

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

Report 1 – MHSA WET Program Evaluation

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Table of Contents

Executive Summary	7
Background	8
Evaluation Methods and Report Structure	9
Evaluation Outcomes	9
Program Effectiveness	9
Expanding Workforce Capacity	10
Addressing Cultural and Linguistic Competency	11
Alignment of Curricula and Requirements to the Needs of a MHSA-Driven Public Mental Health System	12
Increasing Consumer and Family Member Employment	12
Addressing Regional Needs.....	13
Conclusion	13
Frequently Used Acronyms and Abbreviations	15
MHSA 2008-2013 WET State-Administered Programs Evaluation	18
Methods	20
Education/Workforce Preparation Programs	21
Addressing Persistent Vacancies in Hardest-to-Fill/Retain Positions.....	21
Baseline	21
Progress.....	23
Program-by-Program View of Progress to Date	27
Stipend Programs.....	27
Mental Health Loan Assumption Program	29
Song-Brown Residency Program for Physician Assistants in Mental Health.....	30
Psychiatric Residency Program.....	31
Regional Partnerships	32
Client and Family Member Statewide Technical Assistance Center.....	40
WET Programs Addressing Priority Areas	45
Addressing Cultural and Linguistic Competency	46
Baseline	46
Progress.....	48

Alignment of Curricula and Requirements to the Needs of a MHSA-Driven PMHS	51
Baseline	51
Progress.....	53
Employing Consumers and Family Member Participation in the PMHS Workforce	54
Other Accomplishments	55
Discussion	56
Addressing Cultural and Linguistic Competency.....	56
Program Limitations	57
Limitations of the Study.....	58
Conclusions and Recommendations	58
Recommendations	59
Conclusion	60
References.....	61
Appendices	62
Appendix 1: Draft Regional Partnership Survey	62
Survey Questions.....	62
Regional Partnerships	62
Appendix 2: Proposed Abridged County-Level Needs Assessment Form.....	66
Appendix 3: Logic Model	73
Appendix 4: Weighting for Tables 17 and 18.....	74
Appendix 5: Program Data Sources.....	75
Appendix 6: California’s Public Mental/Behavioral Health Workforce Needs Assessment 2013.....	76
Appendix 7: OSHPD WET County Needs Follow-Up Survey 2013	80
Hard-to-Fill/Hard-to-Retain Positions.....	80
Hard-to-Fill/Hard-to-Retain Position 1	82
Hard-to-Fill/Hard-to-Retain Position 2	84
Hard-to-Fill/Hard-to-Retain Position 3	85
Consumer and Family Members as Paraprofessionals	87
State-Administered WET Programs	88
Appendix 8: 2008 County-Level Workforce Survey Tool	91
Appendix 9: MHSA Workforce Education and Training Evaluation Plan for OSHPD	92



Underlying Logic of Evaluation Design.....92

Methods of Measurement and Analysis95

 Establishing a Baseline95

Alternative Impact Measurement Strategies.....96

Analysis, Interpretation and Recommendations96

Timeline97

List of Tables

Table 1: County Ratings of WET Program Effectiveness, 2013.....	10
Table 2: Progress toward Addressing Hardest-to-Fill/Retain Positions: Numbers Served by State-Administered WET Education/Workforce Preparation Programs 2005–2013.....	11
Table 3: Regional Partnership Activities and Supports, 2008–2013	13
Table 4: Frequently Used Acronyms and Abbreviations	15
Table 5: Vacancy Rates Reported in 2008	22
Table 6: Hardest-to-Fill/Retain Positions Reported in 2008	22
Table 7: Progress toward Addressing Hardest-to-Fill/Retain Positions: Numbers Served by State-Administered WET Education/Workforce Preparation Programs 2005-2013.....	24
Table 8: County Ratings of WET Program Effectiveness in 2013*	25
Table 9: Stipend Program Recipients, FY 2008-09 through FY 2012-13*	27
Table 10: Stipend Recipients by Discipline and Region Employed, 2008 – 2013*	28
Table 11: MHLAP Applications FY 2008-09 to FY 2012-13*	29
Table 12: MHLAP Participant Placement, 2009-2012*	29
Table 13: Regional Partnership Activities and Supports, 2008 – 2013*	39
Table 14: Need for Consumer and Family Member Staff at Various Levels of PMHS, 2008 – 2013*	41
Table 15: Ethnic Representation within Workforce Categories Reported in 2008*	46
Table 16: Differences between PMHS Workforce and Target Mental Health Population 2008* ..	47
Table 17: Workforce Gaps in Linguistic Proficiencies Reported in 2008*	47
Table 18: Ethnic Breakdown of Licensed Direct Service Providers in PMHS Workforce, 2008 – 2013.....	49
Table 19: Linguistic Capacity of 2008 Workforce and 2013 WET Progress toward Targets*	50
Table 20: Perceptions of WET Effectiveness in Increasing Cultural/Linguistic Competency, 2013*	51
Table 21: Preparedness of Workforce As Reported in CCCMHA Survey	52
Table 22: Calculation for Table 18.....	74
Table 23: Calculation for Table 19.....	74
Table 24: Program Progress Reports Reviewed for 2013 Evaluation	75

