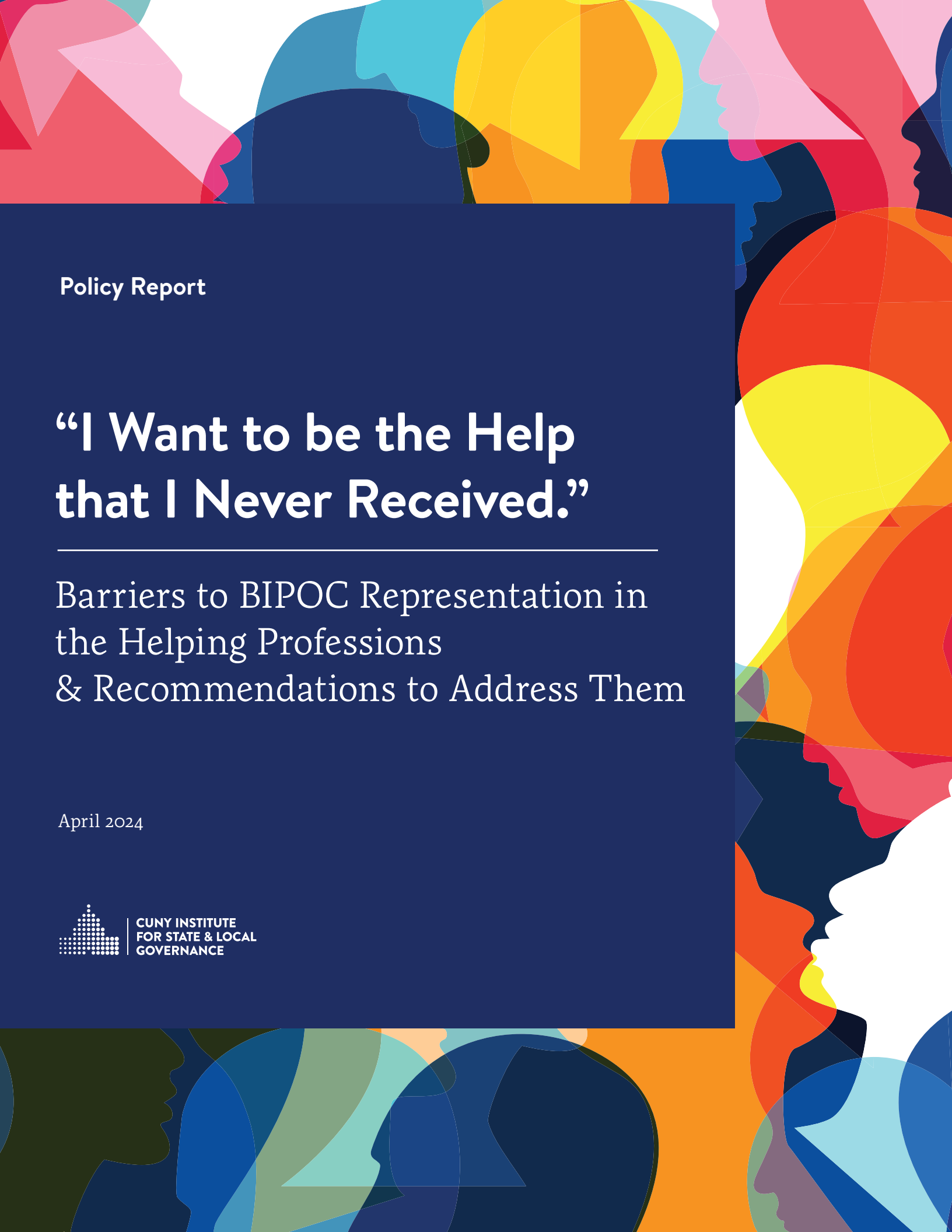

Policy Report

“I Want to be the Help that I Never Received.”

Barriers to BIPOC Representation in the Helping Professions & Recommendations to Address Them

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CUNY INSTITUTE FOR STATE & LOCAL GOVERNANCE

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Introduction

In the second half of 2023, CUNY ISLG embarked on a process to understand the barriers to becoming a helping professional generally and in particular for Black, Indigenous, and People of Color (BIPOC) persons, as well as challenges faced while working and advancing as a helping professional. For the purpose of this work, "helping professions" are defined broadly, and include:

- Careers aimed to support/address people's well-being that do not require a higher education degree, advanced degree or clinical license—including community health workers and credible messengers—and
- Careers that do require a higher education degree, advanced degree and/or clinical license—including social workers, psychologists and psychiatrists.

In addition, "BIPOC people" are defined broadly to include consideration and attention to their intersectional identities, including with respect to immigration status, language, LGBTQIA+ identity, as well as their lived experience which for some includes criminal legal history.

This report brings together the results of this process, laying the foundation for further work and potential investment by government and funders. The first section summarizes the current state of underrepresentation before presenting findings regarding reasons for underrepresentation. The second part of the report offers a set of funding recommendations that take into account the potential scale of investment, need, feasibility, timeline, and impact. Such recommendations include existing promising efforts and efforts not yet being delivered but conceptually sound and ripe for support.

Summary of the State of the Field

BACKGROUND: DISPARITIES IN REPRESENTATION AND ACCESS TO THE HELPING PROFESSIONS

BIPOC People are Vastly Underrepresented in the Helping Professions

According to the 2020 United States census, roughly 60 percent of the U.S. population identified as non-Hispanic white, 14 percent as Black, 19 percent as Hispanic/Latine, 6 percent as Asian, and 3 percent as some other race.[1] Yet, BIPOC people are substantially underrepresented in the clinical professions. According to the American Psychological Association's most recent report on workforce demographics, an overwhelming majority of practicing psychologists identify as white (81 percent), with only 8 percent identifying as Hispanic/Latine, 5 percent as Black/African American, and 3.7 percent as other non-white racial/ethnic groups.[2]

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BIPOC people are similarly underrepresented in the psychiatry workforce.[3] Among social workers, 68 percent identify as white, followed by 22 percent Black/African American, and 14 percent Hispanic/Latine.[4] Although Black people are slightly overrepresented among social workers, Latine people remain underrepresented. Moreover, it is notable that although social work is more diverse than psychology or psychiatry, it has also tended to employ greater concentrations of women[5] and pay significantly less than psychiatry or psychology.[6]

The Disparities Within the Profession Are Reflected in Disparate Access to Treatment, Too

There also exist disparities in accessing mental health care for BIPOC populations. The National Institute of Mental Health (NIMH) estimates that more than one in five adults experience challenges with their mental health in the United States, across all levels of severity.[7] Whereas data indicate similar rates of mental health disorders between white individuals and BIPOC individuals broadly, disorders experienced by BIPOC people tend to last longer and are more likely to go untreated; as one example, although Black and Latine individuals have lower rates of depression than white individuals, their depression is more likely to persist.[8] A study published in 2015 noted that nationally, Black, Latine, and Asian people were less likely to access or take advantage of mental health services than white people.[9] More recent data indicate that a little more than a third of Black (37 percent), a third of Latine (35 percent), and a quarter of Asian (25.4 percent) individuals experiencing any mental illness (AMI) received corresponding services, compared to more than half (52 percent) of white individuals in 2021.[10] Comparing trends among racial/ethnic disparities over time, disparities in

accessing mental health care for Black and Latine individuals have remained stagnant and, in some cases, even grown worse.[11]

Looking deeper into these disparities, numerous studies have documented the discrimination pervasive in the field. For instance, Black mental health patients presenting with the same symptoms as white mental health patients are more likely to be diagnosed with a severe and highly stigmatized mental health condition (e.g., schizophrenia),[12] and are hospitalized more than any other racial group when seeking care.[13] Conversely, Black people are less likely to be offered evidence-based medication therapy or psychotherapy.[14,15] Studies have shown that Black people in treatment are more likely to terminate services early,[16,17] unsurprising considering that they are less likely to receive patient-centered care and more likely to be spoken to aggressively (i.e., in a "verbally dominant" manner) than white patients.[18,19]

This gap in access and treatment can be attributed both to discrimination within the helping professions as well as failures of social institutions that disproportionately harm BIPOC. For instance, BIPOC people exhibiting challenges with their mental health may be more likely to interact with the criminal legal system,[20] child welfare system,[21] or experience other issues such as homelessness.[22] Once a part of these systems or experiences, BIPOC people may suffer further disproportionate consequences to their mental health.

A wide body of research also attests to the profound impact of criminal legal experience on physical and mental well-being, which is disproportionately experienced by BIPOC people.[23] Incarceration has been shown to be associated with a number of negative health outcomes (e.g., stress-related illness, hypertension, heart disease, weight gain), for both current and formerly incarcerated persons relative to the general population.[24,25] Regarding mental well-being, being disconnected from family, loss of autonomy, and a jail or prison environment that is unpredictable and overcrowded is detrimental to a person's mental health even after release.[26] Approximately 25 percent of people involved with the criminal legal system experience psychological distress and another 40 percent receive a mental health disorder diagnosis.[27]

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In addition to BIPOC people and those with lived experience, some evidence points to the LGBTQIA+ community being at significantly greater risk of experiencing poor mental health as well. LGBTQIA+ people are often met with a dual stigma related to their mental illness and being a part of a minority population. For example, LGBTQIA+ people are more than two times as likely to have mental health disorders and two-and-a-half times more likely to show symptoms of depression and anxiety compared to non-LGBTQIA+ people.[28] These mental health disparities are even more prominent within some LGTBQIA+ subcommunities, with one study suggesting that transgender and gender non-conforming (TGNC) people are four times as likely to experience a mental health condition compared to cisgender individuals.[29,30]

The discrimination, harassment, and other various types of societal exclusion LGBTQIA+ people face more frequently compared to non-LGBTQIA+ people interfere with their mental health and their ability to access mental health services.[31]

LGBTIAQ+ people express that mental health professionals often lack understanding and knowledge of their needs. In an effort to avoid further stigmatization and discrimination, LGBTQ+ people may not disclose their sexual orientation or gender identity to providers or, in some cases, may avoid services entirely.[32, 33] In instances where LGBTQ+ people seek mental health services but do not disclose their identity or sexual orientation may feel pressured to do so in fear of negative reactions from the practitioner. As a result, the treatment approach provided may fail to address their underlying needs.[34, 35] TGNC people in particular report feeling unwelcome by mental health professionals because of their identity and feeling more vulnerable when staff fail to acknowledge their gender identity or sexual orientation.[36, 37, 38]

The Underrepresentation of BIPOC Helping Professionals Undermines Efforts to Improve Client Outcomes

With the national population growing more diverse each year, and the ongoing disproportionality of adverse mental health outcomes among non-dominant racial/ethnic groups and LGBTQIA+ people,[39] disparities in the helping professions undermine the professions' ability to serve these communities appropriately and effectively. Accordingly, it is important to increase the representation of mental health professionals to reflect the communities they serve. Increased representation can foster an environment that is more inclusive, where BIPOC people can voice their needs and the needs of their communities. Likewise, environments that affirm the value of lived experience are able to better support professionals and clients with such experience.[40]

Together, a more diverse workforce of professionals brings more diverse perspectives and experiences to the work, ultimately enabling care to be better tailored to each patient and supporting better outcomes. Although training for clinicians on providing services for specific populations is available and can help address the current gap in representation, it is not always mandatory for staff to complete and is not a substitute for the representation of diverse practitioners.[41]

Most of the evidence of the impact of increasing representation on health outcomes is clear when looking at the broader health field. For example, in a study of patient perceptions, researchers found that patient satisfaction was positively associated with racial concordance.[42] Other studies suggest that patients are more likely to adhere to medical recommendations and guidelines when treated by a doctor of the same race.[43, 44] Greater representation within healthcare has been found to help in building trust between patients and providers, which in turn helps patients to feel more comfortable sharing their health concerns.[45, 46] Conversely, the lack of representation contributes to a lack of trust from the patient in the provider; poor uptake and experience of services; and negative impacts on health.[47] Although the research has primarily focused on increasing representation within health care, similar findings and themes likely also apply to mental health care settings specifically.

