees don't necessarily get the encouragement from white-owned organizations that they need to succeed.
- Some providers who are motivated to work with lower-income clients feel that their efforts are devalued in their workplaces and not supported by the reimbursement structure. In addition, the culturally specific approaches that some wish to provide are not accessible, in part due to course fees.

The graph below represents responses from the survey distributed by the task force to mental health professionals. Results indicate that the top factors keeping respondents from remaining in the field were low salaries (65%), lack of an inclusive environment (40%), and lack of qualified supervisors (30%). (See full survey results in the appendix.)



B. Category 2: Training all mental health providers on cultural competency and cultural humility

The Task Force has found a lack of high-quality learning opportunities related to diversity and cultural responsiveness. In addition, there is a lack of prioritization of further learning in this area, as well as very little accountability.

- Diversity-related training lacks depth. For example, training is often "one and done" each year.
- Medical licensing and nursing have practices that meet the definition of behavioral health practices. More information is needed on the continuing education requirements related to cultural responsiveness.
- There is a lack of culturally responsive providers who can provide quality training due to a limited pool of trainers and the time that is required.
- Boards have a process for reviewing cultural training, but an assessment of efficacy or quality may be missing.
- SS Chapter 7, Article 4 requires licensing boards for psychologists, Licensed Marriage and Family Therapists, and Licensed Professional Counselors to have members from outside of the seven-county metro, people of color, and underrepresented communities (defined as a group that is not in the majority concerning race, ethnicity, national origin, sexual orientation, gender identity, or physical ability). While the law now requires the licensing boards to be more diverse, they are not always reflective of or do not represent, the diverse communities they serve, which limits their ability to assess the quality of culturally related training.

The only accountability mechanism is the state-mandated continuing education requirements related to culture. There is a lack of accountability regarding ongoing education in the workplace and how trainers deliver content.

C. Category 3: Assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services

A barrier in this area is the overall practice of one size fits all. Social scientists have assessed whether diagnostic assessments and criteria are culturally appropriate (see "Issues in the Assessment and Diagnosis of Culturally Diverse Individuals" by Francis G. Lu, M.D., Russell F. Lim, M.D., and Juan E. Mezzich, M.D., Ph.D.)[8] As social scientists continue to see evidence that cultural perspective influences reported symptoms, the Cultural Formulation Interview was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and is currently in the DSM-5. Although the DSM-5 is an evidence-based tool used to assist in providing a culturally informed perspective on assessing mental disorders, it

[8] Issues in the Assessment and Diagnosis of Culturally Diverse Individuals

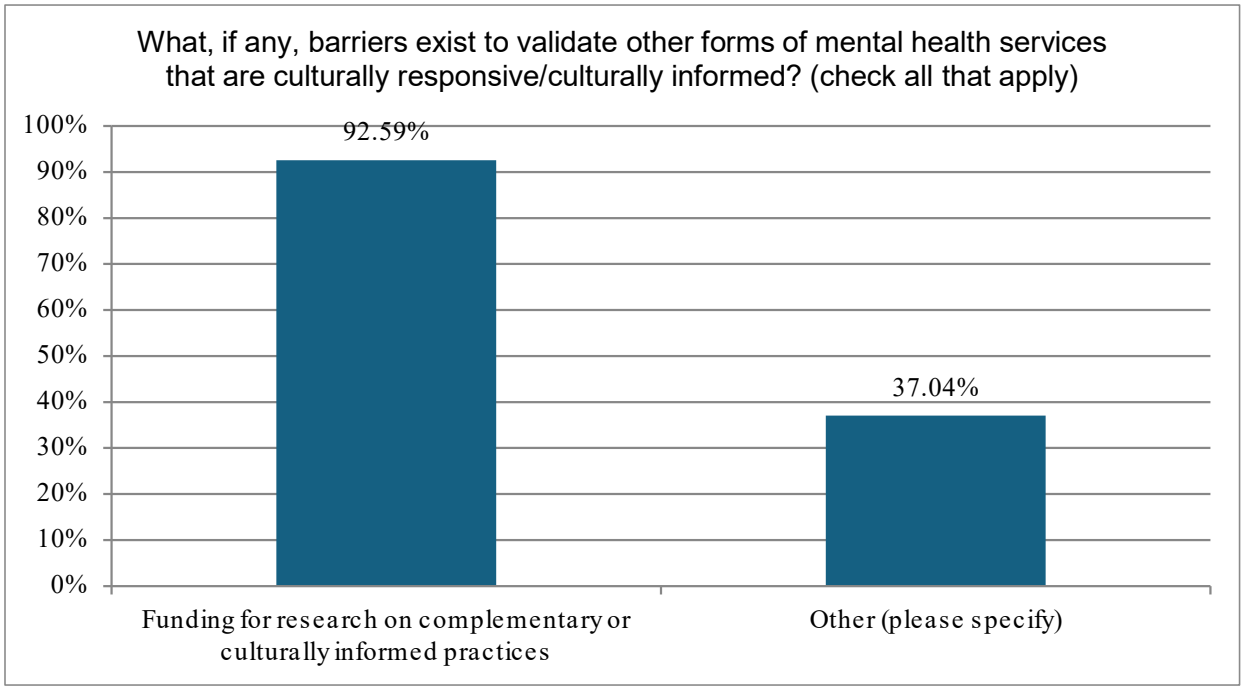
is but one step that is optional for providers (The DSM-5 Cultural Formulation Interview and the Evolution of Cultural Assessment in Psychiatry.[9])

