

Mental Health Services Act (MHSA) Workforce Education and Training (WET) Five-Year Plan 2014-2019 Needs Assessment:

Master Executive Summary to the Final Reports

September 2014



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Funded by Proposition 63 - The Mental Health Services Act via Contract with OSHPD



Executive Summary to the Final Report

The Mental Health Services Act (MHSA) was passed by voters in 2004 to create a transformed, culturally-competent system that promotes wellness, recovery and resilience across the lifespan of age groups such as infants, children, adolescents, transition age youth, and older adults. California's public mental health system (PMHS) suffers from a critical shortage of qualified mental health personnel to meet the needs of the diverse populations they serve. There are critical issues such as the mal-distribution, lack of diversity, and under-representation of practitioners across disciplines with cultural competencies including consumers and family members with lived experience to provide consumer and family-driven services that promote wellness, recovery, and resilience.

To address the workforce issues, the MHSA included a Workforce Education and Training (WET) component to develop programs that create a core of mental health personnel that would support the transformation of the public mental health system. In July 2012, following the reorganization of the former California Department of Mental Health (DMH), the MHSA WET programs were transferred to the Office of Statewide Health Planning and Development (OSHPD) which coincided with the completion of the first WET-Five Year Plan (April 2008 to April 2013).¹

OSHPD was accountable for the development of the second MHSA WET Five-Year Plan 2014-2019. The development of the second WET Five-Year Plan provided the opportunity to refine the vision, values, and goals that guide the distribution of funds based on learnings to date. To strategically deploy funds and create programs that would effectively meet California's public mental health workforce needs, a greater understanding of how the distribution of mental health workers across the state aligns with the current and projected users of the public mental health system was necessary. An array of factors influences the demand and supply of the public mental health workforce in California.

OSHPD engaged Resource Development Associates (RDA) to conduct a large-scale analysis of California's public mental health workforce needs. The four major components of this project are:

1. An evaluation of state-administered WET programs
2. An assessment of public mental health workforce, training, and technical assistance needs as identified by counties and stakeholders;
3. An assessment of mental health education and training; and
4. Workforce projections estimating the supply and demand of California's public mental health workforce in the future.

¹ State of California Office of Statewide Health Planning and Development. (2013). *Proposal to Transfer Workforce Education and Training programs to OSHPD*. Retrieved from: <http://www.oshpd.ca.gov/LawsRegs/MHSAWET.html>

A chief goal of this current project is to establish the composition and needs of California's current public mental health workforce, thus providing a baseline perspective on how the workforce is performing and the foremost issues to be addressed in the coming years. With this information as a baseline, at the end of OSHPD's next cycle of WET funding and administration, a subsequent evaluation project will be able to determine if Statewide WET programs promoted improvements in California's public mental health workforce composition and needs. This set of six distinct reports provides a wealth of in-depth information regarding California's public mental health workforce, and offers a foundation for future efforts by OSHPD and its partners to improve and build the workforce serving California's public mental health consumers.

Presentation of Reports

The findings from this large-scale analysis of California's public mental health workforce are presented across six distinct reports. The executive summary prefacing each of the six reports describes the specific information included in the report, as well as key findings for each. The six reports, and the information included, are as follows:

Report 1. MHSA WET Program Evaluation details findings from evaluations assessing the breadth and effectiveness of current state-administered WET programs. For the first WET Five-Year Plan, programs included: 1) Stipend Programs; 2) the Mental Health Loan Assumption Program; 3) the Song-Brown Residency Program for Physician Assistants in Mental Health; 4) the Psychiatric Residency Program; 5) WET Regional Partnerships; and 6) the Client and Family Member Statewide Technical Assistance Center (Working Well Together).

Report 2. Analysis of Stakeholder Feedback on Public Mental Health Workforce Needs provides analysis of direct feedback from stakeholders regarding California's public mental health workforce needs and perspectives on how to improve public mental health workforce education, training, recruitment and retention. The data reflected in this report is from a series of statewide stakeholder engagement activities conducted by OSHPD in 2013 during the WET Five-Year Plan 2014-2019 development process. Stakeholders included representatives from counties, community-based organizations, educators, consumers and family members, direct service providers, healthcare administrators, and other mental health policy makers.