In recent years, the national associations related to social work, psychology, and psychiatry have acknowledged the inherent racism within their respective fields and that they need to create a more diverse workforce in order to better serve clients. The National Association of Social Workers (NASW) issued a formal apology on behalf of the social work profession for the historic harms against BIPOC people. As a response, the NASW published a report outlining its new commitment to studying, fighting, and eliminating attitudes and practices within the social work profession that continue to cause harm. The report included recommendations on how organizations can foster a more anti-racist employment experience for social workers and in the workplace.[48]

The American Psychological Association (APA) also issued a public apology in 2021, in which the association acknowledged that it had failed to lead the field of psychology in this area and recognized its contribution to systemic inequities and their effects.[49] The association published a brief outlining ways to combat racism within psychology and the need to adopt a uniform understanding and definition for such measures.[50] Similarly, the American Psychiatric Association (APA) recognized the need for strategic efforts to create a more diverse and equitable workforce. The association developed a plan outlining specific goals - one of which is to create an inclusive pathway for early career trainees.[51]

The Lack of Representation Also Undermines Our Collective Well-being

As recent and ongoing crises have demonstrated, these efforts are critical not just to right historical wrongs but rather as a necessary public health strategy that benefits all Americans. The COVID-19 pandemic forced the country to recognize the fragile state of its collective well-being, with a healthcare system unable to cope when the crisis hit due to the prevalence of chronic conditions coupled with profit motivations that function to make the system ever more "efficient."[52] As positions remain vacant, workloads rise for the employees that remain, increasing the risk of departures due to burnout. Nationwide, the lack of mental health professionals—and even more so, those who are BIPOC—undermines the ability to address problems that often develop into longer-term, difficult-to-treat social challenges.[53]

A more diverse workforce is better able to understand and address complex problems that vary across populations, and to advocate for the resources necessary to address them. As new public health crises emerge, these efforts are essential to collective surviving and thriving. Increasing the availability of mental health and helping professionals with shared identities and/or lived experiences has the potential to open up opportunities for greater:

- Awareness of the benefits of therapeutic interventions;
- Access to therapeutic services, especially for those who have experienced trauma;
- Innovation within the trauma and mental health field, allowing for ongoing adaptation of evidence-informed and evidence-based interventions to be culturally response to those being served;
- Knowledge about the benefits of these services in healing and recovery; and
- Connection to other needed services and opportunities (e.g., housing, health, education, employment, community engagement).

These opportunities, in turn, may lead to greater interest in pursuing employment within the helping professions and particularly for those communities with the largest gaps between need and appropriate resources. However, it is important to note that simply diversifying the mental health workforce will not solve all of the gaps in care for historically excluded groups. Rather, the field must also shape the learning and workforce environments so that providers have the necessary training, skills, and culturally responsive approaches to support better mental health outcomes for clients while at the same time improving BIPOC staff retention and advancement in the mental health workforce.

METHODS

With this context in mind, over a six-month timeline, CUNY ISLG staff and partners (Eric Brettschneider, CUNY ISLG Senior Fellow and project lead; Crystal Bobb-Semple and Kenton Kirby, consultants to CUNY ISLG) completed a thorough scan of relevant literature and conducted interviews and focus groups with a wide range of stakeholders to address the following research questions:

- **What are the barriers (systemic and personal) to increasing representation of BIPOC people within the clinical and related helping profession?**
- **What are some of the best practices and strategies to develop a more representative pool of candidates?**
- **What strategies should be considered to increase representation?**
- **What are the challenges associated with increasing representation?**

CUNY ISLG first developed a stakeholder map that consisted of groups, organizations, and people with critical insight into the field. This exercise identified seven key groups for focus, who could provide insights on different aspects and reasons for underrepresentation:

- **Government agencies:** This group encompassed leaders at city agencies (e.g., Administration for Children's Services [ACS], Department of Health and Mental Hygiene [DOHMH], etc) who could provide insight on recruitment and retention barriers as well as strategies at a city level.
- **Community-based organizations (CBOs):** This group comprised organizational leaders and human resources representatives who could speak on retention and recruitment barriers, as well as strategies for service providers who work with underserved communities, employ social workers, and hire people with lived experience.
- **Professional associations**: This group consisted of leaders at professional associations to discuss policies and protocols that affect people employed in the helping profession field (i.e., NASW).
- **University leaders:** This group afforded the perspective of university leadership providing intentional recruitment and support for students pursuing the helping professions.
- **Clinicians and thinkers from the helping professions:** This group included psychologists, psychiatrists, and social workers, with a focus on BIPOC clinicians who have worked in the field and could speak on barriers in recruitment (i.e., education, licensure) and retention (i.e., workload, microaggressions), and recommendations that can address those barriers.
- **Community members:** This group encompassed BIPOC people and people with lived experience in the helping professions. It included undergraduate and graduate students, case managers, advocates, credible messengers and peer staff, community health workers, and program coordinators. Individuals in this group spoke on their experience, barriers, and recommendations in entering the helping profession and advancing in their careers.
- **Other organizational stakeholders:** This group was composed of partners who did not fit into the categories above but play a role in the helping professional field (e.g., labor unions and governing bodies on licensure and education).

Within these groups, CUNY ISLG researchers identified organizations and people who could provide insights on recruitment and retention barriers, as well as strategies on a national, state, city, and community level. Researchers reached out to the organizations and people to schedule interviews and focus groups and also asked them to connect to others who could provide insight. They also emailed organizational partners and people in other networks to help make connections as well.

Another critical component was the creation of an Advisory Group, which convened monthly to provide direction to the project. The advisory group provided field outreach support, feedback on priorities and recommendations based on their experiences of barriers and their work in the helping profession field, and investment landscape, which included strategies they were aware of or had been part of to address barriers. It is important to note that in each stakeholder group, we focused outreach efforts on BIPOC helping professionals, in order to hear directly on the barriers BIPOC people face that limit their representation in the field.

CUNY ISLG developed interview and focus group guides to elicit critical information regarding participants' realization of a desire to enter the helping professions; recruitment and pathways into the helping professions; and retention and advancement within the helping professions once employed there. After obtaining consent from participants, CUNY ISLG conducted 60-90 minute confidential interviews and focus groups exploring these topics. Researchers also asked participants about how they would address underrepresentation in the helping professions "if they had a million dollars." This report does not connect participant names to specific quotes, as agreed to in the consenting process so as to make the conversations as candid as possible. In total, we conducted 51 individual interviews and 22 focus groups, with a total sample of 133 individuals. Representation across the key groups is reflected below. Please note that the sum totals more than 133 due to the known intersection of the seven categories among some participants (e.g., clinicians who are also thought leaders, nonprofit leaders who hold clinical credentials, etc.):

- 6 government agency leaders
- 28 non-profit leaders
- 8 leaders at institutions of higher education responsible for training helping professionals
- 13 thought leaders in the helping professions
- 25 clinicians (helping professionals with clinical licensure, i.e., social workers, psychiatrists, and psychologists)
- 12 LMSW social workers (non-clinical license)
- 31 non-clinical helping professionals (i.e., credible messengers/peer staff, case planners, community health workers, coordinators, advocates, etc.)
- 25 students interested in pursuing the helping professions
- 8 other stakeholders (i.e., unions, foundations, and associations)

CUNY ISLG took verbatim notes for all interviews and coded the notes using NVivo software. CUNY ISLG developed an initial coding scheme based on the research questions and interview instruments, and iterated on this scheme as new themes emerged during coding. Following coding,
researchers identified core themes and illustrative quotations, which are reflected in this report.

In addition, CUNY ISLG conducted a literature scan of these same topics. Specifically, CUNY ISLG started by breaking down each research question into topic areas and identifying

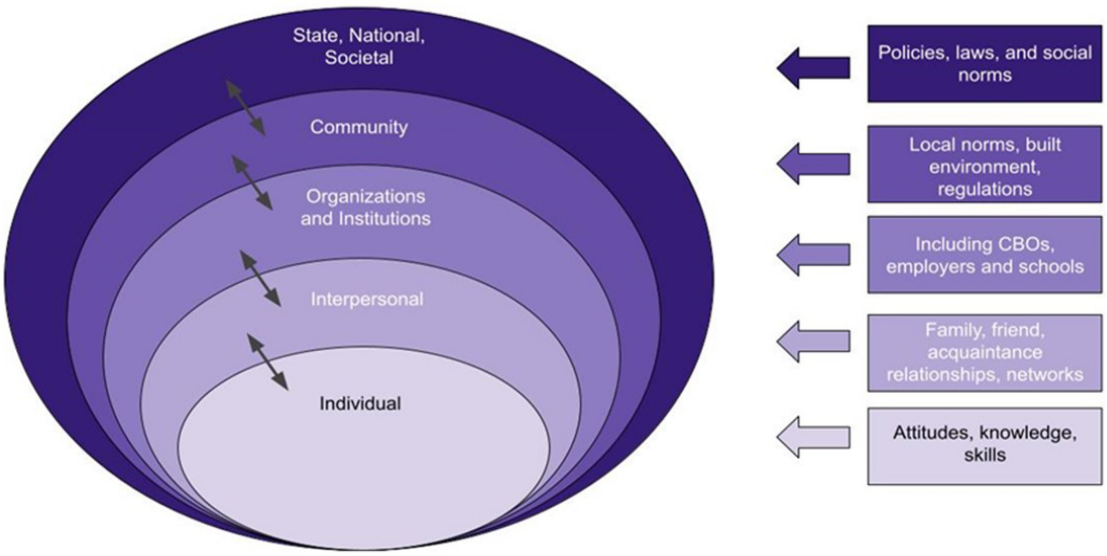
keywords and phrases to use in searching for existing literature relevant to the topics across different disciplines/professions (i.e., social work, psychology, and psychiatry). Once the necessary terminology was identified, researchers used online search engines and educational libraries to locate relevant journal articles, association websites, white papers, and other sources. Key areas of focus in this process included:

- The current demographic composition of the mental health and helping professions, particularly race/ethnicity;
- Education and experience required for different helping professions;
- Challenges or difficulties known to impact the process of becoming aware of, entering, staying in, and advancing within these professions, as well as how these challenges differ for people from underrepresented communities; and
- Strategies that have been implemented to address gaps in representation and whether they are successful in achieving the desired outcomes.

This report brings together findings from both the fieldwork and the literature scan to summarize the barriers—and facilitators—to entering, remaining in, and advancing in the helping professions. The aims of this project align with similar efforts in other fields, such as STEM, that have sought to address underrepresentation of populations that have faced historical, systemic exclusion.[54, 55] Although the focus of the project is on BIPOC communities, CUNY ISLG took an intersectional approach and sought to understand how experiences within this group might also vary with respect to gender, sexuality, immigration, socioeconomic status, and lived experience. That said, most of the literature examined focuses on the experiences of BIPOC groups broadly and less commonly on variations within BIPOC groups.

One theoretical lens drawn on in summarizing our findings is an ecological understanding of social phenomena (see *Figure 1*). This framework acknowledges that individuals are situated within many concentric and overlapping systems–for example, within families, institutions,

FIGURE 1. ECOLOGICAL FRAMEWORK FOR UNDERSTANDING THE BARRIERS AND SUPPORTS FOR INCREASING REPRESENTATION OF BIPOC AND PEOPLE WITH LIVED EXPERIENCE WITHIN THE HELPING PROFESSIONS



communities, and society. This framework enables an understanding of the causes of underrepresentation as well as opportunities for addressing them. Therefore, the themes included in this report can be approached and analyzed at different levels within this framework. For instance, societal-level racism and discrimination permeate the racism and discrimination in employment and education settings discussed throughout the report; race-based geographic segregation affects learning opportunities in schools funded largely through local property taxes; personal attitudes/characteristics affect how one interacts with structures and systems.

By extension, any focus on phenomena at the individual and interpersonal levels should also include an awareness of how more systemic forces affect the phenomena at these levels and our experiences of them. The concluding recommendations acknowledge this reality and are designed to target specific gaps, barriers, and assets in specific settings and systems.

Definition of Key Terms

Before summarizing the findings, to ensure common understanding and ground the discussion, here are definitions of several key terms used in this report.