Another barrier is a lack of awareness and empathy from providers. When providers do not acknowledge that there are racial or cultural differences, or deny the influence of race, racism, or prejudice, clients feel judged and invalidated.

To truly assess the extent to which organizations embrace diversity and demonstrate proficiency in culturally informed and responsive services would require an approach that combines qualitative and quantitative methods, whereby different organizations undergo an audit specifically on diversity, equity, and inclusion related to the racial composition of their staff, leaders, patient populations, policies, procedures, and the training those organizations have provided.

In addition, current policies may present barriers such as diagnostic standards, required treatment modalities, and insurance reimbursement.

Respondents to the task force's survey validated that funding for research on complementary or culturally informed practices is a barrier (see graph below). Other barriers found were a lack of support for other practices, access to culturally informed training, and the cost to clients of quality care.



[9] The DSM-5 Cultural Formulation Interview and the Evolution of Cultural Assessment in Psychiatry

D. Category 4: Increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

Few resources are accessible to BIPOC professionals in the field, including capital, education, and networks.

- There are few, if any, opportunities for financial and business education in this area.
- There is little access to networks and capital to support BIPOC leaders.
- If there is funding for BIPOC practitioners to grow their businesses, it is not well publicized.
- The low level of funding provided through the Cultural and Ethnic Minority Infrastructure Grant program (CEMIG) is an overall barrier to supporting the development of BIPOC mental health professionals as well as building the infrastructure needed to effectively serve diverse communities. There has been a consistent expectation to expect more than what is feasible with the dollars provided.

VI. Recommendations

A. Category 1: Recruiting mental health providers from diverse racial and ethnic communities

The Task Force recommends creating and supporting new ways to enter the mental health field and grow a career, including routes to licensure, career pathways, and increasing awareness of career possibilities. It recommends providing financial support that attracts and retains BIPOC professionals in the field, including a thorough examination of reimbursement rates and other compensation.

A1. Support licensure and career pathways

a) Given that the research demonstrates unequal pass rates by race and possible racial bias in licensing exams (e.g., the Board of Social Work has a provisional license, which is another pathway for licensure for those who have failed and for whom English is not their native language and were born in a foreign country), explore alternative routes to licensure This should be done while continuing to support the exam pathway, to address barriers to passing licensure exams.
   i. Review what all boards and professional associations have already proposed as alternative licensure pathways.
   ii. Support the BOSW with funding in its proposal to expand the provisional licensure to all statuses.

iii. Support the Association of Martial and Family Therapy (AMFTRB) in proposing alternatives to the national exam.
iv. Consider alternatives to a standardized licensure exam, e.g., count work experience.
v. Support licensing boards with funding to come together and propose specific pathways.
vi. State agencies to review policies.

b) Build additional career pathways to allow for different levels of degrees and/or credentials. Explore how to create pathways for paraprofessionals to be compensated for their contributions toward filling important needs.
   i. Create a career pathway for non-licensed individuals at different degree levels to work alongside those with a license.
   ii. Create and support other opportunities toward which non-doctoral levels can grow.
   iii. The legislature and professional associations collaborate to define expanded/additional career pathways.

c) Create more career pathways for individuals with a bachelor-level degree.
   i. Agencies and mental health organizations conduct an updated job analysis to determine if the required qualifications could be revised.

d) Increase reimbursement rates to address barriers to financial sustainability. Demand for mental services is increasing and we need to bring in more professionals.
   i. Increase rates associated with assessment, diagnosis, treatment, group treatment, and facilities.
   ii. Expand those who may be reimbursed (roles/individuals). Work is happening, such as interventions, and not everyone is getting reimbursed for it.
   iii. Expand the number of services that are considered mental health interventions so that they can be reimbursed. Explore researching traditional forms of healing to include them in evidence-based or empirically supported mental health interventions.