Report 3. Analysis of County-Reported Public Mental Health Workforce Needs documents public mental health workforce needs as identified by the state's county mental health departments which includes county strategies used to fill those needs, and county feedback on statewide WET programs to develop their mental health workforce. Information from OSHPD-led direct assessments of the state's county health departments, conducted in Summer and Fall 2013, serve as the foundation for this report.

Report 4. Analysis of Mental Health Workforce Supply offers an in-depth account of the current distribution of mental health providers across California. The information

presented in this report groups the state's mental health workforce into five classes of providers: 1) licensed, prescribing occupations; 2) licensed, non-prescribing, nursing occupations; 3) licensed, non-prescribing, clinical occupations; 4) alcohol and other drugs counseling providers; and 5) non-licensed professionals. Furthermore, provider-to-population ratios offer a picture of the relative concentrations of providers across California's counties and allow for comparisons of workforce distributions over the entire state. This report also provides workforce projections, stratified by the five classes of providers, across the next five years (2014-2019) in order to provide estimates of the projected growth and distribution of mental health professionals across the state.

Report 5. Educational Training of Mental Health Professionals describes the state's current capacity to educate and train mental health professionals. This report details the current educational pipelines that could produce mental health professionals who could potentially join the state's public mental health systems. California's postsecondary educational institutions offer many opportunities for individuals interested in pursuing careers in the provision of mental health-related services to obtain the necessary education and training. The capacity of these institutions is a critical component in a larger strategy to build and improve California's public mental health workforce.

Report 6. Public Mental Health Services Demand/Users documents the current volume and distribution of public mental health services throughout California, which serves as a proxy for the state's current demand for public mental health services. The information presented in this report groups the public mental health services provided across the state into nine categories: 1) case management, 2) crisis intervention, 3) crisis stabilization, 4) day treatment, 5) inpatient services, 6) medication support, 7) mental health services, 8) residential services, and 9) therapeutic behavioral services. Similar to Report 4, *Analysis of Mental Health Workforce Supply*, services-to-population ratios are used to focus on the relative concentrations of services across California's counties and allow for appropriate comparisons of the distribution of services across the state. Additionally, this report projects the availability of public mental health services, stratified by the nine services types, across the next five years (2014-2019) in order to provide estimates of the projected growth and distribution of demand for public mental health services across California.

In summary, Reports 1 through 3 provide retrospective information on California's public mental health workforce and statewide WET programs. Reports 4 through 6 provide current and prospective information regarding the supply of and demand for the public mental health workforce throughout the state. These reports also include a series of literature reviews providing further background to inform OSHPD and readers' understanding of specific workforce supply and demand topics and concepts. Together, Reports 4 and 5 document the state's current workforce, which consists of mental health providers and supporting staff members.

Classification of Counties

There are 58 counties across the State of California. Given the varied geography and demographics across this large state, the reports developed for this effort provide findings not

only on a statewide basis, but also stratified by MHSA region and county size in order to provide a more nuanced understanding of the workforce and its features.

The five MHSA regions are: 1) Bay Area, 2) Central, 3) Los Angeles, 4) Southern, and 5) Superior. The three county sizes are: 1) small, with a population less than 200,000 persons; 2) medium, with populations between 200,000 and 800,000 persons; and 3) large, with populations greater than 800,000 persons. These definitions are used consistently across all six reports. Table 1 lists the specific MHSA region and county size designation for each California county.

Table 1: California Counties – MHSA Regions and County Sizes

County	MHSA Region	County Size	County	MHSA Region	County Size
Alameda	Bay Area	Large	Orange	Southern	Large
Alpine	Central	Small	Placer	Central	Medium
Amador	Central	Small	Plumas	Superior	Small
Butte	Superior	Medium	Riverside	Southern	Large
Calaveras	Central	Small	Sacramento	Central	Large
Colusa	Superior	Small	San Benito	Bay Area	Small
Contra Costa	Bay Area	Large	San Bernardino	Southern	Large
Del Norte	Superior	Small	San Diego	Southern	Large
El Dorado	Central	Small	San Francisco	Bay Area	Large
Fresno	Central	Large	San Joaquin	Central	Medium
Glenn	Superior	Small	San Luis Obispo	Southern	Medium
Humboldt	Superior	Small	San Mateo	Bay Area	Medium
Imperial	Southern	Small	Santa Barbara	Southern	Medium
Inyo	Central	Small	Santa Clara	Bay Area	Large
Kern	Southern	Large	Santa Cruz	Bay Area	Medium
Kings	Central	Small	Shasta	Superior	Small
Lake	Superior	Small	Sierra	Superior	Small
Lassen	Superior	Small	Siskiyou	Superior	Small
Los Angeles	Los Angeles	Large	Solano	Bay Area	Medium
Madera	Central	Small	Sonoma	Bay Area	Medium
Marin	Bay Area	Medium	Stanislaus	Central	Medium
Mariposa	Central	Small	Sutter	Central	Small
Mendocino	Superior	Small	Tehama	Superior	Small
Merced	Central	Medium	Trinity	Superior	Small
Modoc	Superior	Small	Tulare	Central	Medium
Mono	Central	Small	Tuolumne	Central	Small
Monterey	Bay Area	Medium	Ventura	Southern	Large
Napa	Bay Area	Small	Yolo	Central	Medium
Nevada	Superior	Small	Yuba	Central	Small