- **BIPOC:** Refers to Black, Indigenous, and People of Color with the intention to center the experiences of these groups and provide a sense of solidarity between communities of color.
- **Credible messengers:** Often people with lived experience, particularly with the criminal legal system, and deep ties with their community who work to promote change within their communities.
- **Historically excluded groups:** Refers to groups of people who have been denied full privileges, rights, and opportunities in society based on their identities.
- **Intersectionality:** Involves the examination of how multiple identities (e.g., gender, race, and sexuality), particularly those excluded or discriminated against, interact to compound disadvantages.
- **LGBTQIA+:** An abbreviation used to describe a person's sexual orientation or gender identity, referring to lesbian, gay, bisexual, transgender, queer or questioning people and more.
- **Lived experience:** Experience leveraged by individuals to bring credibility and cultivate trust between individuals, such as criminal legal involvement or substance misuse. Shared experience and the trust it creates are an important enabler for relationship-building and service provision.
- **Microaggressions**: Verbal or non-verbal behaviors that, whether unintentionally or intentionally, communicate negative or derogatory messages towards a person based upon their belonging to a marginalized group.
- **Non-dominant racial/ethnic group:** Sometimes used to describe members of certain races or ethnic groups (e.g., Hispanic/Latine, African American, Asian, Native American, Hawaiian/Pacific Island, Multiracial) outside of the dominant racial/ethnic group (i.e., white, non-Hispanic) within various systems of oppression.

ACRONYMS USED IN THIS REPORT

- **AMI**: Any mental illness
- **APA**: American Psychological Association
- **APA**: American Psychiatric Association
- **ASWB**: Association for Social Work Boards
- **BIPOC**: Black, Indigenous, and People of Color
- **CBOs**: Community-based organizations
- **CSWE**: The Council of Social Work Education
- **DOE**: Department of Education
- **EPPP**: Examination for Professional Practice in Psychology
- **ETS**: Educational Testing Service
- **GRE**: Graduate Record Examination
- **LGBTQIA+**: Lesbian, Gay, Bisexual, Transgender, Queer or Questioning people, Intersex, Asexual, and more
- **MCAT**: Medical College Admission Test
- **MSW**: Master of Social Work
- **NASW**: National Association of Social Workers
- **NIMH**: National Institute of Mental Health
- **TGNC**: Transgender and gender non-conforming

FINDINGS

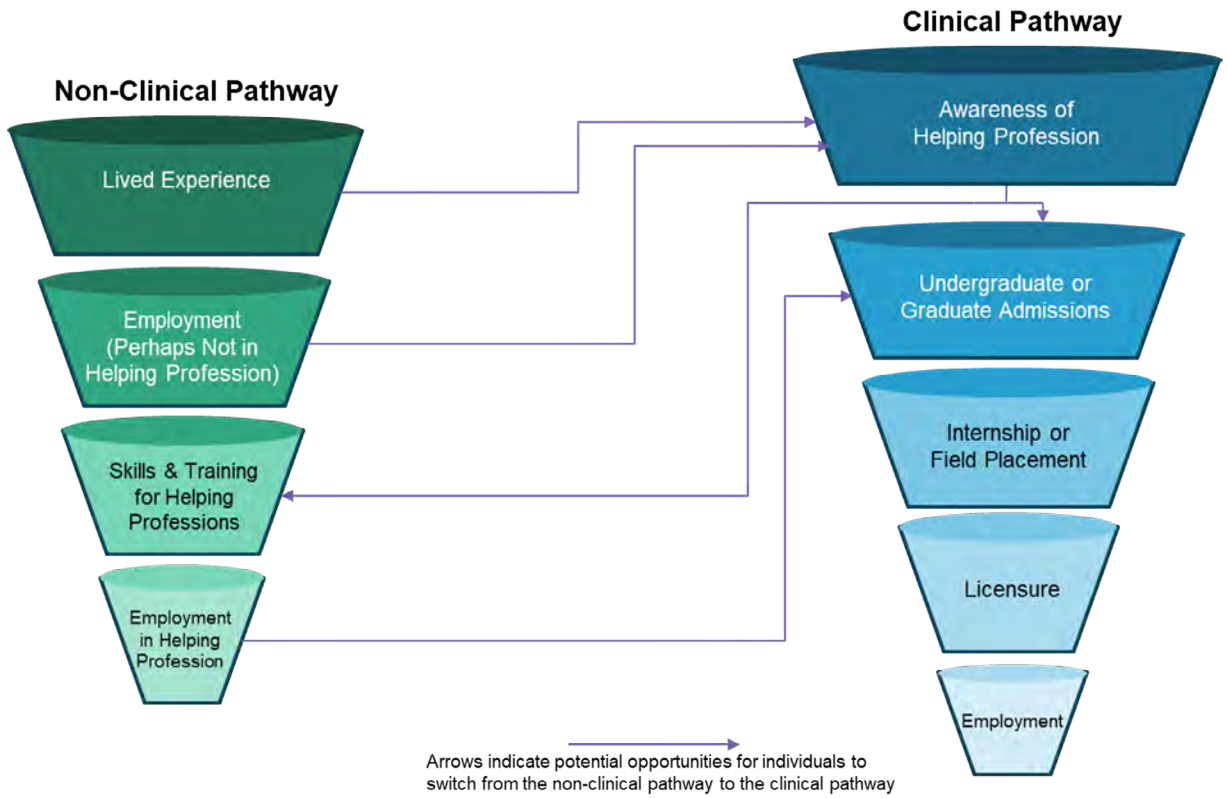
Barriers to Increasing Representation

This summary of findings begins by unpacking the specific barriers to increased representation in the helping professions, as found in both literature and focus groups. This section focuses on three steps in the pathway to greater representation:

- **Recruitment, or getting underrepresented individuals into the field**
- **Retention, or keeping underrepresented individuals in the field**
- **Advancement, or ensuring that underrepresented individuals progress in the field.**

As a roadmap to the findings below, this conceptual diagram (Figure 2) conveys how increased representation in the helping professions must begin with increased awareness of, and exposure to, these professions. Moreover, the pathways to eventual employment in the profession differ for clinical vs. non-clinical roles. Yet, it is also important to acknowledge and support the opportunities for translating non-clinical experiences and motivations to clinical roles, in furtherance of greater representation in the field more broadly, as well as clinical roles and in leadership ranks, specifically.

FIGURE 2. CONCEPTUAL FUNNEL FROM EDUCATION TO EMPLOYMENT FOR NON-CLINICAL AND CLINICAL PATHWAYS



Pathways into the Profession are Constrained at Every Step

Existing research on increasing representation of historically excluded communities with the mental health and helping professions suggests that a key task is increasing the representation of historically excluded communities pursuing and accepted into higher education, particularly in advanced degree programs required for many clinical careers.[56] The disparities in access to education and information start from the moment a child enters the education system. Funding and resources for schools from elementary to high-school is based in large part on local property taxes, which in turn contribute to large disparities in educational funding across neighborhoods.[57]

For instance, in New York State, this funding structure results in average per-pupil spending of $17,758 per pupil in economically marginalized communities compared to $27,845 per pupil in wealthy communities.[58] The U.S Commission on Civil Rights concluded in 2020 that New York has an inequitable school funding system that discriminates against the economically marginalized and Black and Latine children.

The effects of limited funding are profound, leading to a lack of afterschool programming, college access, career exposure, and overall support. These disparities were echoed in focus groups and interviews. One nonprofit leader with lived experience stated:

> *"If you boil it down, in essence, you can say that certain people or certain communities of people, certain cultures… are not getting the same opportunities as others."*

Due to the segregated opportunity and disparate funding of education, BIPOC students continue to be underrepresented in higher education and advanced degree programs. For example, while the number of people earning college degrees has increased for all racial and ethnic groups over the years, the percentage of students enrolling in doctoral psychology programs continues to be majority white (54 percent), followed by Latine (11 percent), Black (10 percent), Asian, (9 percent), and multiethnic (5 percent) students.[59] These factors constrain opportunity throughout the entirety of educational pathways and amplify as students work toward higher-level education, especially at institutions that are predominantly white.[60]

The recent Supreme Court ruling[61] curtailing affirmative action in college admissions is likely to exacerbate this underrepresentation. The states that banned affirmative action before the ruling provide stark insight into the impact this ruling may have on a national level: In 2006, Michigan banned affirmative action in college admissions, and the share of Black undergraduate students declined sharply from 7 percent to 4 percent. Universities in California also experienced a drop in Black enrollment after the removal of affirmative action.[62] These changes will now layer onto the existing obstacles faced by BIPOC students when trying to obtain the required education to enter the mental health and helping professions.

Enrollment in educational institutions often begins with a decision to pursue a particular degree in the hopes of entering a related field of work. These decisions are shaped by an individual's life experiences, access to resources, and exposure to others in the field. For many BIPOC people, attraction to the field derives from motivations/factors such as passion and desire to address mental health service gaps and to be of service to their communities, whether defined by geography or identity. For instance, one graduate social work student said:

> *"I'm Latina, and in my community, mental health is not acknowledged or encouraged. I had anxiety growing up and… it was perceived as me acting out… I felt I always needed therapy and it was never offered to me because it's not offered in the Latino community…I just feel like I want to be that help that I could not get in my community. It's also more comfortable when you see people who look like you… I want to be the help that I never received."*

These motivations are also present for people with lived experience who want to help underserved communities who face additional obstacles such as having prior criminal legal involvement or being a survivor of intimate partner violence. One undergraduate social work student shared:

> *"I became interested in helping people because I experienced challenges getting my children back from foster care. I am a recovering addict, and I live a life of recovery. While going through the process, I realized there was not a lot of information for people to get through the system and how to respond to the situation."*

Similarly, a social worker mentioned the desire to bridge the gap of disenfranchised communities:

> *"There are so many challenges breaking social barriers because of lack of knowledge, and for Asian communities, a language barrier… There is a big gap, especially the communication gap and social benefits gap. For me, I'm the bridge between different generations of immigrants, so I help them."*

For BIPOC people and people with lived experience, entering the helping profession is personal. Their goal is to represent the communities they serve and address service gaps in their communities. Of the experiences and resources that may hinder historically excluded individuals from aspiring to enter the clinical field and pursuing a necessary degree path, research highlights family and finances as top influences. Financially, higher education costs are rising across the nation, and the stress associated with borrowing can be particularly burdensome for potential students. This is especially true for students from economically marginalized families who, therefore, may be less inclined to pursue graduate degrees in fields in the mental health professions like psychology. These same students may also have less experience with and awareness of the application process, and lower access to and trust of financial institutions given their historical exclusion from them.[63] One helping professional stated plainly:

> *"Here is the problem: we do not have people of color going into mental health or these fields because they cannot afford it."*

Compounding this, the narrative that going into social work means being "overworked and underpaid" is pervasive among potential students, some of whom also bear the additional responsibility of providing for their families. Parents or other family members may express concern with whether a profession in the mental health field, such as a social worker, would provide enough financial security or if the challenges faced in

the field after graduating would be too much to handle.[64] In these circumstances, prospective students often sacrifice their personal aspirations:

> *"For some, having a good income for themselves and their families … will take priority over what is more fulfilling."*

Once deciding to pursue a degree in the mental health field, the next set of barriers faced are in the preparation of and during the admissions process. Undergraduate colleges that implement more of a selective admissions process (i.e., that are "competitive") typically rely heavily on an applicant's grades, coursework in high school, and test scores as determining factors. Applicants who do not have access to advanced high school work, then, are disadvantaged in this process. Even when offered in their schools, the quality of previous STEM coursework may leave students unprepared for college admissions and coursework. The disparities in opportunity stemming from school segregated tracks and funding disproportionately impact BIPOC individuals.[65]

College admissions practices exacerbate these disparities. College admissions frequently consider an applicant's Scholastic Aptitude Test (SAT) score, performance on which is associated with socioeconomic status. Specifically, the historical disinvestment in schools attended by BIPOC students undermines their ability to gain admission to more competitive institutions, ultimately perpetuating inequities in the helping professions.[66] Research on the Graduate Record Examination (GRE) has shown it to be biased against non-dominant groups: according to a report by the Educational Testing Service (ETS), the administering organization of the GRE, women test takers are outscored by men an average of 80 points and Black/African American test takers are outscored by white test takers by roughly 200 points.[67] Such merit-based admissions criteria discourage potential students, particularly from historically excluded communities, from applying to desired programs.

A study of MCAT examinees found Black and Hispanic test takers showed lower odds of applying to medical school compared to their white counterparts, with explanatory factors related to finances (e.g., loans, challenges affording test prep materials), interpersonal discrimination (e.g., negative influence by an advisor), and access to extracurricular educational opportunities (e.g., pre-medical programs, college labs, shadowing physicians).[68] In addition, standardized exams are only offered in English, creating an additional barrier to accessibility especially for bilingual test takers, who would be primed to work with non-English speaking populations. Interviewees also questioned the value of standardized exams, referring to research which critiques these exams for failing to recognize different learning styles and privileging Eurocentric modes of thinking.