e) Build awareness among youth of the opportunities to enter the mental health field.
   i. Fund a mentorship structure for high school youth (e.g., graduate-level students go to schools).
   ii. Require a psychology course in the public-school curriculum. Require a lesson on careers that include mental health professions.
   iii. Establish a pool of speakers or presenters who can visit schools.
   iv. Provide funding to higher education institutions to implement initiatives to recruit and admit students from underrepresented racial/cultural backgrounds into their programs. Without these efforts, the boards' licensing applicants will not be diverse. Higher education needs targeted funding to intentionally recruit particular students to their programs.

A2. Provide financial support to attract mental health professionals to the field and to retain them

a) Examine the overall compensation of mental health providers, including reimbursement rates, to better reflect the current demand for mental health services. The status of mental health has now been determined to be a crisis. Working in community mental health, where many BIPOC clients are, often puts clinicians in a position of serving as advocates. Clients in these contexts have complex needs that must be attended to; this often detracts from the billable "therapy hour."

b) Paying competitive wages is active allyship. Organizations that espouse values of dignity, equity, etc. can practice their values in this way.
   i. Establish higher reimbursement rates overall that reflect a fair price and require larger organizations to compensate their behavioral health professionals at a higher rate.
   ii. Expand the DHS program that provides grants to mental health providers for whom at least 25% of their clients are on public insurance (MA, MinnesotaCare) and who primarily serve underrepresented communities.
   iii. When determining eligibility for loan forgiveness, consider the intensity of the work required to serve mental health clients; revise what counts as billable hours. Include case management tasks as billable time, including efforts like providing housing resources and coordinating care.
   iv. Establish mechanisms for mental health organizations to emphasize a total benefits package that includes professional development, which can help offset the low salary. Certain certifications may come with an increased reimbursement rate from insurance companies.
c) Revise the RFP process to prioritize mental health-related grant applications.
   i. Secure federal grant money for scholarships for people who are not eligible for mental health licensure, encouraging targeted communities to enter the mental health field (build upon the Rochester School-Based Mental Health Scholars Program).
d) Reduce the financial barriers to passing licensing exams.
   i. The legislature can continue to provide grant funding for the Mental Health Provider Supervision Grant Program and similar programs that cover licensure exam fees and licensure prep for underrepresented groups.

B. Category 2: Training all mental health providers on cultural competency and cultural humility

The Task Force would like to see numerous improvements to training. It recommends improving the authenticity and quality of training already offered, particularly by inviting culturally proficient experts and community members to lead these changes. It recommends enhancing the offered training as well as access to it; elevating culturally responsive training is a high priority.

B1. Improve authenticity and quality of training

a) To improve the accuracy and overall quality of training content and delivery, invite specific community members to lead training development and delivery. It is important that the state not be the author of the training content. The leadership of community voices in developing these offerings is critical. Consult with communities and community leaders to define cultural humility and what culturally informed care would look like in each community.
   i. Engage BIPOC communities and frontline mental health workers to define mental health.
   ii. Ensure training in cultural competency includes an intersectional focus (gender identity, sexual orientation, age, ability, etc.)

iii. Seek out and engage with experts who are currently proficient in providing culturally specific care to capture their expertise and increase the accuracy of training.
iv. Develop the trainers' capacity to navigate the system and structure their content by assisting them in aligning it to CE's expectations.
v. Support boards with the funding needed to provide CE opportunities that are free and culturally accurate to the community being served to ensure quality education; boards should work with BIPOC organizations to ensure CEs are accepted.
    i) Partnerships might include healing justice organizations, South Asian wellness organizations, African American organizations, etc.

b) Create a speakers bureau comprised of leaders from diverse communities (identified by each cultural community) that could provide appropriate training. Trainers should be compensated for their knowledge.
    i. Create high-quality, culturally informed, community-vetted training and an open-source format to enhance the standardized culturally appropriate content.

c) Examine the content of culture-related training courses and the extent to which instructors adhere to the curriculum content.
    i. Support licensing boards with the funding needed to evaluate culturally specific CEs to ensure quality and appropriate culturally informed training. They should consult with an expert from the communities represented.
    ii. Review what accrediting bodies currently require.

d) Bring clarity to the varied definitions of "culture" and establish guidelines so that licensing boards can be specific in their requirements. Clearly define what qualifies as cultural continuing education credits. Standardize this definition across all mental health boards.

e) Set a minimum standard for all continuing education being submitted, not just culturally specific training, to build in a culturally diverse and specific case scenario that is informed by people who are from those cultures.