Navigating the Reports

RDA recognizes the variety of audiences that will be interested in the six reports resulting from this effort. Together these reports present a significant quantity of information. It is understood that some readers may be interested in only a portion of the total report. The following brief guide is intended to support readers in identifying the reports that best reflect their specific interests.

The following topics may be of interest to readers:

- MHSA WET Programs
- Stakeholder and County Perspectives on Public Mental Health Workforce Needs
- Mental Health Workforce Supply
- Education of Mental Health Professionals
- Demand for Public Mental Health Services
- Prevalence Rates of Individuals with Severe Mental Illnesses
- Regional Findings
- Population Size Findings

MHSA WET Programs

MHSA's WET program currently administered by the state support a large variety of activities that serve to build and improve California's public mental health workforce. The current state-administered WET programs are: 1) Stipend Programs, 2) the Mental Health Loan Assumption Program, 3) the Song-Brown Residency Program for Physician Assistants in Mental Health, 4) the Psychiatric Residency Program, 5) MHSA Regional Partnerships, and 6) the Client and Family Member Statewide Technical Assistance Center (Working Well Together). Readers interested in the current state of MHSA WET programs and the needs identified by these programs may choose to review the following reports:

- Report 1 – MHSA WET Program Evaluations
- Report 2 – Analysis of Stakeholder Feedback on Public Mental Health Workforce Needs

Stakeholder and County Perspectives on Public Mental Health Workforce Needs

This project was able to examine a vast amount of information collected from MHSA stakeholders and county mental health departments regarding the state's public mental health workforce via community forums, focus groups, conference calls, and surveys. Stakeholder and county perspectives provide numerous insights into the current state of counties' public mental health workforces, as well as the unmet needs and desires of stakeholders and counties. The data collected directly from stakeholders and county representatives offers on-the-ground insights about the workforce, providing valuable information to accompany the concrete numerical workforce findings also presented in this set of reports. Readers interested in further

understanding the stakeholder and county perspectives on the state's public mental health workforce needs may choose to review the following reports:

- Report 2 – Analysis of Stakeholder Feedback on Public Mental Health Workforce Needs
- Report 3 – Analysis of County-Reported Public Mental Health Workforce Needs

Mental Health Workforce Supply

California's mental health workforce is extremely multi-faceted and diverse. This project examined the current distribution of mental health professionals across the state, and developed grounded projections of the future supply of providers. Findings were generated across three levels of analyses: 1) statewide, 2) by MHSA region, and 3) by county size. The information presented in this project groups the state's public mental health workforce into five classes of providers: 1) licensed, prescribing occupations, 2) licensed, non-prescribing, nursing occupations, 3) licensed, non-prescribing, clinical occupations, 4) alcohol and other drugs counseling providers, and 5) non-licensed professionals. Readers interested in detailed descriptions of the state's current and projected public mental health workforce distributions, as well as the pertinent issues affecting the workforce, may choose to review the following reports:

- Report 4 – Analysis of Mental Health Workforce Supply
- Report 5 – Educational Training of Mental Health Professionals

Education of Mental Health Professionals

In order to plan for California's public mental health workforce, it is important to understand the volume of future providers coming from state's postsecondary educational institutions with education and training in mental health-related disciplines. This project examined detailed information, as well as collected its own data, about postsecondary educational institutions across the state, and their capacity to contribute professionals to California's public mental health system. Readers interested in how the state's postsecondary educational institutions factor into the development of the state's public mental health workforce may choose to review the following report:

- Report 5 – Educational Training of Mental Health Professionals

Demand for Services

A wide variety of public mental health services are provided throughout California. This project examines in-depth the volume and breadth of mental health services provided to individuals billing Medi-Cal. Additionally, this project provides detailed projections of the future demand for public mental health services across the state. The information presented in this report groups the public mental health services provided across the state into nine categories: 1) case management, 2) crisis intervention, 3) crisis stabilization, 4) day treatment, 5) inpatient services, 6) medication support, 7) mental health services, 8) residential services, and 9) therapeutic behavioral services. Readers interested in the current and projected distributions of demand for public mental health services in California may choose to review the following report:

- Report 6 – Public Mental Health Services Demand/Users

Prevalence Rates of Individuals with Severe Mental Illnesses

Individuals with severe mental illnesses are increasingly likely to seek mental health services. Examining the prevalence of severe mental illnesses amongst individuals from populations that may seek public health care services provides another avenue for understanding the potential demand for public mental health services in California. Readers interested in a detailed analysis of the current prevalence rates of severe mental illnesses across the state may choose to review the following report:

- Report 6 – Public Mental Health Services Demand/Users

Regional Findings

Throughout this project, information and findings are not only presented at the statewide-level, but also geographically according to MHSA regions. The five MHSA regions are: 1) Bay Area, 2) Central, 3) Los Angeles, 4) Southern, and 5) Superior regions. Throughout this project's reports, when findings are stratified by MHSA regions, the corresponding region for each figure, table, or piece of narrative is clearly marked. All of the reports from this project offer findings stratified by MHSA region; therefore, readers interested in learning about findings for specific county MHSA regions should review all of the reports with an eye for findings specific to their region's interest.

Population Size Findings

Throughout this project, counties' population size is also used as a filter by which to examine the public mental health workforce. The three county sizes used in this project are: 1) small, 2) medium, and 3) large; small counties have populations less than 200,000 persons, medium counties have populations between 200,000 and 800,000 persons, and large counties have populations greater than 800,000 persons. Throughout this project's reports, when findings are stratified by county sizes, the corresponding county size for each figure, table, or piece of narrative is clearly marked. All of the reports from this project offer findings stratified by county size; therefore, readers interested in learning about findings for specific county population sizes should review all of the reports with an eye for findings specific to their county size of interest.

Key Findings

Across its six reports, this project generated numerous findings regarding California's public mental health workforce. Following is a compilation of the key findings or recommendations from this project, grouped according to the reports that they pertain to. For the in-depth presentation and discussion of the detailed information behind these key findings, please refer to their respective reports.

MHPA WET Program Evaluations

- ***The MHPA, Social Worker Stipends, and Marriage and Family Therapist (MFT) Stipend Programs were rated as most effective by a majority of county survey respondents.*** The Song-Brown Residency Program for Physician Assistants and the Clinical Psychology Stipend Program were rated as the two least effective WET programs.
- ***The state-administered WET programs addressed many of the personnel gaps identified by counties in 2008 by increasing public mental health system workforce capacity.*** The MHPA, Stipend, and Residency Programs were utilized by individuals serving in some of the hardest-to-fill/retain positions in the public mental health system.
- ***The state-administered WET programs appear to have been effective in contributing to the recruitment of and support for people of diverse racial/ethnic backgrounds and people speaking threshold languages.*** Sixty-six percent (66%) of the individuals served in statewide MHPA, Stipend, and Residency Programs were from groups currently underrepresented in the public mental health system workforce, and it is estimated that over half were competent in a language other than English.
- ***Since 2008, there have been a number of improvements in the formal education structure and curricula so that students can emerge better prepared to meet the needs of a public mental health system that aligns with MHPA principles.*** Education institutions that have been directly contracted for a state-administered WET program have made a conscientious effort to add courses and adapt degree requirements so that program graduates have pertinent skills and competencies including cultural competency training, knowledge of evidence-based practices, and recovery principles into teaching approaches.
- ***A clear goal of MHPA and WET specifically is to increase the number and proportion of people with lived experience as consumers or family members in the public mental health system workforce.*** While work toward this goal has occurred to a certain extent within all state administered WET programs, the majority of the work was assumed by the Client and Family Member Statewide Technical Assistance Center (Working Well Together).
- ***The five Regional Partnerships made progress toward meeting goals around increasing general capacity, cultural and linguistic competency, the alignment of educational structures and curricula, and increasing consumer and family representation in the public mental health system workforce.*** Because the regions and their corresponding needs and efforts differ so greatly, it is not possible to conduct a region-by-region appraisal of accomplishments-to-date, nor is that a worthwhile evaluation approach. The evaluation attempts to line up areas of focus based on what each Regional Partnership has reported as their accomplishments.