List of Figures

Figure 1: Program Effectiveness and Workforce Distribution, 2013.....	26
Figure 2: MHLAP Awardees by Region, FY 2008-09 through FY 2010-11*	30

Executive Summary

The Mental Health Services Act (MHS) 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 MHS 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 MHS 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 MHS 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>

At the conclusion of its analysis, RDA produced six reports containing detailed descriptions of its methods, research and findings. The documents in each report are clustered by topic, in order to facilitate review by a diverse potential audience. Each report is prefaced with an Executive Summary to provide a brief description of the documents and key findings contained within each report. Please refer to the “OSHPD MHSA WET Five-Year Plan: Executive Summary to the Final Report” document for guidance regarding the overall objectives of the project and each of its six reports.

This report, *Report 1 – MHSA WET Program Evaluation*, presents RDA’s original plan for evaluating MHSA’s WET programs, as well as the evaluation of California’s state-administered WET programs based on OSHPD’s research questions and the data available. The original plan for evaluating MHSA’s WET programs was not completely feasible due to the limitations noted in this report regarding the data available. However, the original plan should be consulted for future work as a model for an ideal evaluation of MHSA’s WET programs. The original plan is presented in the last appendix of this report.

This report provides a detailed picture of California’s state-administered WET programs funded from 2008-2014 and specific points for potential improvement for future state-administered WET programs. This is the only report focused on evaluating MHSA WET’s state-administered programs.

Background

In 2008, California’s former Department of Mental Health (DMH) developed the first WET Five-Year Plan, which set forth the vision of MHSA WET.² To advance this vision, DMH implemented the following six programmatic strategies to form a state-administered WET approach:

- **Stipend Programs:** Funded education institutions to provide stipends to graduate students who commit to work for 12 months in the PMHS and to incorporate the MHSA principles into graduate level curriculum. The graduate degrees funded for stipends include: Social Work (MSW); Marriage and Family Therapist (MFT); Clinical Psychologist (PsyD); and Psychiatric Mental Health Nurse Practitioner (PMHNP).
- **Mental Health Loan Assumption Program (MHLAP):** Offered loan repayment of up to \$10,000 to mental health professionals in hard-to-fill and/or hard-to-retain positions in the PMHS in exchange for a 12-month service obligation.
- **Song-Brown Residency Program for Physician Assistants in Mental Health:** Supported Physician Assistant (PA) programs that train second-year Residents to specialize in mental health.

² “We envision a public mental health workforce, which includes clients and family members, sufficient in size, diversity, skills and resources to deliver compassionate, safe, timely and effective mental health services to all individuals who are in need and their families and caregivers, and contributes to increased prevention, wellness, recovery and resilience for the people of California.” -WET Five-Year Plan 2008-2013

- **Psychiatric Residency Program:** Funded Psychiatric Residency Programs to increase their capacity to train Residents, align curricula to the needs of the public sector mental health system, and provide Psychiatric Residents with rotations in the PMHS.
- **Regional Partnerships:** Created five Regional Partnerships (RPs) across the state to promote and implement programs to improve local workforce, education and training resources. The Regional Partnerships represent Bay Area counties, Central Valley counties, Southern counties, Los Angeles County, and Superior Region counties.
- **Client and Family Member Statewide Technical Assistance Center:** Funded Working Well Together (WWT) to provide leadership, training, and technical assistance to promote the recruitment, hiring, retention and support of current and prospective public mental health system employees who have lived experience as mental health consumers and family members.

The MHSA WET programs were originally overseen by DMH, but in July 2012, following the reorganization of the former DMH, the MHSA WET programs were transferred to OSHPD.

Evaluation Methods and Report Structure

The goal of the state-administered program evaluation was to reveal the impacts, strengths, and challenges of program implementation. RDA developed a logic model and evaluation plan which are included in this report. The findings presented include aggregate outcomes across all six programs, including baseline measurements from 2008, progress made through the years, and impact findings at the end of 2013 and a program-by-program analysis. RDA also conducted a brief voluntary county survey that asked county mental/behavioral health departments about the perceived impact of the state-administered WET programs. The survey conducted during this evaluation captured information from 26 counties (45% response rate).

There are limitations to this study. Due to incomplete data, several methodological assumptions were made that must be recognized as stipulations to any findings or conclusions contained in this report. The full evaluation report lists several recommendations pertaining to data collection for future evaluation efforts. The recommended improvements in data collection procedures are meant to help ensure that those subsequent evaluations can speak more accurately, and perhaps, persuasively to the difference state-administered WET programs have made. The key results of the evaluation are summarized below.

Evaluation Outcomes

Program Effectiveness

In terms of program effectiveness, MHLAP, Social Worker Stipends, and MFT Stipend Programs were rated as most effective by a majority of county survey respondents. The Song-

Brown Residency Program for Physician's Assistants and the Clinical Psychology Stipend Program were rated as the two least effective WET programs. It should be noted that some of these programs' impact may not yet be noticed, as a large portion of students in the Stipend and Residency Programs have not matriculated through the program all the way to the placement in the PMHS.