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U.S. graduate programs' use of merit-based factors (e.g., standardized tests) in the admissions process impose financial burdens on applicants. Standardized tests, such as the GRE and the Medical College Admission Test (MCAT),[69] are required application components for many programs. The financial cost of these assessments alone can be burdensome for people from lower socioeconomic backgrounds. For example, the GRE currently costs $220 to take and additional $30 per school an individual sends their scores to, not including the cost of prep courses which can exceed hundreds or thousands of dollars.[70] The standard registration fee for the MCAT is $335, and although a fee assistance program is available that reduces registration to $140, this cost can still be exclusionary.[71]

Individuals with prior legal system involvement face various collateral consequences, which often prevent full engagement in education, employment, housing and other supports necessary to rebuild their lives personally and professionally.[72] These individuals face unique challenges when applying to higher education, including graduate programs, due to the common requirement to disclose any history of legal system involvement by "checking the box."[73] A vast majority of Master of Social Work (MSW) programs mandate disclosure of criminal backgrounds for their applicants, leaving those with criminal records with more limited chances of obtaining the educational credentials for licensure.

This exclusion stems from the belief that prior legal system involvement may predict future engagement in criminal activity. Therefore, institutions might justify this inquiry as a means to protect their campus community.[74] However, this practice disproportionately affects BIPOC populations given the biases within the criminal legal system itself. Additionally, while disclosure may be seen as a way to promote safety, such blanket exclusions fail to meet their goal of preventing harm because applicants who disclose may be further disadvantaged by not having the chance to pursue a degree in higher education.[75] A leader in the nonprofit field with lived experience plainly stated that barriers are doubled…

"…if you are system-impacted from a disenfranchised community. If you grew up in these neighborhoods but add to the mix of being system-involved, our world becomes twice as hard because we have to deal with all those systems … Even if someone system-impacted gets an education, they may not get a license because of their criminal background.

I hear it from my brothers and sisters who are going into social work. I hear from my mentors, who are criminologists, who are already coming to [work at] colleges and working in the field but finding it difficult to get tenure because of their background. It is difficult for them to find a place where they do not have to move every year because you're a professor, and it is hard to get tenure because you have a criminal justice background.

This is why I am seeking a Ph.D. I am not doing it for academia, I am not doing it to teach in a university … where I must fight with the school to recognize my proficiency level because they will be looking at my background. There are gatekeepers and barriers, and some can be navigated, negotiated, and you can go around. But there are some [that you cannot]; unfortunately, it is because it is how systems are structured."

As BIPOC students enroll in graduate and doctoral programs, they continue to experience institutional obstacles as they work to complete their degrees. Research shows that some of the main reasons students may not complete their graduate school programs include financial hardship (i.e., cost of tuition), inadequate relationships

with program faculty (i.e., lack of support, mentorship), and negative interactions with peers—much of which are experienced disproportionately by BIPOC students.[76, 77]

The lack of representation in the field in general is also mirrored in the composition of faculty where future practitioners are educated. In 2021, 73 percent of postsecondary full-time faculty were white, compared to 6 percent who were Black and 6 percent who were Hispanic.[78] This lack of diverse and culturally competent faculty prevent BIPOC students from developing relationships that can offer mentoring, navigation of the program, and insight into the field. Accordingly, institutions that fail to prioritize these relationships may experience difficulty in recruiting and retaining BIPOC students and faculty.[79] In addition, the curricula themselves can be experienced by BIPOC students (and others) as antiquated and irrelevant to their own experiences. One psychology professor shared what a doctoral student expressed about the program:

> *"He was telling me that he likes his psychology doctoral program but also doesn't see faculty or students of color. And it's not only that, but he doesn't feel like the curriculum is inclusive. And when you talk about the different professions and the different fields, psychiatry and psychology could be considered more similar. We have social work, where the field in and of itself is much more focused on addressing social and structural barriers to care, accessing services, and things that are important issues that people of color often face.*
>
> *And I think that the curriculum in psychology programs should be inclusive. There should be more faculty hired that are more representative, and at the same time, the curriculum could be improved so that it doesn't differ from social work and that type of field."*

These programs may also feature didactic styles of learning that fail to appreciate the varying educational paths of the student body, including BIPOC students. In response to these obstacles, interviewees mentioned that establishing support systems for students is vital, such as student groups and mentoring programs that center their identities and experiences and provide safe spaces for them to be together.

Students from marginalized groups also experience negative statements or behavior directed at them based on their identity, which contribute to an unwelcoming or even hostile learning environment. Even when BIPOC students gain access to historically exclusive spaces, the racism and discrimination that historically excluded them continue to operate in powerful ways. A common way this occurs is microaggressions, defined as unintentional yet discriminatory actions (verbal or non-verbal) that reinforce the presumed inferiority of marginalized groups often normalized by individuals in more dominant groups. The messages conveyed are marked as aggressions in that they are harmful to the well-being of the group in which the messages were directed toward. They often function to deprecate the assets that BIPOC folks bring to these positions and roles, so as to further delegitimize their presence in the space,

such as a BIPOC clinician being told "but you don't sound like a therapist" if they are using plain or colloquial language.

Microaggressions, as well as other forms of discrimination like tokenism (i.e., being treated as a spokesperson for one's identity group), can lead students to feeling as though they do not belong, they are undervalued, and they are intentionally excluded.[80, 81] One social worker described how alienating these experiences can be, sharing:

> *"Once we are in school, we are faced with systemic racism—we are not always validated for our knowledge and expertise in areas. And we may be used as examples in classroom settings when discussing cases related to racism and injustices, and this causes more harm and shame in the classroom … and causes us to want to be invisible and drop out. We do not feel safe in classes that are predominantly guided by white professors and white students with privilege."*

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An MSW student described superficial treatment of racism in the curriculum:

> *"I feel like in most classes, I was the only Black person, so there's a lot of topics … discussing racism, and I'm just like, 'I don't really need to be taught this, I live this!' I sat in [class] for three hours talking about racism, and you guys did not ask me once if I was okay; this is not something that I need to learn."*

Repeated experiences like these can compound one another, eventually leading BIPOC professionals to leave their jobs and/or the field. One professional reflected:

> *"I still look back at those who are left behind because of the same feelings that I was feeling: being shut down, not being allowed to talk because my voice was not valid, and being told I did not have good input. I started walking out of meetings because they shut me down too much, so I decided I would leave."*

A study examining the impact of discriminatory behavior found that BIPOC students in graduate psychology programs experienced frequent race-based microaggressions and lower levels of belongingness, which were closely associated with lower levels of academic engagement.[82] Another study at a school of social work reported a vast majority (98.8 percent) of minority students having experienced microaggressions.[83] Moreover, in addition to microaggressions, BIPOC people continue to experience overt discrimination as observed in graduation rates: more than half of those who graduate, on average, are white.[84] The discrimination and unconscious bias that form the basis for microaggressions affect how BIPOC people "show up" in these spaces and function to depreciate their assets and marginalize them, even when they are present.

Discrimination and microaggressions are further experienced by subpopulations such as the LGBTQIA+ community, compounding their effects for BIPOC students with multiple marginalized identities. A survey of social work students found that LGBTQIA+ content in the classroom is often excluded or tainted with anti-LGBTQIA+ bias and that educators may lack the necessary preparation to tackle issues of homophobia, heterosexism, and transphobia, which leads related microaggressions to be overlooked and unaddressed.

In the classroom, LGBTQIIA+ students may experience microaggressions in the form of slurs,

stereotypes, or having their experiences invalidated. Specific transphobic microaggressions encompass behaviors such as misgendering or disclosing someone's identity without their permission denial of privacy. Consequently, these microaggressions contribute to students feeling unsafe and unsupported, compelling them to take on the role of educators or tokenistic spokespersons for their respective identity groups. As a result, their academic and social engagement may suffer. The patchwork of labor protections in the U.S. leave TGNC individuals particularly susceptible to discrimination in hiring.[85, 86]

Lack of financial support, financial pressures, and cost of tuition are obstacles echoed by students across clinical degree paths. BIPOC students report not consistently being made aware of or having access to adequate funding. In a study assessing the influences of finances on students' well-being, non-traditional students, first-generation students, and students from lower socioeconomic backgrounds were more likely to encounter challenges focusing on their academics due to financial stressors and worries.[87]

One of the largest financial stressors is the sheer cost of college tuition, leading to fairly large amounts of student loan debts for many students. A Council on Social Work Education report highlighted how nearly 75 percent of social work undergraduate and graduate students have loan debt, with the average debt of $29,323 and $46,591, respectively.[88, 89] This debt can surpass $100,000 for advanced degrees in psychology and psychiatry.[90, 91]

Field education is an essential component of the mental health profession as it allows students to apply what they have learned in school to real-world settings, yet the volume of hours required and lack of payment for them disproportionately burden low-income students. For the helping professions specifically, students may struggle to balance the volume of academic and professional training required for their degrees with the limited time they can commit to working in order to pay for school; degree requirements can exacerbate financial hurdles, and vice versa.[92] MSW students pointed to completion of unpaid internship hours, a condition of enrollment at all accredited social work schools, as a major barrier to maintaining gainful employment outside of school. Such challenges are experienced disproportionately by BIPOC students.[93] One student described this dilemma:

> *"I think the biggest barrier to completing a degree not just for me, but probably for most students is the … hours for placement just because that's a big deal to lose out on a day that you could be working."*

The Council of Social Work Education (CSWE) requires MSW students to obtain 900 hours of supervised field instruction.[94] However, some social work graduate programs require more, presenting a substantial hurdle to students financially as well as for program completion. As one student stated,

> *"The CSWE has a minimum of 900 hours for an MSW student but in our school, we're working 1,200 hours to graduate. All this unpaid time is at our own expense, or we have expenses throughout the process, particularly students who are working in the [Department of Education (DOE)] are made to pay for their own fingerprinting or certain background checks. I've heard of students having to pay to get drug tested."*

Some graduate programs may simultaneously discourage students from working for pay during the rigorous field placement hours:

> *"The [school] discourages students who are working part time. But everyone has to work. I don't know anyone who's not working."*

In fact, students shared that this sentiment begins when applying to the program:

> *"During the application process, it tells you multiple times that you cannot work full-time and be a full-time student and I read that three times and then I was like, okay, that must be serious. I need to make sure that I have enough savings and still I worked throughout my whole first semester."*

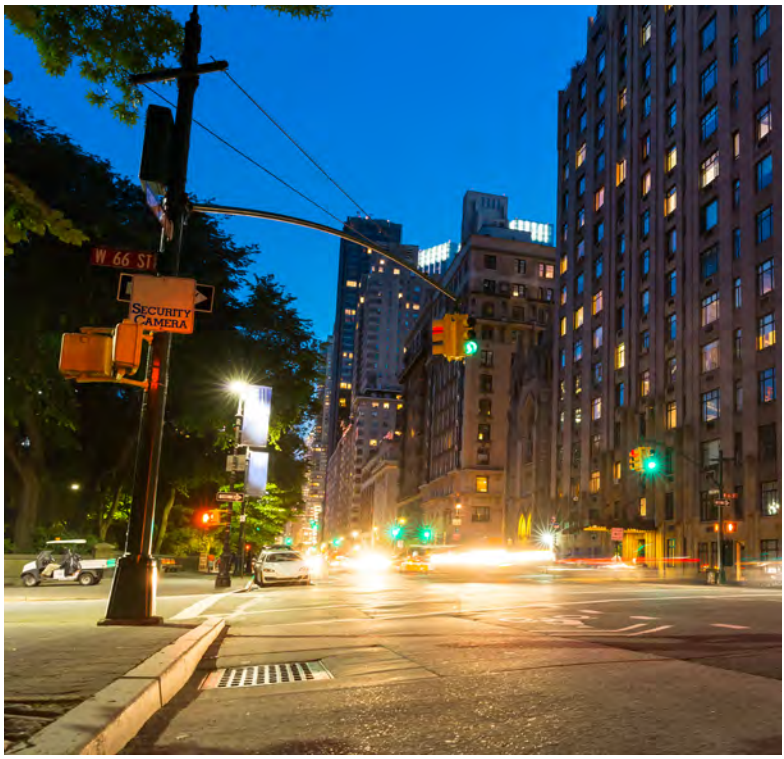
Beyond requirements for field hours, the placement settings themselves can be hostile environments. BIPOC students face barriers during interviews for placement, with supervision, and in trying to establish relationships with staff at the agencies where they are placed. A study of BIPOC social work students found that these students often had difficulty with cross-cultural conversations with their instructors (who most often are white, due to lack of representation in the field), particularly on issues related to race. This experience often led to racial tensions within the placement environment, as well as microaggressions and tokenism. Regarding tokenism, these students struggled to balance the negative experiences of feeling as though they were the token person of color with the recognition that their presence was important to make change in the field.[95] Much of the onus currently is on students themselves to assess the placement climate. For instance, during pre-placement interviews, students are advised to ask about any agency's policies (e.g., policies around anti-racism and discrimination). Through these questions, BIPOC students might be able to gauge whether their potential supervisor has in-depth knowledge and practice around these concepts.[96] However, they do not fundamentally alter the placement sites/staff themselves, and in their positions of power, potential supervisors could also view these questions as provocative or evidence of a poor fit with the student.