Analysis of Stakeholder Feedback on Public Mental Health Workforce Needs

- **Diversify public mental health workforce.** In order to better address communities' mental health needs, stakeholders discussed the importance of building a linguistically and culturally diverse public mental health workforce over the next five years. In addition, stakeholders also recommended expanding the definition of cultural competence beyond race and ethnicity to include proficiency in working with other communities such as the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) and disability communities. As such, shifting the definition of cultural competency towards a client-centered perspective would be beneficial.
- **Develop a formalized infrastructure for training and employing consumers and family members.** The majority of stakeholders recognized a significant added value to having lived experiences within the workforce. Stakeholders across all 14 community forums reported a need to increase staffing in consumer-led peer positions. Accordingly, stakeholders identified several strategies to aid in furthering this goal: 1) establish a statewide peer certification program for consumers and family members; 2) institute a standardized hiring guideline to support administrative staff in the recruitment of consumers and family members; and 3) expand training for the current mental health staff on the consumer movement, which will increase knowledge around mental health in the current public mental health workforce.
- **Increase educational resources and employment in rural counties.** Due to the constraints by living in geographically isolated regions, recruiting and sustaining a strong mental health workforce in rural communities is a challenge. Stakeholders recommended the use of telepsychiatry as well as distributing learning programs to address this issue.
- **Expand opportunities for partnership and collaboration with the aim of promoting integrated care.** Stakeholders reported a need for more opportunities to dialogue across disciplines and sectors of the community in order to break down silos that currently exist in the public mental health workforce. In particular, stakeholders identified a strong need for more partnership between primary care, behavioral/mental health, and substance abuse professionals. To accomplish this goal, stakeholder feedback indicated that it might be beneficial to allocate resources towards curriculum development around integration as well as training on substance abuse/treatment of co-occurring disorders across mental health professions.

Analysis of County-Reported Public Mental Health Workforce Needs

- **Psychiatrists were identified as the highest workforce shortage, and hard-to-fill, hard-to-retain occupation.** This pattern was consistent within each MHSA region and across all county sizes. Additionally, Psychiatrists with child/adolescent specialties ranked as the second highest workforce need across the state. Other noted workforce

needs across the state included Licensed Clinical Social Workers (LCSWs), Marriage and Family Therapists (MFTs), and Psychologists.

- ***The Superior region, small counties, and medium counties reported bilingual capabilities as a workforce diversity need more frequently than other regions or other county sizes.*** While this region and small and medium counties have the state's smallest concentrations of minority populations, these areas reported important needs to serve their minority clients.
- ***Counties reassigned duties to existing staff in similar/same positions to compensate for current workforce shortages.*** This strategy puts increased demands on existing staff, and could potentially lead to burnout and lower retention.
- ***Large counties had the highest utilization rates of current WET programs, including the Stipends, Mental Health Loan Assumption Programs, and Residency programs.*** Small and medium-sized counties had lower WET program utilization rates. This may be due in part to the dependency on access to schools and students for some of the WET programs.
- ***Reported workforce needs do not intuitively align with counties' participation in statewide WET programs.*** Although Psychiatrists were most frequently reported as the state's highest workforce need, only 20% of counties reported use of the Psychiatric Residency program. This pattern also applied to Psychiatric Mental Health Practitioners, which were also reported as high workforce needs but whose participation in WET programs is low. This may indicate that counties lack the resources to implement or take advantage of these programs, and that more immediate assistance may be needed to help meet workforce needs. This may also indicate that there were no WET program awardees in those counties which reported low WET program participation.