Table 1: County Ratings of WET Program Effectiveness, 2013

State-Administered WET Program	N*	Average Rating (out of 4)	% Rating the Program Somewhat or Very Effective
MHLAP	26	3.42	92.3%
Social Worker Stipend Program	21	2.67	53.9%
MFT Stipend Program	20	2.55	56.0%
PMHNP Stipend Program	17	2.24	39.1%
Psychiatric Residency Program	19	1.68	21.7%
Clinical Psychologist Stipend Program	17	1.59	13.0%
Song-Brown Residency for Physician's Assistants	12	1.08	0%
OVERALL	--	2.32	--

*Includes responses from 26 counties.

Expanding Workforce Capacity

The state-administered WET programs addressed many of the personnel gaps identified by counties in 2008 by increasing PMHS workforce capacity. The MHLAP, Stipend, and Residency Programs were utilized by individuals serving in some of the hardest-to-fill/retain positions in the public mental health system. While the state-administered WET programs progressed towards addressing positions identified as hard-to-fill/retain in 2008, several positions were identified in 2008 for which, other than MHLAP, there are no other corresponding state-administered WET programs.

Table 2: Progress toward Addressing Hardest-to-Fill/Retain Positions: Numbers Served by State-Administered WET Education/Workforce Preparation Programs 2005–2013

Hard-to-fill/retain positions identified in 2008	MHLAP	Stipend	Psychiatric Residency	Song-Brown PA	Total Participants
Psychiatrist, General	230	--	--	--	230
Licensed Clinical Social Worker	255	1,838*	--	--	2,093*
Marriage and Family Therapist	1,259	474	--	--	1,733
Licensed Supervising Clinician	0	--	--	--	0
Psychiatrist, Child/Adolescent	--	--	10	--	10
Psychiatrist, Interdisciplinary Medicine Specialty	--	--	15	--	15
Registered Nurse	12	--	--	--	12
CEO or Manager above Direct Supervisor	3	--	--	--	3
Psychiatric or Family Nurse Practitioner	8	92	--	--	100
Licensed Clinical Psychologist	23	283	--	--	306
Analysts, tech support, quality assurance	0	--	--	--	0
Family Member Support Staff	0	--	--	--	Unknown*
Clinical Nurse Specialist	1	--	--	--	1
Psychiatrist, Geriatric	--	--	--	--	Unknown*
Consumer Support Staff	9	--	--	--	9
Positions not identified as hard-to-fill/retain in 2008					
Physician Assistant	0	--	--	1,382	1,382
Licensed Professional Clinical Counselor	14				14
Bachelors Social Worker	46				46
Associate Clinical Social Worker	629				629
Other	235				235
TOTAL SERVED:	2,719	2,687	25	1,382	6,813

*Programs did not report on positions filled to this level of detail, therefore, it cannot be stated for certain if any program participants filled these roles.

Addressing Cultural and Linguistic Competency

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 Stipend, MHLAP, and Residency Programs were from groups currently underrepresented in the PMHS workforce, and it is estimated that over half were competent in a language other than English. The Regional Partnerships have also undertaken efforts to increase the cultural and linguistic

competency of the workforce, including delivering cultural competency trainings, providing support for existing staff to enroll in language institutes, and partnerships with universities to expand focus on cultural competency.

Among the 26 counties that responded to the 2013 follow-up survey conducted for this evaluation, 85% felt the state-administered WET programs were effectively increasing the linguistic competency of the workforce in their county, and 58% felt the programs were helping to increase the diversity of the workforce in their county.

Alignment of Curricula and Requirements to the Needs of a MHSA-Driven Public Mental Health System

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 MHSA 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. The work toward curriculum advancement at the Regional Partnership level should also be acknowledged, as the majority of the Regional Partnerships (four of five) have worked with their local institutions of higher education to advance curricula that correspond to the workforce needs.

Increasing Consumer and Family Member Employment

A clear goal of MHSA and WET specifically is to increase the number and proportion of people with lived experience as consumers and/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 Working Well Together (WWT). The accomplishments of WWT have been largely in the realm of:

- Providing individualized technical assistance to counties as they make the move toward increasing the representation of consumers and family members in their workforce;
- Developing training curricula and offering trainings to support the recruitment, employment, and successful integration of consumers and family members in the workforce; and
- Creating tools and reports for use by professionals working in the public mental health system.

WWT has conducted 159 site visits to county mental health departments to help them build their capacity to recruit, hire, and retain consumer and family-member-identified individuals in their workforce, and has offered 34 trainings in communities, engaging a total of 3,677 (duplicated) individuals.

Other state-administered WET programs also succeeded in supporting individuals with lived experience in the PMHS workforce. MHLAP provided loan repayment to four designated consumer and family member positions; 55% of MHLAP awardees had a consumer/family member background; two Regional Partnerships engaged in stigma reduction activities; and in Fiscal Year (FY) 2012-13, 40% of MFTs and PMHNPs, and 26% of Clinical Psychologist stipend recipients had a consumer and family member background. While all of these accomplishments are noteworthy, it is difficult to measure the extent to which all state-administered programs had an impact on the actual number or proportion of individuals with lived experience within the PMHS workforce.