B2. Enhance training offerings and access to them

a) Make available and encourage more ongoing continuing education courses regarding DEI.
    i. Establish BIPOC/cultural-specific initiatives and programming.
    ii. Provide more training to clinics about using interpreters, ensuring smaller clinics have access.
    iii. Make training courses about cultural considerations when working with specific cultures available to mental health professionals.
    iv. Support licensing boards with the funding needed to work together to organize the training offered and share courses with other boards.
    v. DHS should develop the infrastructure/framework of the training so it is cost-effective for the boards; boards should adapt it for their providers.

b) Increase access to DEI and culturally related training offerings. Free training will reach more people.
    i. Provide free culturally appropriate online training. For example, a free monthly continuing education course on culture could be offered to the provider community. State agencies should fund the cost of training.
    ii. Incentivize participants with the opportunity to earn CEUs, including virtually.

c) Explore mentorship as an informal learning opportunity in addition to formal training.
   i. Pay BIPOC mental health providers to provide mentorship to other BIPOC professionals working toward licensure, as well as to allies working in those communities. Compensation is important, and it is also important that compensation be targeted to BIPOC individuals.
   ii. Establish a referral list of BIPOC mental health professionals who can provide professional advice regarding working with specific cultural communities. The compensation of these advisors is important.
d) Work with senior leadership to address implicit bias and racism at this level of their organizations.
e) Create a library of culturally aware and culturally appropriate training courses that are endorsed by all boards – and vetted by specific communities; shared with all licensees.
   i. Support licensing boards with funding to appropriate toward culturally appropriate BIPOC organizations to develop and disseminate CEs for mental health professionals.

B3. Prioritize the importance of training in cultural responsiveness

a) Respond to current and projected demographic changes in Minnesota by advocating for intentional training in this area instead of a primary focus on CEUs. This will help to eliminate long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds, improve the quality of services and primary care outcomes, and decrease the likelihood of liability/malpractice claims. Evidence suggests that better outcomes result when training shifts away from white-centered models.
   i. RFPs that are currently issued do not truly address disparities. Ensure use of and adherence to DHS' Equity Analysis Toolkit and BIPOC representation in the development of RFPs, especially in the early phases..
   ii. Advocate at the state level for de-colonizing the evaluation process for BIPOC organizations so the data is more accurate, meaningful, and culturally appropriate for that community.
b) Require a set percentage of diversity related CEUs to be specific to BIPOC, that is, race and ethnicity.
   i. Licensing boards should ensure that licensees and non-licensed mental health workers take CEUs related to race and ethnicity, allowing for virtual offerings.
c) Require agencies, organizations, and corporations that claim to serve a majority of BIPOC individuals to show that a high proportion of their staff have received specific continuing education related to these populations.
d) Support advocates in the field outside of legislation to create programs that help providers serve clients better.
e) Hold educational institutions accountable for taking action that demonstrates they value cultural responsiveness in the mental health field.
   i. Establish guidelines for training in graduate school and incorporate the expectations through to licensing boards.
f) Provide funding and require boards to intentionally discuss how to define culturally competent vs culturally responsive training and codify that definition in the board rules; trainers must be required to meet those criteria.

g) Provide licensing boards with funding needed to collect data on completed continuing education related to cultural responsiveness and submit that data for approval. It would be helpful to see trends in what is being approved or denied.

C. Category 3: Assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services

The Task Force recommends collecting data to track, evaluate, and share progress in this area. It also recommends several ways to support systems change, including a policy analysis and the formation of an accrediting body to assess culturally informed practices. In addition, the task force recommends that outside perspectives including community voices be engaged in making changes.

C1. Collect data and track progress

a) Legislatively mandate and provide the funding needed for licensing boards to collect demographic data. Knowing and understanding the data will help providers target people who need additional support.
   i. Licensure boards should collect data and review data that identifies who is accepted into programs.
b) Require standard program evaluation and reporting in this area.
c) Decolonize the processes for evaluating data that addresses any health disparities in BIPOC communities. Decolonized evaluation research should inform future RFPs to address disparities in those respective communities.
   i. Collaborate with BIPOC evaluators who can provide evaluations that are specific to targeted BIPOC communities.
   ii. MDH and DHS should have appropriate people from the community involved in informing the process.
d) Where data is collected, share it transparently and effectively and find ways to support the conversation about disparities.