Issues with field placements were made clear in focus groups with students, with students expressing being treated as an administrative employee and not provided with educational learning opportunities; some students mentioned that their internship consisted of unloading boxes and pantry work, for example. One student expressed:

> *"It's not fair because we have a whole year of doing things that do not benefit us. We're paying the tuition for it. We're not getting paid for this labor. It takes away time from an actual job."*

Students were wary of speaking out about issues with their placements because of the power imbalance:

> *"We are seeing the way that students are collectively punished for speaking out about their field placements. I was like, I'm not going to say anything. What I don't want is for me … to say, 'hey, this field placement is really messed up', and for them to put me on an internal student review… where they suspend you."*



Despite the hurdles students face, they find community and support amongst each other and from mentors in the field. Another student upon reflecting on her first year in the program mentioned:

> *"It makes no sense to stop because there's barriers. You put your eyes on your goal, and you accomplish your goal. I want to be a therapist, so even though my first year wasn't the best...I have to suck it up because at the end of the day, I'm going to be a therapist. I'm going to help people in the way that I wasn't helped."*

Advanced Degree Completion is Only Part of the Battle

To become a clinical social worker, psychologist, or psychiatrist, individuals must meet specific requirements, including exams, in order to obtain licensure. This study focused on clinical licensing in the state of New York to illustrate an example of the requirements needed for these specific clinical professions with regard to education, experience, and licensure fees (see Table 1). In addition to exam and registration costs, test takers often spend hundreds of dollars in test prep material or courses. Although requirements may be consistent across the country for psychiatry, requirements for other fields vary substantially from state to state. For example, although most states will grant licensure to individuals with a bachelor's degree in social work, Connecticut, Colorado, and New York grant licensure only to those with their master's degree in social work (MSW).[97]

Social work graduates who wish to enter the clinical field or be competitive in the job market must also take the Licensed Master Social Work (LMSW) exam, which costs $524. Throughout the focus groups with MSW students, it was clear that the cost of tuition and limited time to work due to completing field placement hours makes it difficult to pay for the LMSW exam. An MSW student referring to the exam mentioned:

> *"How are we supposed to have money to pay for the exam? I still haven't gotten a full-time job yet, and you're asking me to ... dish out more than $500 to pay for this exam, to potentially get a job. And then on top of that, I must fight for [a] $65k salary."*

An Licensed Clinical Social Work (LCSW) social work advocate on licensing and pay equity for social workers mentioned that the LMSW exam is another barrier for BIPOC people and people with disabilities to become clinicians. The social worker stated:

> *"We're being tested on how well we create relationships. How do you test for that in multiple choice? It doesn't make any sense to evaluate us on a metric that doesn't apply to our field. It's 'white nonsense;' it's a standardized test for a specific person and learner ... We need to deconstruct how people feel about the exam being the means to the end of licensure. I think a lot of people have trouble divorcing themselves from that, even though four states have eliminated the exam so far."*

"We're being tested on how well we create relationships. How do you test for that in multiple choice? It doesn't make any sense to evaluate us on a metric that doesn't apply to our field."

Similar to other standardized tests, the LMSW exam is in English, and this format has critical consequences given the high demand for Spanish-speaking social workers. A Latine clinician and advocate elaborated:

"We need to create the exam in Spanish—that's the language that's most needed, due to the fact that we have many bilingual and bicultural social workers that think in Spanish [who] are serving the communities that speak that language. And the exam is harder to pass when it is not in a language that you are thinking in. I made this recommendation to the DOE and I was told in order to be a social worker, you have to know English. Everyone is asking for bilingual social workers, but you are not providing a pathway for that, because the exam is only in English."

TABLE 1. CLINICAL LICENSING REQUIREMENTS IN NEW YORK[98]

	Social Workers	Psychologists	Psychiatrists
Education	Master's degree in social work (M.S.W) or its equivalent	Doctoral degree in psychology Successfully defended dissertation	Pre-medicine undergraduate requirements Medical school (approximately 3-4 years)
Experience	At least 36 months (3 years) of supervised experience, in diagnosis, psychotherapy and assessment-based treatment planning under a qualified supervisor Must first become an LMSW to complete experience and then apply for LCSW	2 years of full-time supervised experience (1750 clock hours per year) or part-time equivalent No more than one year of full-time supervised experience or its equivalent as part of an internship may be submitted. The remaining experience must be completed after receipt of the qualifying doctoral degree	4-year residency emphasizing biology, psychology, and social components of mental illness, 1,500 contact hours of supervised experience in which no less than 750 hours must consist of direct contact with clients Remaining activities not involving direct contact with clients may include supervision, personal analysis, and professional development but all under the same supervisor in the same setting General/Adult Psychiatrist- 4 years total after residency (3 years of training and 1 internship) to be eligible for board exam for psychiatry Child Psychiatrist - same as general, but with a 2-year fellowship
Fees	$294 for licensure and first registration Once approved by state or provincial social work board, eligible to register with ASWB for clinical exam $260 [99]	$294 for licensure and first registration Once approved by state or provincial psychology board, eligible to register with ASPPB for clinical exam (EPPP Part 1-Knowledge) Exam fee $600 + Pearson test site sitting fee is A$91.88 = $691.88; EPPP (Part 2-Skills) has not been adopted in NYS	3 sets of exams to be licensed physician ABPN: part I of the boards at the of second year, part II during internship, and part III after internship - initial certification exam fee = $1,945; initial subspecialty certification exam fee = $1,900[100] $371 for licensure and first registrations; medical licensing exam
Continuing Education	Complete 36 hours of continuing education during each 3-year registration period	Complete 36 hours of continuing education every three years	Complete 50 hours of continuing education (25 of which have to be formal credited materials) Renew license and prescriber number every two years (costs about $1,500 combined)

One organizational leader that serves immigrant survivors of domestic violence stated that:

> *"[Mastery of] language is the hardest thing [to find], especially for our social workers. There is no role where we cannot have someone without a strong mastery of the [non-English] language. Someone must have a deep or preferably a native understanding of the [non-English] language to be culturally affirming, especially when providing mental health services. Someone needs to be fluently bilingual … to be able to understand nuances in the discussion and host mental health discussions. So many people say they are, but they aren't. Language fluency is one of the hardest things to come across."*

Much of the existing literature on clinical licensure and the challenges associated with obtaining it are in reference to social work. However, it is likely that similar challenges exist across other clinical licensing requirements. When examining licensing rates among social workers, the number of first-time clinical exam test takers has increased steadily from 2011 to 2021. During this time, test-takers mostly identified as white, making up 75 percent in 2011 but falling to 63 percent in 2021. The decreased proportion of white first-time test-takers coincides with an increase in the proportion of first-time test-takers from BIPOC communities, which grew from 21 percent to 35 percent.[101] Looking at clinical exam performance by race/ethnicity for first-time test takers from 2018-2021, pass rates were typically highest among white test-takers, averaging 84 percent, whereas Hispanic/Latine (65 percent), Native American Indigenous peoples (63 percent), and Black (45 percent) had much lower first-time pass rates.

Eventual pass rates (whether on the first or a subsequent attempt) indicated higher pass rates overall across all racial and ethnic groups but showed a similar pattern of disparities in performance as first-time pass rates (white: 90 percent; Hispanic/Latine: 77 percent; Native American/Indigenous peoples: 74 percent; Black: 57 percent).[102] Similarly, a survey of American Psychological Association (APA) members found that while most (90 percent) of the members passed the Examination for Professional Practice in Psychology (EPPP) on the first try, the likelihood of a member passing was greater for white test-takers compared to BIPOC students, highlighting the need to examine these tests to address any racial biases as well as provide support specifically for these students.[103]

Given the time and cost commitment associated with the more advanced clinical degrees such as social work, some students may gravitate towards other master-level helping professions perceived to be more easily obtainable. For instance, clinical pathways such as marriage and family therapists or mental health counselors are growing in popularity given that these degrees can often be completed much more quickly and with fewer costs compared to the more advanced and lengthy degree program pathways for social workers, psychologists, and psychiatrists, as described above. Accordingly, from 2018 to 2022, the number of licenses issued for both marriage and family therapists and mental health counselors saw a steady increase.[104, 105]

Mental Health Professionals Experience Barriers Even When Remaining and Advancing within the Field

Effective helping professionals show the ability to be empathetic and compassionate toward the communities they serve. Yet, it is these same qualities that also put helping professionals' emotional and psychological well-being at risk. As noted above, helping professionals of all backgrounds, but perhaps BIPOC people in particular, are driven to enter these fields because of their compassion, desire to improve the field for people

like them, and to better support their communities. But these professionals, both clinical and nonclinical, are susceptible to burnout given the nature of their work. Burnout among mental health professionals has been shown to lead to anxiety, poor performance, a lack of personal fulfillment, and negative interactions with clients.[106]

Common causes of burnout amongst helping professionals include negative work environments due to high caseloads, and lack of professional support and supervision.[107] For reference, an average caseload size for a child welfare worker ranges from 24-30 per social worker, though Child Welfare League of America recommends a social worker's caseload not be more than 15.[108] A study on burnout amongst BIPOC social workers in New York indicated that respondents were chronically stressed and that burnout was related to issues of large caseloads, low or unequal salaries, and other workplace stressors (e.g., staff shortages, poor supervision).[109] One helping professional interviewed for this project shared:

> *"Exhaustion for sure is the biggest factor. Deep drain and sadness. It's beyond that. You know when your mom says, 'I'm not mad, I'm disappointed.' It's that feeling times a million. I'm pouring myself [into this] and I don't have more to give."*

There was resounding consensus around these feelings of disappointment and disillusionment. Another individual added:

> *"I think that a lot of people burn out because they want to help and they want to do good. And they feel like they can't, and so you have … moral injury. Moral injury over and over and over again. And then you leave."*

In response to burnout, many workplaces have created affinity/support groups to achieve a better work-life balance, and to address the trauma of working as a helping professional. Oftentimes, however, they take place during off-hours, and BIPOC individuals who are already overburdened at work and other life demands may find it difficult to take part in them.

Helping professionals dedicate their time and careers to helping others, many with complex mental health needs. It is through this assistance, and through their expression of empathy, that helping professionals may be exposed to trauma. Helping professionals, therefore, may frequently experience the emotional and physical impact of direct or indirect exposure to clients' negative life events or trauma—increasing the potential risk of compassion fatigue. Compassion fatigue involves a reduced capacity for empathy as a result of chronic vicarious exposure to trauma, with symptoms often including difficulty concentrating, low self-esteem, guilt, anxiety, and possible intrusive thoughts. In turn, work performance and personal relationships may be negatively impacted, especially if symptoms are not addressed.[110]

Discrimination and microaggressions occur beyond the classroom and constrain opportunities in the workplace, too. For instance, at work, microaggressions experienced by BIPOC individuals may include someone describing a Black co-worker as "articulate" after a

presentation they have given, or excluding a colleague who identifies with the LGBTQIA+ community from an informal social gathering. Microaggressions such as these can potentially become disruptive to an employee's workday as they try to navigate and process these dynamics.