Addressing Regional Needs

The five Regional Partnerships also 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.

Table 3: Regional Partnership Activities and Supports, 2008–2013

Regional Partnership	Cultural competency trainings	Curriculum-focused efforts w/ academic institutions	High school mental health career pathways	Core competencies project	Movement toward recovery orientation in WET	Programs targeting the underserved	Explicit stigma reduction efforts	First responder training and MH First Aid trainings
Central	X	X		X	X	X	X	X
Greater Bay Area	X		X	X	X		X	
Los Angeles	X	X				X		
Southern	X	X	X	X	X			
Superior		X	X		X			

Conclusion

In conclusion, this evaluation, based on reports from program contractors, interviews conducted by the RDA evaluation team, a county-level survey, and additional data provided by OSHPD, finds that progress was indeed made toward WET priorities in the First WET Five-Year Plan. Some programs are perceived as more effective in addressing workforce gaps and needs than others—differences in perceived effect appear to be associated not only with the number of individual served by the program, but also with the level of need for specific positions and program contractors’ communication strategies. The evaluation found several limitations to state-administered WET programs although these were outnumbered by program strengths and

accomplishments and should be considered alongside the methodological limitations of the study. Long-term program impacts have yet to be felt. Subsequent evaluations may more accurately demonstrate the effect of the WET programs reviewed here.

Frequently Used Acronyms and Abbreviations

Table 4 lists the frequently used acronyms and abbreviations used in this report, as well as their definitions.

Table 4: Frequently Used Acronyms and Abbreviations

<u>Acronym</u>	<u>Definition</u>
AA	African American
AOD	Alcohol and Other Drug
API	Asian/Pacific Islander
ASW	Associated Social Worker
AU	MHSA Annual Update Report
BA	Bachelor of Arts Degree
BEA	United States Bureau of Economic Analysis
BLS	United States Bureau of Labor Statistics
BSN	Bachelor of Nursing
CaIHR	California Department of Human Resources
CaISWEC	California Social Work Education Center
CAMPHRO	California Association of Mental Health Peer Run Organizations
CBHDA	County Behavioral Health Directors Association of California
CBO	Community-Based Organization
CFM	Consumer/Family Member
CIMH	California Institute for Mental Health
CNS	Clinical Nurse Specialist
CPEC	California Postsecondary Education Commission
CSU	California State University
CSW	Clinical Social Worker
DCA	California Department of Consumer Affairs
DES	Doctorate Employment Survey
DHCS	California Department of Health Care Services
DMH	California Department of Mental Health
EBP	Evidence-Based Practice
EQRO	External Quality Review Organization
FTE	Full-Time Equivalent
FY	Fiscal Year
GDP	Gross Domestic Product
HRSA	United States Health Resources and Services Administration
HTF/HTR	Hard-to-Fill / Hard-to-Retain

<u>Acronym</u>	<u>Definition</u>
IPEDS	Integrated Post-Secondary Education Data System
K-12	Kindergarten through 12th Grade
LA	Los Angeles
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning
LPN	Licensed Practical Nurse
LPT	Licensed Psychiatric Technician
LVN	Licensed Vocational Nurse
MA	Master of Arts Degree
MBC	Medical Board of California
MEd	Master's of Education
MES	Master's and Specialty Education Survey
MFT	Marriage and Family Therapist
MH	Mental Health
MHLAP	Mental Health Loan Assistance Program
MHSA	Mental Health Services Act
MSN	Master of Nursing
MSW	Master of Social Work
NAICS	North American Industry Classification System
NAMI	National Alliance on Mental Illness
NHSC	National Health Service Corps
NP	Nurse Practitioner
NPI	National Provider Identifier Registry
OES	Occupational Employment Statistics
OSHPD	Office of Statewide Health Planning and Development
PA	Physician Assistant
PEERS	Peers Envisioning and Engaging in Recovery Services
PEI	Prevention and Early Intervention
PGY	Post-Graduate Year
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMHS	Public Mental Health System
PsyD	Clinical Psychologist
P-to-P Ratio	Provider-to-Population Ratio
QCEW	Quarterly Census of Employment and Wages
RDA	Resource Development Associates
RN	Registered Nurse
RP	Regional Partnership
UC	University of California

<u>Acronym</u>	<u>Definition</u>
WET	Resource Development Associates
WF	Workforce
WIC	Welfare and Institutions Code
WRAP	Wellness Recovery Action Plan
WWT	Working Well Together Training and Technical Assistance Center

MHSA 2008-2013 WET State-Administered Programs Evaluation

In November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA) which imposes a 1% tax on personal income in excess of \$1 million to support the public mental health system (PMHS) via prevention, early intervention and services. Historically underfunded, California's PMHS suffers from a critical shortage of qualified mental health personnel to meet the needs of the diverse population they serve. Pressing issues include lack of diversity, mal-distribution, and under-representation across disciplines of practitioners with cultural competencies including consumers and family members with lived experience. These challenges limit PMHS capacity to provide consumer- and family-driven services that promote wellness, recovery, and resilience. To address these workforce issues, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. A total of \$444.5 million was made available for the WET component within the former Department of Mental Health (DMH), \$234.5 million of which were set aside for state-administered programs.