C2. Support systems change

a) Analyze and identify policies that may dictate how mental health organizations address issues of cultural responsiveness, for example, diagnostic standards, required treatment modalities, insurance reimbursement, etc. A literature review may be necessary.
   i. Build accountability measures into any assessment so words reflect practice.
   ii. Intentionally include diverse voices in defining minimum standards and throughout implementation, e.g., community forums.
b) Mandate that mental health organizations engage in pay equity and leadership equity for BIPOC professionals.
c) Educate the public and licensees about courses of action to take when complaints of racism come in; establish a system to track complaints.
d) Identify organizations that serve diverse cultural communities to explore and discover an interest in forming an accrediting body that would assess culturally informed practices.

C3. Engage outside perspectives

a) Generate ways clinicians can work with traditional healers from the community; establish a system to track these partnerships and collaboration.
b) Gather feedback from clients regarding their treatment plans to ensure they receive care that is aligned with their cultural values.
    i. Offer clients a regular survey to evaluate the quality of care. This may be included in the review of treatment plans, for example, ask "Do you believe you received care aligned with your culture?"
    ii. Involve communities in the definition and development of culturally informed practices.
c) Increase the awareness of mental health programs in communities by using more targeted marketing.

D. Category 4: Increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

The Task Force sees a critical opportunity to invest in resources and structures that will support the growth of BIPOC-led organizations. It recommends enhancing funding support to these organizations, including an examination of grantmaking processes, enhancement of current programs, and increased reimbursement. It also has specific recommendations for building organizations' capacity.

D1. Enhance funding opportunities

a) Given the competitiveness of funding and the risk of those who need it most not getting served, intentionally fund those who are most underserved. Be clear with language that funding is to intentionally prioritize BIPOC-owned (for-profit) organizations and BIPOC-led organizations (nonprofit).
    i. Ensure BIPOC representation in the RFP planning process before the RFP is made public so it more adequately addresses the issues and creates an RFP that is more representative of communities' needs.
b) Look at grant criteria, requirements, and other structural elements to avoid unintentionally excluding BIPOC-led and owned organizations from funding opportunities.

i. DHS should evaluate how it scores grant proposals, particularly from small or new organizations. Organizations that propose a one-size-fits-all approach should be identified and flagged as potentially unable to meet diverse needs.

c) Continue and enhance funding to pay BIPOC mental health professionals to become supervisors.
   i. Expand the Cultural and Ethnic Minority Infrastructure Grant program (CEMIG) to further compensate BIPOC supervisors. To support BIPOC supervisors in the completion of the required education/training to be a board-certified supervisor, provide funding needed for boards to track which supervisors were funded as well as program outcomes.
   ii. Examine the reach of the Mental Health Cultural Community Continuing Education Grant Program (MHCCC), which is intended to help BIPOC mental health professionals become supervisors.
   iii. Create a statewide diversity and equity incentive program that rewards organizations for hiring or promoting leaders who represent BIPOC communities (leadership roles in grants, funding opportunities, etc.).
d) Collect data on how this funding has been used to date, e.g., how many people have achieved supervisor status, and the services they provide.
e) Reimburse BIPOC-owned businesses that provide culturally specific services at an enhanced rate.

D2. Build internal capacity

a) Provide technical support to build infrastructure, knowledge, and capacity of BIPOC-owned and led organizations.
   i. Working with the Department of Administration, establish a hub for smaller providers to share resources, support their capacity-building, and provide ideas for shaping policies.
   ii. Provide education regarding how to write competitive grants to have a sustainable business, board development, etc.
   iii. The MN Department of Employment and Economic Development should provide consultation services around business processes.
b) Build an infrastructure to foster partnerships between smaller practices and larger organizations. Invite large, successful organizations to mentor clinicians of color as a part of their own DEI initiatives.

VII. Conclusions

The Task Force sees that diversity and cultural responsiveness in the field of mental health are not adequately prioritized. There is a lack of investment needed to build awareness of the need for cultural responsiveness, to educate practitioners on their skills to effectively serve BIPOC clients, to support and retain BIPOC professionals and leaders in this field, and to build infrastructure. This includes accountability measures that can elevate diverse communities' voices and meet their needs. This lack of investment and the resulting low diversity and cultural responsiveness in the field has an inequitable and harmful effect on BIPOC communities.

To pursue the vision that the mental health workforce is diverse, accessible, and responds respectfully to cultural needs, the Task Force makes multiple recommendations that detail the actions that should be taken by the state legislature, licensing boards, state agencies, and mental health organizations.