If individuals report or confront these experiences, they may be subjected to victim blaming, convinced to question their own perception, or open to further microaggressive experiences (e.g., seen as oversensitive).[111] Collectively, microaggressions can lead to a lower sense of well-being for employees that can, in turn, have a negative effect on their performance and their tenure at the organization.[112] When BIPOC professionals encounter microaggression in the workplace, it leaves them feeling disheartened and vulnerable. One psychologist stated:

> *"I think there's two Black women psychologists working with children in all of the [hospital] network … so there's an isolating piece to that. There's a piece about if microaggressions happen, do I want to be the one to speak up? I already feel isolated. Why does it have to be me?"*

Another helping professional shared:

> *"I would say as a woman of color, a lot of time people second guess my ability, which leaves you having to prove yourself that you're capable so people can see you as an expert. I am also young, so I have to triple prove myself."*

In addition to microaggressions, BIPOC people continue to face overt discrimination and barriers to hiring and advancement (e.g., hiring disadvantages, exclusion from social networks, and wage disparities).[113] In a study conducted by the Pew Research Center, a quarter of BIPOC adults reported being treated unfairly when it came to being hired, their pay, or promotional opportunities. With regard to pay in particular, for example, Black people make on average 75 percent of white people's earnings, with the gap narrowing only slightly over the last few decades; the gap for Hispanic people is even greater.[114] The result, as one professional described it, is organizations "look[ing] less diverse as you get further and further to the top." Another helping professional cited "not having leaders that look like us" as a major obstacle to the overall advancement of BIPOC individuals.

A common barrier to promotion and advancement is the lack of available opportunities within and outside of their current organizations. One CBO leader shared, "I see folks leave us because there is no upward mobility." Even when workplaces have more opportunities for senior positions, existing staff may not feel that they would be competitive for these opportunities if they do not meet the exact qualifications for the role. For instance, such positions are typically advertised to those with advanced degrees, discouraging those with lived experiences from applying if they lack paper credentials. One frontline worker explained:

> *"When you first look at fancy titles, you wouldn't think you qualify for them … My mentor used to tell me, 'Even if you don't have the credentials, apply anyway.' [It] opened the door to many more opportunities [for me]."*

Indeed, preferences for individuals with advanced degrees often overshadow similarly-situated candidates whose expertise is drawn from lived experiences. One frontline staff member described this as the "paper ceiling": individuals without advanced degrees who would otherwise succeed in an advanced role are not meaningfully considered for promotions. One executive director explained their decision to pursue an advanced degree after serving as a top-level peer, saying:

"My experience was just as valid as anyone else there. But I needed a degree, and there was no mobility for me without it."

"My experience was just as valid as anyone else there. But I needed a degree, and there was no mobility for me without it."

Helping professionals in interviews and focus groups all shared that lack of a livable wages and the burden of additional responsibilities contribute to burnout and high turnover rates in the helping professions. A psychologist stated:

"There is a standard salary that you really can't get above. ... So that's another aspect of burden that if you do want more income, there's all these other hurdles that you have to jump over."

A clinician who works in private practice echoed that sentiment and added:

"There is a lack of information about the business of social work. How to grow a practice, have wealth - that we all deserve - and not feel bad to get paid for your time. I get paid for my time just like a lawyer would ... There is this idea that if you are a social worker you are doing this out of the good of your heart and if you are asking for more, it goes against your values."

Helping professionals who are bilingual also mentioned lack of compensation despite mastery of another language, as reflected by one Latine social worker:

"Because we know the language, more is asked of us so we are less able to give to ourselves. We have a higher burnout rate. We need to stop overburdening our social workers of color with too many caseloads and not enough compensation and not enough time for self-care."

Furthermore, non-clinical helping professionals (e.g., case managers, credible messengers, etc.) who wish to advance to a clinical role face challenges balancing their need to support family with wanting to pursue a clinical pathway. One helping professional said of advanced degree requirements:

"It is such a sacrifice here and it is a huge barrier to our [non-clinical] staff even if they love the idea of being a clinician. A lot of people have to support their households and can't afford to live like a college student."

A related theme expressed by CBO leaders and frontline workers with lived experience is that the helping professions overall do not value lived experience. CBO leaders mentioned that one of the root causes of the issue is grant or funding requirements that require social workers but do not provide adequate pay or opportunities for people with experience but no credentials. A CBO leader emphasized that:

"You might have positions in mind, but you have to tailor it to the RFP. In order to get the contract, the position has to be a master's with 8 years' experience...etc."

A clinician echoed this issue and added that people with lived experience with years in the field are often in the position where they are not paid adequately due to not having credentials, but are nonetheless given additional management responsibilities:

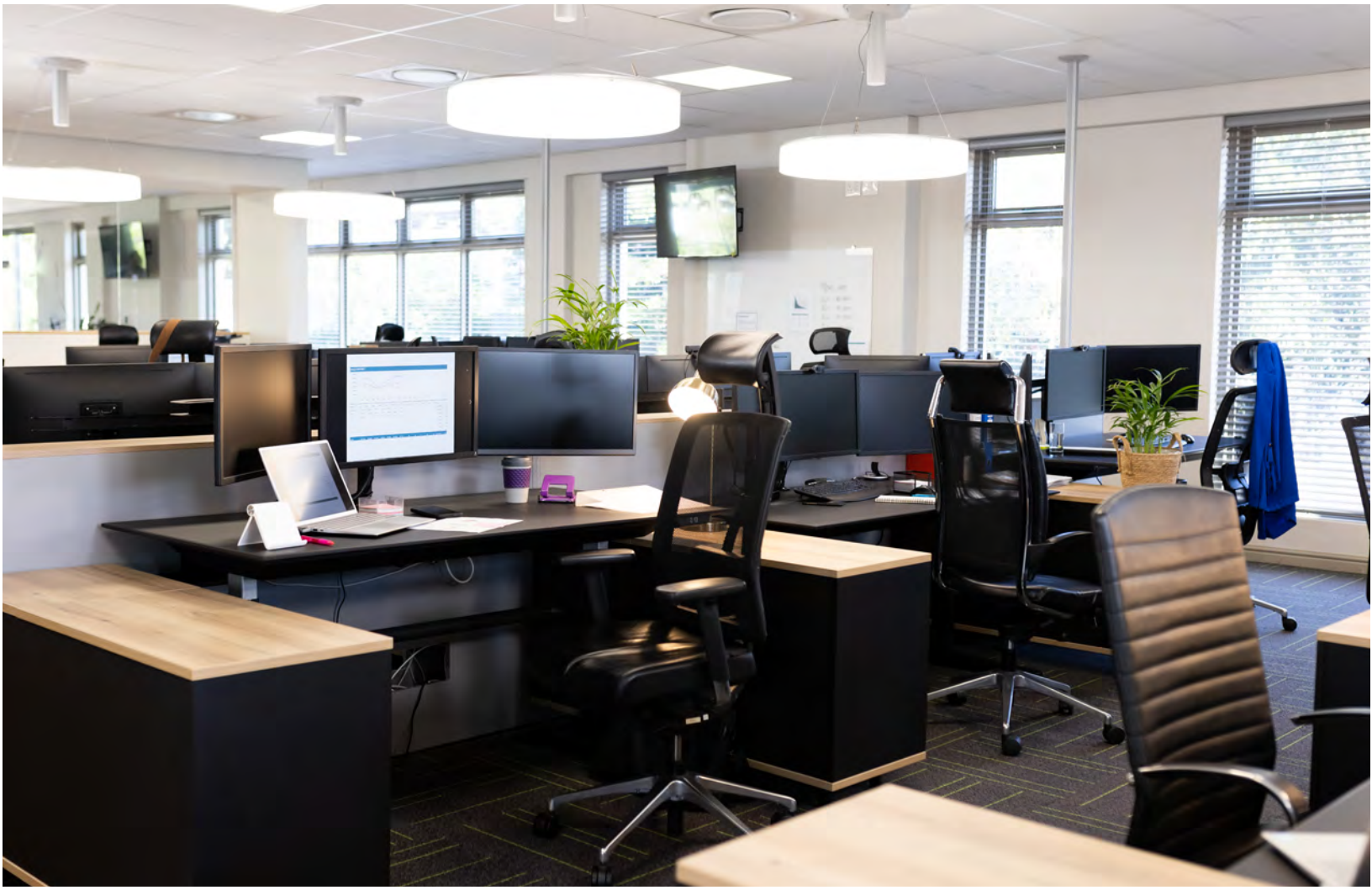
"If I am not promoting you because you don't have the master's [degree], but if I give supervisor level responsibilities, maybe I should start promoting you to the role because you are doing it."

The focus groups and interviews all echoed the same sentiment, that people with lived experience may not have the paper credentials but do have the expertise to help their communities. One helping professional stated:

> *"You want degrees, but how can I give you those degrees when you won't let me into the colleges. People believe that with this kind of background you are supposed to be a warehouse worker... and that's what the image is. People who are the closest to the problem are often the closest to solution, but furthest from the resources."*

Another helping professional shared that lived experience is not viewed as a legitimate substitute for advanced degrees:

> *"Certain positions you want, but you can't [have]. You're great at your job, but you need that piece of paper to make money. I see that across the board. It's hard continuing education and moving up; you can be stuck. [You can] have the experience, but not the degree."*



Recommendations

In this section, CUNY ISLG synthesizes the recommendations that emerged directly from three sources: fieldwork (interviews and focus groups), literature review, and discussions with the Advisory Group. The Advisory Group reviewed a draft list of the recommendations to indicate priorities and, conversely, areas where the landscape is already saturated. Although these recommendations are not fully operationalized for a specific context or project, they offer possible areas of investment which should be considered and explored further.

These recommendations, drawing from interviews and focus groups, are condensed and organized into 13 different topic areas related the particular problem they aim to address. They are clear responses to the barriers summarized in Section I of this report. The barriers prevent BIPOC individuals from entering and advancing in the mental health field, and this section of the report presents opportunities for how to address them. They are organized around the particular problem they aim to address, such as increasing exposure and awareness, addressing microaggressions, and providing opportunities for advancement. More broadly speaking, they could be implemented across four primary domains relevant to this project: educational settings, workplaces, the local community, and policy/advocacy.

1 CREATE A CONTINUUM OF EXPOSURE OPPORTUNITIES FOR FUTURE BIPOC HELPING PROFESSIONALS.

Create a Continuum of Exposure Opportunities for Future BIPOC Helping Professionals. Community-based organizations are support systems for underserved communities and play a critical role in building awareness of the career opportunities in the mental health field. Likewise, schools—starting in elementary and all the way through postsecondary—are often the first exposure for young people to possible careers they may want to pursue. Accordingly, awareness of the helping professions could be increased through a three-pronged approach, potentially led by CBOs with legitimacy in communities where BIPOC people live:

1.1 Expose young people to careers through school-based programs and guidance counselors.

This may include leveraging influential people (e.g., practitioners, educators, counselors) in promoting or demystifying their profession and related career pathways to clients/patients/students. Several approaches could be deployed, such as presentations, informal discussions, workshops, and the creative use of marketing strategies (see below), all of which have the potential to communicate information about educational programs and how they transfer into potential employment in the helping professions.[115] Additional school-based pathways could include leveraging engagement in field-related activities to inspire pursuit of the activities as a career (e.g., discussion of a pathway to becoming an art therapist while engaging youth in art therapy). For example, the Charles R. Drew University of Medicine and Science offers the Community Health Youth Advocates (CHYA), a year-long academic program for high school students to learn about the healthcare landscape, health disparities on a local and global level, and empower them to design their own path toward a degree and career within the field of healthcare.

1.2. Center recruitment activities in underserved communities.

Efforts to have an explicit presence in histori cally underserved communities (e.g., geographic locations such as Brownsville, East Harlem, South

Bronx, etc.) to reach those who may have interest in entering the field but don't otherwise have exposure to, or access to information on, the varied careers and educational pathways. Outreach could be implemented by a variety of stakeholders, including CBOs and educational institutions, and could take several forms, including:

1.2.a Leveraging community-based partnerships to conduct street outreach in neighborhoods with concentrations of people with key lived experience to promote employment and educational opportunities.