In 2008, the former department of mental health developed an assessment that included stakeholder engagement and a statewide survey of counties was conducted to capture workforce needs within the PMHS workforce. This effort provided an overall understanding of persistent and problematic workforce vacancies, shortcomings of the workforce in terms of racial/ethnic representativeness, and aspects in which workforce preparedness did not align with the needs of the system or the principles of MHSA. It also took into consideration how individual counties' plans were addressing workforce issues specific to their locales.

From this assessment, the first WET Five-Year Plan was developed, which set forth the vision of MHSA WET.³ To advance this vision, the former DMH implemented the following six programmatic strategies to form a state-administered WET approach:

- **Stipend Programs:** Funded education institutions to provide stipends to graduate students who commit to perform their supervised hours in the PMHS and work for 12 months in the PMHS. The goals of the Stipend Programs are to increase the number of licensed mental health professionals in the public system, and to incorporate the MHSA principles into graduate level curriculum. The graduate degrees funded for stipends include: Social Work (MSW); Marriage and Family Therapist (MFT); Clinical Psychologist (PsyD); and Psychiatric Mental Health Nurse Practitioner (PMHNP);
- **Mental Health Loan Assumption Program (MHLAP):** Offers loan repayment of up to \$10,000 to mental health professionals in hard-to-fill and/or hard-to-retain positions in the

³ "We envision a public mental health workforce, which includes clients and family members, sufficient in size, diversity, skills and resources to deliver compassionate, safe, timely and effective mental health services to all individuals who are in need and their families and caregivers, and contributes to increased prevention, wellness, recovery and resilience for the people of California." – WET Five-Year Plan 2008-2013

PMHS in exchange for a 12-month service obligation. The hard-to-fill and/or hard-to-retain positions eligible for stipends are identified by each county;

- **Song-Brown Residency Program for Physician Assistants in Mental Health (Song-Brown Residency Program)**: Supported physician assistant (PA) programs that train second-year Residents to specialize in mental health including administering and managing psychotropic medications, completing rotations in Psychiatry/Behavioral Medicine, training in telepsychiatry, and didactic and clinical education in mental health services;
- **Psychiatric Residency Program**: Funds Psychiatric Residency Programs to increase their capacity to train Residents, align curricula to the needs of the PMHS, and encourages Psychiatric Residents to continue working in the California PMHS when their rotations are completed;
- **Regional Partnerships**: Created five Regional Partnerships (RPs) across the state to promote and implement programs to improve local workforce, education and training resources. The Regional Partnerships represent Bay Area counties, Central Valley counties, Southern counties, Los Angeles County, and Superior Region counties; and
- **Client and Family Member Statewide Technical Assistance Center**: Funded Working Well Together (WWT) to provide leadership, training, and technical assistance to promote the recruitment, hiring, retention and support of current and prospective public mental health system employees who have lived experience as mental health consumers and family members..

The MHSA WET programs were originally overseen by DMH, but in July 2012, following the reorganization of the former DMH, the MHSA WET programs were transferred to OSHPD. In 2013, at the conclusion of the first WET Five-Year Plan and five years into state-administered WET program operations, OSHPD engaged Resource Development Associates (RDA) to conduct an evaluation of the effort.

RDA collected data from various sources to assess the effectiveness of statewide programs in advancing the vision and strategies set forth in the first WET Five-Year Plan. The goal of the evaluation is to reveal the impact, strengths and challenges of implementation. The evaluation is guided by the goals of each of the funded program areas. The report begins with a section describing the evaluation methods, which is followed by a general discussion of program impact on workforce capacity. The report then describes deliverables and perceived effectiveness of each program area:

- 1) Educational/Workforce Preparation Programs (Stipends, MHLAP, Song-Brown PA Residency, and Psychiatric Residency);
- 2) Regional Partnerships; and
- 3) Working Well Together.

It should be noted at the outset that several limitations restrict the applicability of this evaluation as a conclusive assessment of MHSA WET program impact. These are related to inconsistent program reporting on numbers served, the impracticality of conducting a comprehensive county workforce survey, and the fact that several of the programs have longer cycles or effect rather

subtle changes, which may require multiple years before any perceptible impact on the PMHS workforce can be measured. These limitations are detailed further in the Discussion section.

Methods

A first step in the inquiry was to pull information from source documents, including the 2009 *California's Public Mental Health Workforce: A Needs Assessment* (Shea, 2009), which details data from 2008, including county-reported needs, to establish baseline measures for each of the evaluation questions. While there were some limitations to using the report as a source for baseline data, there were several data points that could be used effectively to demonstrate the baseline need among counties. The 2009 needs assessment report is based on the completed 2008 needs assessment survey and county WET work plans received from 28 counties.

Additionally, RDA compiled numerous program reports from state-administered WET program grantees to document the extent to which efforts to ameliorate baseline needs have been made. To the extent possible, numbers served by the programs were gathered from these reports to provide a sense of each program's reach, intermediary accomplishments, and the process by which outcomes might eventually be achieved. While there was some inconsistency among the reports, especially in terms of how program participation was tracked and the extent to which program participants' characteristics and placements were monitored, these reports provided the evaluation team with a general impression of the progress WET programs have made toward meeting intended goals. Some additional information was obtained by following-up with program administrators via phone and email.