Analysis of Mental Health Workforce Supply

- ***Overall, most professions in the public mental health workforce grew from 2006 to 2013, and are anticipated to continue growing from 2014 to 2019.*** Observed trends from 2006 to 2013 showed that the total number of mental health workforce increased each year from 2006 to 2013. These trends were forecasted to continue through the next five years for all professions in the public mental health workforce.
- ***Rates of growth varied by profession and by provider class.*** The number of Registered Nurses was estimated to increase by 50% over the next five year period, corresponding to the highest growth rate of all professions. Conversely, the number of Psychiatrists was estimated to increase by 14% over the same period, correspond to the lowest growth rate of all professions.
- ***Of the 19 different types of providers in the public mental health workforce, Marriage and Family Therapists (MFTs) comprise the largest share, both in 2013 and for 2019 estimates.*** MFTs constituted 46% of the licensed, non-prescribing, clinical

class of providers, which was the largest group of providers in 2013. This distribution is forecasted to continue through 2019.

- ***Among the licensed, prescribing class, Psychiatrists and Physician Assistants comprise the largest share, while Psychiatric Mental Health Nurse Practitioners comprise the smallest share of providers.*** Psychiatrists comprised 47% of the licensed, prescribing providers, while Physician Assistants were 51% of the provider class. The highest counts of each profession are located in the Bay Area region, followed by the Southern and Los Angeles regions. Providers in both professions were located mostly in California's large counties.
- ***While retirement is a key concern discussed in the literature and identified by counties, reliable estimates about retirement for all mental health professions were difficult to obtain.*** In the supply projections, the notion of retirement was adjusted for by using proxy indicators to estimate approximate providers' duration of practice from education to retirement. Based on the supply projections, retirement will not seriously affect the supply of Psychiatrists, MFTs, or LCSWs.
- ***While the Bay Area, Los Angeles, and Southern regions had the largest concentrations of providers in the state, the highest provider-to-population ratios for some professional categories occurred in the Central and Superior regions.*** This implies that when considering the number of providers relative to the populations of those regions, the Bay Area, Los Angeles, and Southern regions have fewer providers relative to their populations. However, both the Central and Superior regions have counties with rural populations; a rural community will have greater difficulty accessing providers even if they are available.

Educational Training of Mental Health Professionals

- ***Across California, most of the educational institutions conferring mental health-related degrees and certificates were located in the Los Angeles and Southern regions of the state.*** By contrast, rural communities have the highest need of mental healthcare professionals. Given the concentration of postsecondary educational institutions in the Southern part of the state, most of California's graduates come from these two regions. This trend reflects the fact that a large proportion of California's total population is concentrated in this area of the state. Strategies that encourage graduates from the southern regions of the state to practice in the more rural Central and Superior regions of the state, would contribute to meeting mental health needs statewide.
- ***From 1999 to 2009, the numbers of California post-graduate mental health program graduates increased for most of the disciplines analyzed. Furthermore, the forecasts predicted that graduation rates were expected to grow through 2014 at least.*** Based on the previous rates of enrollment across the state, it is anticipated that graduation rates from mental health-related programs will continue to rise in California. However, it still must be determined whether the projected increasing counts of mental

health professionals will match the increasing needs of the state's public mental health consumers.

- **Females comprised two-thirds of graduates in mental health-related disciplines statewide. Additionally, White graduates represented the greatest percentage of all race and ethnic groups; however, when all non-White graduates were combined, they comprised the majority of all graduates.** An assessment of the current demographic distributions of mental health professionals, in conjunction with comparisons of the demographics of the educational pipeline of mental health professionals, is necessary to understand if the projected future workforce will reflect and meet the needs of the state's public mental health consumer populations.

Public Mental Health Services Demand/Users

- **Due in large part to the ACA and the associated expansion of Medi-Cal eligibility, the numbers of individuals receiving any type of public mental health service is expected to increase after 2012.** This is in accordance with past upward trends in the use of all types of public mental health service across California.
- **Of the nine types of mental health services explored in this report's analysis, general mental health services comprised a majority of all types of public mental health services utilized across the state (52%, n=386,820).** Utilization of the remaining eight types of mental health services was observed in decreasing order: medication support, crisis intervention, inpatient services, case management, therapeutic behavioral services, day treatment, residential services, and crisis stabilization.
- **Individuals of White/Caucasian race/ethnicity comprised the largest proportion of the state's public mental health consumer populations.** Across the mental health service types explored in this report, Hispanic/Latinos and African Americans were generally the next two most prevalent race/ethnicities utilizing the state's public mental health services.