This can include community career and college fairs that promote certification programs (e.g., Hostos Community Health Worker Program). Community outreach can include intentional outreaching methods such as mobile activities. An example of mobile outreach is Bronx Móvil, a bilingual mutual aid collective that provides mobile harm-reduction services, nutritional support, urban living supplies, and community trainings to people who are unhoused in the Bronx and Washington Heights. Creating community partnerships with intentional outreach activities that target key areas in NYC where there is a lack of information and resources can increase knowledge of available resources and supports for entering the field.

1.2.b Conducting outreach in local institutions and businesses, such as barbers or beauty shops, to promote relevant career and educational pathways.

The Confess Project's Beyond the Shop: Barbershop Mental Health Advocacy Training prepares hairstylists to take on the role of health workers,[116] offering insight into how local institutions can help expand what are considered effective mental health approaches. Specifically, these efforts include implementing new and highlighting existing approaches for BIPOC people founded in community care (e.g., support within the broader community, culturally based practices such as informal support systems with culturally rooted values, behaviors, and customs), and self-directed care (e.g., emphasizing autonomy in the type of services received).[117] When needed, community members could additionally be linked to other local CBOs/funding for financial or service support while they pursue mental health certifications.

1.3 Create marketing and social media campaigns targeting teenagers and young people, such as on TikTok.

Many CBOs and mental health professionals do not have the resources to develop customized and impactful marketing and social media campaigns. A campaign could be supported by a third-party expert who could provide training and/or develop communications guidelines and materials, including input of CBOs, mental health professionals, and key leaders/influencers. The campaigns could distill complex clinical ideas into digestible tidbits while also promoting pathways into the field.

2 PROVIDE TRAINING & TECHNICAL ASSISTANCE TO NONPROFIT AND UNIVERSITY LEADERSHIP TO PROMOTE HOLISTIC, EQUITABLE ADMISSIONS AND HIRING

2.1 Support more holistic admissions approaches.

Advocate for and support educational institutions in moving away from strict merit-based operations, starting with the continued de-emphasis of standardized tests, such as the SAT and GRE. A holistic admissions process involves reviewing the whole individual and incorporates other information about them (e.g., volunteering experience, whether they speak another language), rather than reducing their application to test scores and grade point averages. This approach shifts from the person's success as a student to how the person will contribute to the profession. It calls for balancing academic metrics with experiences and attitudes.[118]

Develop centralized guidelines that include academics, skills (e.g., bilingual ability), and fieldwork experience and/or volunteer experience. A holistic admission process does not only focus on grades, but also the student's ability to engage with faculty and their peers, contribute to the learning experience, and overall thrive in college; in turn, this process will also foster a more diverse student body.[119]

2.2 Foster more holistic hiring approaches

Create toolkits with resources for institutions to use in lieu of, or as a complement to, traditional approaches to hiring. These toolkits would promote current best practices in hiring and recruitment, which in turn would lead to more equitable hiring practices. A finalized toolkit could include relevant frameworks, considerations for hiring experts with lived experience, guidance on participatory decision-making, and considerations for selection criteria which reduce barriers for candidates and mitigate the impact of bias on the hiring process.

3 OFFER FINANCIAL SUPPORT AND WRAPAROUND SERVICES TO BIPOC STUDENTS WHO ARE PURSUING CAREERS IN THE HELPING PROFESSIONS

3.1 Offer and expand scholarship programs for underrepresented students in mental health and/or helping profession degree programs.

Recently, the Governor of New York announced $4 million in federal funding to support underrepresented students entering or enrolled in mental health degree programs at City University of New York (CUNY) or State University of New York (SUNY) campuses to provide assistance with tuition, paid internships, and offer stipends to multilingual and minority students. This initiative not only aims to address the lack of diversity in the field and the disparities in care delivery for marginalized populations that can stem from a lack of representation in the workforce, but it also incentivizes minority and multilingual students to enter or continue a path that will prepare them for the mental health field.

Similar investments could have the greatest impact at public institutions which, compared to private institutions, typically cost less, have fewer

financial resources, and are disproportionately more likely to enroll BIPOC students. However, since not all prospective students are admitted to public programs, scholarships or financial resources for BIPOC students in private institutions should also be considered. A funder may wish to target select areas for improving representation, including ethnic or cultural backgrounds, language, identity, or lived experience, among other characteristics.

3.2 Provide wraparound services for students in addition to scholarship support.

This can entail connecting students with housing, childcare support, food pantries, transportation and other services. For instance, CUNY's Medgar Evers College provides students who are predominantly BIPOC with heavily subsidized childcare through the Ella Baker/Charles Romain Child Development Center. In addition, the college helps unhoused students navigate the shelter system to connect them to housing through the Transition Academy. Students who are facing food insecurity also have access to the school's food pantry.

3.3 Subsidize professional development (e.g., certificate programs) for community members and people already working in the helping professions (particularly those who are not in advanced/clinical roles).

This both strengthens pathways within the field for individuals and improves retention in the field by investing in fellowship programs and/or higher education for helping professionals or clinicians. Other options would be to provide free or low-cost continuing education which offers Continuing Education Units (CEUs) to licensed helping professionals. Given the costs associated with sustaining licensure, this would incentivize helping professionals to remain in the field while also enhancing their professional toolkit and/or advancing professionally. The benefits of peer-to-peer learning approaches is another consideration. As seen from the benefits of mentoring, treating peers as experts can be an untapped benefit to the field, including in the provision of continuing education. Peer-to-peer learning collaboratives that offer CEUs have the potential to be particularly powerful, such as with the Silberman School of Social Work at Hunter College's Community Navigator Program and Exodus Transitional Community's Center for Trauma Innovation (CTI).

3.4 Fund student internship placements.

The current systemic approach to unpaid internships disproportionately disadvantages students from economically marginalized households and historically excluded backgrounds. Allocate funding for students enrolled in mandatory internships within a helping profession degree program (e.g., MSW field placements, Mental Health Counselor internships). This funding would reduce the financial burden of internships on a student's ability to remain in higher education programs, thereby improving graduation rates. Funding could go to students directly (e.g., via scholarships/stipends), or to the institutions where they are employed (e.g., through a match program). Ideally, for organizations where students are placed, the paid placement would come with an expectation that the student can be hired full-time following completion of the placement hours.

3.5 Pay immigration fees for students who represent immigrant communities through their shared linguistic, cultural, and experiential background.

Social service providers struggle to recruit staff who have a shared cultural background with clients from cultures outside of the U.S. This need is also reflected in the broader lack of bilingual/multilingual helping professionals (e.g., due to a limited number of Nahuatl speakers among helping professionals, Nahuatl speakers are typically

offered services in Spanish, a language they may not be proficient in). While scholarships are a key resource, some talented professionals experience an additional barrier related to immigration. Funding could support immigration legal fees for working visas for 1) international students following graduation and 2) undocumented or out-of-status students and graduates.

3.6 Promote retention and recruitment of BIPOC staff through financial incentives, benefits, and resources.

Funds could support higher pay for clinicians and helping professionals. Also, provide advancement opportunities or financial incentives for specific groups such as people with lived experience, since that experience carries with it unique skills to support communities being served. Incentives could also include specific/additional compensation for helping professionals who are bilingual/multilingual, which could be paired with training that supports mental services being provided in languages other than English.

An investment could also involve advocacy or funding to CBOs to allow them to provide more comprehensive benefits for helping professionals, especially when unable to afford significant salary increases or when their funders impose salary caps. These benefits could include, but are not limited to, hybrid work schedules, childcare, transportation support, and affordable health coverage for employees and their families.

4 INCENTIVIZE REPRESENTATION IN DEGREE PROGRAMS AND WORKPLACES

4.1 Measure and track representation in the workplace/field.

Design a system to set targets and hold schools and employers accountable. The standards should not just focus on raw numbers, but rather, should focus on power structures, power sharing, and decision-making (e.g., if the CEO is a BIPOC, but the entire board is white, the CEO may still be relatively constrained in decision-making). Even if staff lines reflect participant identities, the measurement should assess who holds the power. An example of how measurement of representation in the helping profession workforce could be achieved is reflected in a report by New York City Department of Cultural Affairs Workforce Demographics Pilot Study.[120]

4.2 Link and expedite educational pathways.

By reducing the time required to advance through the academic components of clinical pathways, barriers for many students can be reduced. This may include combined bachelor's and master's programs ("4+1") or similar expedited pathways (e.g., students with a bachelor's degree in social work are eligible for Advanced Standing Social Work graduate programs, where they earn a Master's degree in one year). When programs are not linked, many students who otherwise could complete the requirements do not do so . Advocate for or provide support to develop these programs, especially in institutions where BIPOC students are already concentrated but where they may not be available.

5 CREATE MORE INCLUSIVE CURRICULA AND APPROACHES AT LEARNING INSTITUTIONS

5.1 Incorporate ethnically empowering curricula that centers culture and lived experience.

Develop and assess clinical degree programs that align with a commitment to anti-racism. Recognize and build the legitimacy of non-Western treatment models. Change standard practice and increase awareness of the innovative practice examples that respond to the wants and needs of underserved community residents, which will also increase the appeal of the professions. An investment would need to include BIPOC folks in the creation of new/recognized mental health, healing, and well-being approaches. This could include funding pilot programs that demonstrate and assess different ways of supporting mental health. Create ethno-culturally competent models across all three professions (psychiatry, psychology, and social work), such as core courses incorporating ethno-culturally competent approaches and their importance, where all students learn about the intersection of race and well-being (e.g., differences in metabolism, impacts of cultural differences on well-being). This knowledge is currently lacking in the field's preparation of future helping professionals.

5.2 Link and expedite educational pathways.

By reducing the time required to advance through the academic components of clinical pathways, barriers for many students can be reduced. This may include combined bachelor's and master's programs ("4+1") or similar expedited pathways (e.g., students with a bachelor's degree in social work are eligible for Advanced Standing Social Work graduate programs, where they earn a Master's degree in one year). When programs are not linked, many students who otherwise could complete the requirements do not do so. Advocate for or provide support to develop these programs, especially in institutions where BIPOC students are already concentrated but where they may not be available.

6 OFFER FOUNDATIONAL AND REMEDIAL COURSES FOR UNDERREPRESENTED STUDENTS AND PRACTITIONERS

6.1 Offer academic support to BIPOC students at the beginning of their college education to address any foundational/remedial needs.

Advocate for or provide remedial/foundational courses to account for disparate educational opportunities prior to postsecondary education (e.g., foundations in writing, math, and best practices for studying and time-management). This additional support could help prevent drop-out of new college students who otherwise could enter the helping professions. These could be offered at higher education settings or prior to enrollment in higher education, or outside of this setting.

7 PROVIDE MENTORSHIP AND INTERPERSONAL SUPPORT DURING DEGREE PROGRAMS, INTERNSHIPS, PLACEMENT, AND IN SECURING AND ADVANCING IN PERMANENT POSITIONS

7.1 Mentor new students.

As more individuals from underrepresented communities enroll in graduate programs, mentors must be supportive of students' academic and professional growth while also being culturally sensitive to their backgrounds.[121] Funding could support mentors, who may be alumni or college faculty (e.g., professors, advisors) to check in with students in the first few months of their program who may be at risk of dropping out/falling behind. They could also outline the steps needed to achieve their goals; many students go into psychology, for example, without knowing what they want to do, and may learn they need to complete certain milestones later in their trajectory, which delays their progress and risks abandoning their pursuit. This is particularly relevant to first generation students who may need additional support in navigating their career paths and workplace.

Mentors could also provide support in finding a clinical supervisor. In addition, they could provide transparency around the "business side" of clinical professions, including pay, the reality of private practice, and dismantling the idea that asking for more money, benefits, or support somehow makes the profession less altruistic (encouraging advocating for oneself). In that sense, mentors could be external to the higher education setting. Both the Mentoring of Students and Igniting Community (MOSAIC) program and Scholars Committed to Opportunities in Psychological Education (SCOPE)[122] provide mentoring that seeks to foster a sense of community among faculty and students through support, resources, professional development, and being culturally responsive to the needs of underrepresented students in the health and mental health fields.

7.2 Tap into mutual aid/support organizations to provide peer support.

In recognition of the value of peer support and the collective strengths of BIPOC students pursuing these fields, it is essential to promote and support mutual aid, affinity, or advocacy groups that are founded and run by BIPOC students in efforts to create community and uplift their peers. These informal supports are vital for students' success when pursuing these fields.