Finally, RDA partnered with OSHPD to conduct a brief county needs follow-up survey that asked county mental/behavioral health departments about the perceived impact of the state-administered WET programs. The workforce needs assessment conducted in 2008 captured the impressions of 28 of California's county behavioral/mental health departments—just under half of California's 58 counties (48% response rate).⁴ The follow-up survey conducted in 2013 for this evaluation captured information from 26 counties (45% response rate),⁵ 12 of which overlapped with the counties surveyed in 2008. There were 16 counties for which no survey data were collected in either 2008 or 2013. Most of the questions on the 2013 follow-up survey were constructed as Likert-type scales to capture county perceived effectiveness of the programs (see "Appendix 6: California's Public Mental/Behavioral Health Workforce Needs Assessment 2013" for survey questions). It must be noted that replicating the 2008 Workforce Needs Assessment questionnaire might have produced a more reliable measure of WET program impact. Nevertheless, it was recognized by both OSHPD and RDA that:

⁴ The 28 counties for which 2008 data are included are as follows: Large: Los Angeles, Alameda, Contra Costa, Kern, Merced, Monterey, Orange, Placer, Riverside, San Bernardino, San Francisco, Santa Barbara, Santa Cruz, Stanislaus, Ventura; Small/Rural: Calaveras, Colusa, Glenn, Humboldt, Madera, Modoc, Mono, Plumas, Sierra, Trinity, Tuolumne; Small/Other: El Dorado, Kings.

⁵ The 26 counties for which 2013 follow-up survey data are included are as follows: Large: Los Angeles, Contra Costa, Kern, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Solano, Stanislaus, Ventura; Small/Rural: Amador, Calaveras, Inyo, Mariposa, Mendocino, San Benito, Tulare; Small/Other: Butte, El Dorado County, Imperial, Kings, Sutter.

- 1) Such a survey would impose a significant burden on counties and would extend the timeline of the evaluation study beyond a practical limit;
- 2) Many of the state-administered WET programs have a longer cycle and may not yet have had the time to produce a perceptible impact in actual vacancies filled; and
- 3) Counties' impressions of the potential for the programs to make a difference were, at this point, a highly valuable indicator of whether WET programs are perceived to be on the right track.

This evaluation report presents data gathered through these methods according to each funded program category. A logic model is attached as Appendix A.

Education/Workforce Preparation Programs

Incentivizing participation in the PMHS workforce by helping to defray the costs of education and workforce preparation has been a significant focus of the state-administered WET programs. Together the Stipend, MHLAP, and Residency programs, all of which require a commitment from participants to work for a period of time in the PMHS, have advanced progress against persistent workforce shortages identified at baseline (Shea, 2009). The program priorities for the education/workforce preparation programs include filling vacancies in hard-to-fill or retain positions, increasing the diversity, linguistic and cultural competency of the workforce, and working with formal educational structures and universities to ensure that workforce preparation is aligned with PMHS needs and MHSA values.

This section first provides an aggregate picture of how education/workforce preparation programs have addressed persistent vacancies in hard-to-fill/retain positions, then offers a program-by-program view of accomplishments to date. The section goes on to examine how the education/workforce preparation programs have helped promote greater cultural and linguistic competency, and provides a discussion of the changes that have been made in formal education and workforce preparation requirements to support the development of a workforce that is prepared to work in the PMHS in a way that is consistent with the principles of MHSA.

Addressing Persistent Vacancies in Hardest-to-Fill/Retain Positions

WET program approaches were designed to meet identified needs and shortages within the PMHS workforce. Among these were persistent vacancies in county mental/behavioral health departments and service delivery systems in the hardest-to-fill/retain positions.

Baseline

Information gathered in 2008 from 28 counties showed that the vacancy rates were highest among licensed direct service mental health staff and support staff, which were tied at a vacancy rate of nearly 12 vacancies per each 100 positions.

Table 5: Vacancy Rates Reported in 2008

Major staffing group	% positions that are vacant
Licensed Mental Health Staff (direct service)	11.9%
Support Staff	11.9%
Managerial and Supervisory	11.0%
Unlicensed Mental Health Direct Service Staff	9.1%
Other Health Care Staff (direct service)	6.2%

The top 12 positions identified in 2008 as the hardest-to-fill/retain are listed below (including ties). Counties were simply asked to identify which positions were hard-to-fill or retain in their counties, based on their county's needs⁶. The 2008 numbers show a discrepancy between vacancy rates and survey responses pertaining to which positions are hardest-to-fill or retain. The vacancy rate for "Support Staff" is equal to that of "Licensed Mental Health Staff." A far larger percentage of the positions named by county mental health departments were direct service positions than were support or managerial. The vast majority (13 out of 15) of the "top 12" hard-to-fill/retain positions in 2008 were direct service positions, and the vast majority of those (10 out of 13) were more specifically licensed direct service staff positions.⁷

