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Written testimony submitted to the Oregon Legislature

Chair Sanchez, Vice-Chair Moore-Green, Vice-Chair Nosse, and members of the committee. My name is Dr. Anjabeen Ashraf. I am here testifying in support of House Bill 2949 and the dash 5, 7, and 8 amendments.

I am a Licensed Professional Counselor in the stage of Oregon, a counselor educator holding my doctorate, and a private practice owner. I am also the first in my family to pursue a doctorate in mental health, a child of immigrants, a woman of color and a Muslim, those last two identities I do not see reflected in the mental health workforce in Oregon.

Imagine, as Dr. Blount and Dr. Johnson have just articulated that you are a counseling student who has undergone thousands of hours of training. Imagine you are a Black, Indigenous or Student of Color, emerging into a field in Oregon that is approx. 90% white. What are you, as a new BIPOC mental health professional emerging into? How will you survive, perhaps even thrive, and stay in the profession?

Financial solvency is one large barrier to entering and staying in the profession. Graduate mental health programs often cost more than the graduates can expect to be paid their first year out of school. Few scholarships exist to assist students financially in these programs. While in their program, students are expected to work for free in various mental health sites for experiential training.

The financial constraints continue after graduation, when the costs of obtaining the initial Intern license are the new graduate's responsibility. If the site does not offer supervision or they are in private practice, the cost of supervision is the new professional's responsibility.

During the post-graduate intern and supervised practice phase, new professionals can expect to be paid an average of approximately $45,000 before taxes and additional costs like supervision and licensing fees if working within an agency. If the intern goes into private practice, their income is limited to clients who can afford to pay out of pocket as most insurance companies will not allow interns to bill, which as you can imagine, limits not only who can afford to access their services but also the new professional's total income. Clearly, the time during and after their degree programs place students and new professionals in precarious financial situations.

The embedded classist expectations within our mental health professions lead to self-selection of certain backgrounds into the field. From the cost of the graduate programs, to unpaid internships, and underpaid post graduate positions, these barriers to entry are easier for some to overcome than others. For BIPOC communities, who on average hold less generational wealth than their white counterparts, a relevant question to ask is, Who can afford to pay to

become a mental health professional and to be ready to be underpaid when they become a mental health professional?
For BIPOC mental health students and new professionals, the stressors do not end with financial concerns. The added stress of race-based trauma, vicarious trauma, and the lack of healing pathways for self contribute to the hardship of practice. BIPOC mental health professionals, particularly those who can speak a second language in addition to English, often find themselves isolated in agencies in which they are but one or perhaps a few. Not only does this contribute to isolation and possible race-based trauma, but also the burden of ever-increasing waitlists and caseloads specifically for these counselors due to their unique lived experience and expertise.For example, it is not a good feeling to be the only Spanish-speaking counselor in an agency and know that your waitlist is twice as long as other colleagues. There is certainly a moral injury in experiencing this.

Vicarious trauma for BIPOC mental health professionals occurs when, in the course of conducting their work, they are exposed via their clients to trauma material. This is further compounded the more the counselor identifies with the client. In other words, the more that the two individuals have in common and that we are able to see ourselves in the person who experienced trauma, the more deeply it affects us. Trauma is nearly universal and within the white supremacist systems of Oregon, BIPOC individuals are routinely exposed to race-based trauma. Trauma that they may seek mental health services for, thereby leading to possible vicarious trauma within their counselor.

The problem with the lack of BIPOC mental health professionals in Oregon is exacerbated when we consider whom BIPOC mental health professionals themselves reach out to for their mental health. For example, if you were to search today for a Muslim counselor on a leading national directory for mental health professionals, you would find only a small handful of Muslim counselors listed in all of Oregon other than myself. Great! You might think, go see them. The problem? I know them. They are members of my community. I might need to refer to them professionally. So where do I, and my fellow BIPOC mental health professionals, seek our own mental health support?

The combination of financial insolvency, race-based trauma, vicarious trauma, and lack of wellness spaces for BIPOC mental health professionals creates a perfect storm of barriers to entering the profession and even staying in the profession. Further, if one does remain in the profession, the challenge to remain well while practicing in an area of high need for our communities is very hard.

This is why I strongly support HB2949. The legislation addresses the challenges of recruiting and retaining Black Indigenous and People of Color in the mental health profession. I strongly believe based on my 11 years of experience in the mental health field, as a counselor educator, and an individual who went through the licensing process in Oregon, that HB 2949 and amendments -5, -7, and -8 amendemnts will make a difference. From pipeline development, to grants and scholarships for training, and reducing the time to full independent licensure, we can increase the number of BIPOC mental health professionals so that when we sit with BIPOC

mental health students and professionals, we can say “wow there are so many of you and you are doing well” instead of “where are the rest of you?”