7.3 Draw on alumni to support BIPOC students.

BIPOC students could also benefit from connection with alumni who have experience in the workforce and can help with networking opportunities. Alumni could serve as mentors, per above.[123] Alumni offer students mentorship from the perspective of someone who completed the same program or had similar life experiences, and may fill gaps other mentorships are unable to meet. When alumni share similar identities to the students they are mentoring, it can help students feel a greater sense of connectedness to their career path.[124]

7.4 Offer mentorship throughout career trajectories.

Create opportunities for early career helping professionals to connect with mid-senior ones, (e.g., through an online network, and share challenges in their workplace). Identify sources of support to whom professionals can turn to and ask, "I've experienced harassment/microaggressions. What should I do?" Folks may be more likely to share challenges with someone more advanced in the field who is not part of their current workplace. Group mentorship approaches may be especially salient as a way to build connections/networks across new professionals to navigate their experiences. Mentorship should also not be limited to young professionals, but also include pre-career, mid-career clinicians, supervisors, senior leaders, and executive directors.

8 IMPROVE INTERNSHIP PLACEMENT EXPERIENCES

8.1 Expand the number and variety of clinical placements.

Incentivize a wider variety of organizations to host students. Partner with schools to increase the variety of placement opportunities. Develop internships that connect students to a greater diversity of practitioners, including those without master's degrees, as these professionals often have more field experience and valuable knowledge to impart, especially from more innovative and non-traditional perspectives.

8.2 Provide culturally responsive training to internship placement supervisors.

Increase their cultural responsivity and awareness to address misalignment between students and supervisors, which in turn may lead to students dropping out of the professional pathway. There is a need to foster environments of collaboration, teamwork, and culture open to addressing biases and microaggressions.

9 HELP STUDENTS PREPARE FOR PLACEMENT AND LICENSURE EXAMS

9.1 Prepare students for licensure exams prior to graduation (i.e., when students first enroll).

Pass rates are disparate across racial/ethnic groups, and targeted support during exam preparation could address the drop out associated with not passing on the first attempt. Support could be in the form of subsidized licensure prep courses that cover licensure topics on ethics, clinical approaches, cultural considerations, etc.

10 CREATE PATHWAYS FOR NON-CLINICAL PROFESSIONALS SEEKING EMPLOYMENT IN THE HELPING PROFESSIONS

10.1 Leverage volunteers, interns, peers, and participants to become staff.

Provide job or training opportunities to those in volunteer positions who were often participants themselves. Treat volunteer experience as work experience. These individuals already understand the value of engaging in this work and could be powerful advocates for it for others. Examples of such structures are evident in The Bridge Inc.'s Safe Options Support (SOS) Team and Exodus Transitional Community's Walking Through the Wilderness Workshop.

Funding could support volunteers directly while obtaining training, or could subsidize positions at CBOs to transition them into paid roles. The organizational and advancement structure could also incorporate peer supervision approaches to give non-traditional practitioners opportunities for growing in their helping career.

10.2 Establish certification programs and/or standards for translating lived experiences to bolster legitimacy, such as programs designed for formerly incarcerated people to become certified peers for system-involved youth.

Develop a program and/or develop guides for translating these experiences so that they are more universally recognized and valued by potential employers.

10.3 Expose non-clinical professionals to clinical professionals, and vice versa.

People working in the helping professions often experience feelings of being siloed, particularly if they are part of underrepresented groups. Consider strategies for cross-pollination/to learn from one another. Explore programs that center mutual exchange between non-clinical professionals (e.g., credible messengers) seeking to become clinical professionals (e.g., social workers), and vice versa. Doing so would expose both parties to more opportunities and field knowledge. Create networking opportunities for helping professionals of all different titles/career stages (i.e., clinician and non-clinicians, students in social work/psychology/public health programs) to foster meaningful partnerships.

10.4 Support clients in entering the profession through scholarship programs.

Establish funding for former clients and other people with lived experience to pursue or advance their careers in the helping professions.

10.5 Create a library of guides/resources that outline various career opportunities/paths.

These could include positions/careers that do and do not require a license. Even some folks who earn a license do not necessarily know all that they can do with it; they may just know that it helps them secure employment but not necessarily what kind.

11 INVEST IN ADVANCEMENT OPPORTUNITIES FOR BIPOC HELPING PROFESSIONALS

11.1 Create career exchange opportunities rather than linear pathways.

Entering the helping profession workforce can take many forms, including frontline workers becoming clinicians or people switching career fields. It is important to create web-like approaches that support growth and advancement into the helping professions rather than linear pathways. This could entail creating fellowship and certification programs that afford people the opportunity to enter and advance into the helping profession, or to be exposed to other careers within the profession where their skills and interests could be better supported.

For instance, the Institute for Transformative Mentoring has a certificate program for credible messengers that also provides college credit with The New School that can be applied to a degree. Similarly, Hostos Community College has a Community Health Worker Certificate Program that also provides college credit for those who wish to pursue a degree. Funding opportunities can provide additional support to expand certificate programs and networking opportunities mentioned above.

It is important to create web-like approaches that support growth and advancement into the helping professions rather than linear pathways.

11.2 Create leadership pathways for BIPOC helping professionals.

Nonprofits where mental health professionals practice are often led by white people and even by non-mental health professionals. Accordingly, there is a need for the field to develop leadership from within. Several approaches could help address this need: comprehensive and intentional tracks within degree programs, or continuing education and the fellowship recommendations described above. This could also include providing a repository of resources for clinicians to explore the "business side" of the mental health profession. BIPOC clinicians who wish to start a private practice that promotes social justice and innovative healing strategies would have access to guides in becoming an LLC or incorporated, navigating insurance billing for private practice, and equitable sliding scales for clients, for instance.

11.3 Provide government civil service requirements and exam information to graduate students.

Given the need to reduce the lag time from exam to hiring and the increasing number of civil service hurdles, allowing time for exam taking during graduate programs would be helpful. This also applies to community mental health workers and other non-traditional practitioners not pursuing a graduate degree who may qualify for government-based helping roles.

12 IMPROVE WORKING CONDITIONS

12.1 Provide meaningful self-care (e.g., paid time off, retreats, counseling) that goes beyond the bare minimum (e.g., pizza parties).

Consider how to creatively use building spaces to support staff, such as offering yoga to staff on Monday mornings when a conference room is unlikely to be needed. Provide non-traditional resources for staff that contribute to community-building and feeling valued/supported, such as. hosting events for staff and their families. Develop strategies to ensure staff engage with mental health/supportive services—sometimes it's not enough to just make them available). Specific strategies can draw from SimplePractice Learning's Compassion Fatigue Among Therapists of Color module, NSAW-NYC's Self-Care in Social Work webinar, and New York University's Silver School of Social Works' Clinician Care eight-week personal development course tailored for therapists, nurses, physicians, and other helping professionals.

12.2 Train supervisors.

Similar to with field placement supervisors, implement specific training and ongoing mentorship for supervisors or for workplaces more broadly, to address gaps in cultural knowledge and microaggressions.

12.3 Create and promote affinity/support groups for staff to connect with others with shared identities.

Funding could support their creation and operation, similar to how LGBTQ+ and race/ethnicity-specific affinity groups at many private employers. In particular, they should intentionally be scheduled during work hours to show commitment to staff support, balance, and self-care.

13 PROMOTE REFORMS TO ORIENT THE FIELD TOWARD JUSTICE AND EQUITY

13.1 Ensure that practicum/internship hours are paid and are on par with national practicum hour requirements.

For instance, the Council of Social Work Education (CSWE) requires 900 hours however, in New York, most Graduate Social Work Programs require 1,200 hours. Recently, a few of graduate programs in New York, such as the New York University's Silver School of Social Work, have changed their placement hours from 1,200 to 900. Unpaid internships are exclusionary, especially for students from economically marginalized backgrounds. The unpaid hours take a financial toll on students; subsidizing placements can assist students financially and encourage them to finish their program. Proposed legislation in Michigan would help address the issue of unpaid student internship hours for students pursuing mental health fields, and can be replicated and advocated for in other states, with appropriate funding.

13.2 Advocate for higher base pay, regular raises, and elimination of salary caps.

As educators see their salaries rise with experience, the same should be true for helping professionals. Government agencies and funders that support service providers/organizations could be lobbied to build in higher base rates and expectations for

normal raises and advancement, as part of their funding requirements. Foundations and federal, state, and local government institutions should remove salary caps in requests-for-proposals (RFPs). Doing so would also address the disadvantage many CBOs face, who often feel they are "in competition with" hospitals and schools who can pay more to social workers than CBOs often can.

Also, special considerations should be made when grants require credentialing of staff, including with respect to clinician requirements, language, and lived experience. This will allow CBOs to include helping professionals who do not have credentials but are experts in the field to lead projects, which would encourage mobility in the helping profession.

13.3 Require salary transparency.

Increase salary transparency, especially in spaces where there are racial and gender disparities in pay. Doing so may help close pay gaps and make the helping professions more tenable for BIPOC individuals. Yet, this should be done carefully, because on the flip side, it could unintentionally create a ceiling on people who don't have credentials. Efforts at greater transparency must be accompanied by commitment to valuing lived experience as well as more traditional pathways.

13.4 Remove criminal legal history as an automatic disqualifier from clinical careers, where applicable.

Some faculty are ineligible for tenure because of previous involvement with the criminal legal system. Similarly, individuals may not be eligible for licensure because of previous involvement with the criminal legal system. Instead, criminal legal history should be considered on a case-by-case basis. Recently, the APA voted to no longer ask about felony history on applications for membership; there is continued need for other professional associations and institutions to consider similar changes.[125]

13.5 Advocate for manageable workloads and additional support for clinicians.

High caseloads, coupled with poor compensation packages and a lack of employer support, have caused widespread burnout in the field. That burnout leads to skilled professionals leaving the field, and reduces the quality of services provided. To remedy this issue, ensure that clinicians have manageable caseloads and adequate administrative support. One lever for achieving this aim would be to articulate minimum standards around caseloads in funding opportunities.

13.6 Advocate to insurance companies and government for waivers and to address barriers of regulation and reimbursement.

Change the way mental health is practiced by leveling the playing field in terms of reimbursements. For instance, encouraging insurance companies to pay for outreach services rather than just diagnosis and intake. Currently, nontraditional outreach approaches are less likely to be approved for reimbursement, though using them may reach populations that traditional methods miss. Reimbursement for outreach specifically designed to reach populations that face barriers to engagement can help increase their access to services.

13.7 Allow for exams in languages other than English for bilingual, bicultural clinicians.

If the field continues to demand bilingual therapists, then the exams should be offered in more languages than simply English. By requiring a high level of English literacy to obtain licensure, language functions as a structural barrier to representation of those from non-English speaking countries and cultures (in addition to reducing resources for those seeking non-English language services).

13.8 Reform placement exams themselves.

In addition to supporting students to pass the exams at higher rates, the exams themselves could be reformed so that content is more relevant to different populations and to the fields themselves. Reforms could include incorporating cultural healing approaches or practices. In this vein, due to the disparate passing rates across BIPOC social workers in the LMSW exam, the National Association of Social Workers-NY Chapter and elected officials have proposed the Social Work Workforce Act, which moves towards repealing the LMSW exam in New York. Supporting advocacy measures in repealing this exam requirement could mitigate barriers BIPOC students and/or helping professionals face when pursuing the social work profession.

13.9 Require exposure to diverse perspectives, including for white students.

When completing clinical rotations, assign white students to BIPOC/LGBTQIA+/other identity-centered clinics to gain experience not only working with individuals unlike themselves, but also see them in positions of authority. Working in partnership with colleagues who have different perspectives, identities, and lived experiences opens up the clinician's world view and begins to dismantle biases.

Using these findings as a roadmap for going forward, CUNY ISLG seeks to continue this work. With all that has been done in the past decade toward righting inequities in the helping professions, the time is ripe to take a meaningful, data-driven approach to supporting BIPOC people in preparing for, entering, and advancing in these fields. CUNY ISLG welcomes any inquiries or collaborations from interested partners.

Endnotes

1. *U.S. Census Bureau Quickfacts* (United States Census, 2020), https://www.census.gov/quickfacts/fact/table/US/POP010220#POP010220. Please note, these are estimates and it is possible certain groups (i.e., Black, Latine, American Indian and Alaska Natives, and some other race) may be undercounted while non-Hispanic White and Asian populations may be overcounted

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