Table 6: Hardest-to-Fill/Retain Positions Reported in 2008

Hardest-to-fill/retain positions in 2008	Rank
Psychiatrist, General*	1
Licensed Clinical Social Worker*	2
Marriage and Family Therapist*	3
Licensed Supervising Clinician*	4
Psychiatrist, Child/Adolescent*	5
Registered Nurse*	5
CEO or Manager above Direct Supervisor	6
Psychiatric or Family Nurse Practitioner*	7
Licensed Clinical Psychologist*	8
Analysts, tech support, quality assurance	9
Family Member Support Staff*	10
MSW, Registered Intern	10
Clinical Nurse Specialist	11
Psychiatrist, Geriatric	12
MFT, Registered Intern	12
Consumer Support Staff*	No ranking

*Position mentioned as a hard-to-fill/retain position in open-ended comments

⁶ There is no state-recognized definition for "hard-to-fill" or "hard-to-retain" positions. County interpretations are therefore subjective.

⁷ While a strong argument could be made that "Licensed Supervising Clinician" is more of a managerial or supervisory position, here it is recognized as a direct service position because, although a large portion of a Supervising Clinician's duties are focused on Managing Clinicians and Interns, it is customary in many counties for the Supervising Clinicians to carry a small caseload themselves, as well as perform diagnostic and treatment tasks.

The preponderance of licensed direct service positions may imply that there were greater obstacles in attracting and committing people to this sort of position, or perhaps simply that there was more urgency in the perceived need to fill these positions because of their essential role in treating consumers.

The key labor market-related reasons for workforce shortfalls noted in the report from 2008 were as follows:

- Competition from other industries or other geographic areas;
- Cost of living (and, presumably, the inability of PMHS salaries to meet these costs); and
- Rural factors such as feeling geographically isolated.

The report on 2008 data (Shea, 2009) did not provide specific definitions or descriptions of the rural factors that affected workforce shortfalls beyond geographic isolation, but it did note that “rural, small counties face several occupational shortages due to geographic barriers and the lack of (or lack of awareness of) educational opportunities” (Shea, 2009: p.14). Data were not otherwise broken down by county size, so no further analysis of how rural factors or county size affected workforce shortages can be noted.

Progress

The state-administered WET programs were designed to address many of the shortages identified in 2008. Several of these programs were designed to incentivize entering or remaining in the PMHS workforce in general or in specific positions.

Altogether, Stipend, MHLAP, and Residency programs were able to assist a significant number of individuals destined for or currently working in the PMHS. Table 7 lists the hardest-to-fill/retain positions identified in 2008, alongside the number of individuals that state-administered WET programs served who hold or are in process toward obtaining those positions. The Stipend and Residency Programs roughly align with the hardest-to-fill/retain positions identified at baseline, with a few caveats:

- Hardest-to-fill/retain positions identified by counties in 2008 included specialties such as “Psychiatrist, Child/Adolescent,” while the Residency Program designed to help ameliorate the shortage supports psychiatrists irrespective of specialty. For these programs, the number of program participants is counted under the generalized (not specialized) position.
- Stipend Programs serve students pursuing positions that require a license. Some of these positions require an extensive internship before full licensure is granted. For these positions, the number of program participants is counted under the licensed position rather than the intern position, even if both were noted as hard-to-fill/retain in 2008.
- Consumer Support Staff was not identified as a hard-to-fill/retain position in 2008, but it is included in the table because it emerged as a hard-to-fill/retain position in counties’ open-ended responses and because the creation, filling, and retaining of these positions is a clear part of the MHSA vision.

- Physician Assistants (PAs) were not identified as a hard-to-fill/retain position in 2008, but they are included in the table because there was a state-administered WET program specifically designed to increase the number of PAs in the PMHS workforce and PAs may serve as a labor substitution for Psychiatry due to their prescribing authority.

Table 7: Progress toward Addressing Hardest-to-Fill/Retain Positions: Numbers Served by State-Administered WET Education/Workforce Preparation Programs 2005-2013

Hard-to-fill/retain positions identified in 2008	MHLAP	Stipend	Psychiatric Residency	Song-Brown PA	Total Participants
Psychiatrist, General	230	--	--	--	230
Licensed Clinical Social Worker	255	1,838*	--	--	2,093*
Marriage and Family Therapist	1,259	474	--	--	1,733
Licensed Supervising Clinician	0	--	--	--	0
Psychiatrist, Child/Adolescent	--	--	10	--	10
Psychiatrist, Interdisciplinary Medicine Specialty	--	--	15	--	15
Registered Nurse	12	--	--	--	12
CEO or Manager above Direct Supervisor	3	--	--	--	3
Psychiatric or Family Nurse Practitioner	8	92	--	--	100
Licensed Clinical Psychologist	23	283	--	--	306
Analysts, tech support, quality assurance	0	--	--	--	0
Family Member Support Staff	0	--	--	--	Unknown**
Clinical Nurse Specialist	1	--	--	--	1
Psychiatrist, Geriatric	--	--	--	--	Unknown**
Consumer Support Staff	9	--	--	--	9
Positions not identified as hard-to-fill/retain in 2008					
Physician Assistant	0	--	--	1,382	1,382
Licensed Professional Clinical Counselor	14				14
Bachelors Social Worker	46				46
Associate Clinical Social Worker	629				629
Other	235				235
TOTAL SERVED:	2,719	2,687	25	1,382	6,813

*Includes Stipend Program for Social Work participants from the program's inception in 2005.

**Programs did not report on positions filled to this level of detail, therefore, it cannot be stated for certain if any program participants filled these roles.

In November 2013, a county needs follow-up survey was distributed to all counties participating in MHSA WET—26 county mental/behavioral health departments responded. Counties were asked to rate the effectiveness of each of the state-administered WET programs designed to

place or retain personnel in hard-to-fill/retain positions, including Stipend Programs, MHLAP, Song-Brown Residency program, and Psychiatric Residency Program.

Each county’s respondent⁸ was asked to use a scale of one-to-four where one indicated “not at all effective,” two indicated “not very effective,” three indicated “somewhat effective,” and four indicated “very effective.” The combined average rating of programs was 2.32 with MHLAP rating highest at 3.42 and Song-Brown Residency Program rating lowest at 1.08. The results suggest that county agencies felt MHLAP has been most effective in helping them place or retain personnel in hard-to-fill/retain positions, while the Song-Brown Residency Program has had low impact to date. Table 8 shows the mean ratings by program, as well as the percentage of respondents indicating the program has been either “somewhat” or “very” effective.

Table 8: County Ratings of WET Program Effectiveness in 2013*

State-Administered WET Program	N**	Average Rating (out of 4)	% Rating the Program Somewhat or Very Effective
MHLAP	26	3.42	92.3%
Social Worker Stipend Program	21	2.67	53.9%
MFT Stipend Program	20	2.55	56.0%
PMHNP Stipend Program	17	2.24	39.1%
Psychiatric Residency Program	19	1.68	21.7%
Clinical Psychologist Stipend Program	17	1.59	13.0%
Song-Brown Residency for Physician’s Assistants in Mental Health	12	1.08	0%
OVERALL	--	2.32	--

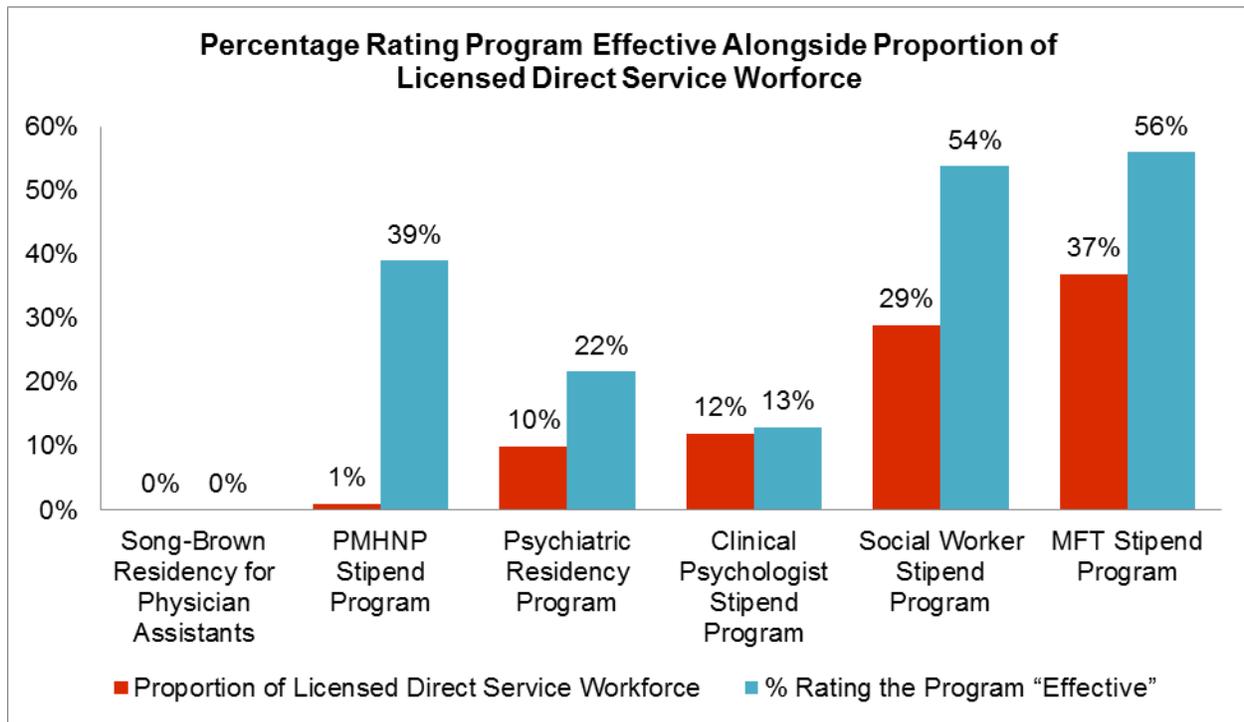
* Data obtained through County Needs Follow-Up Survey 2013

** Includes responses from 26 counties.

With the exception of the MHLAP program, for which anyone working in the PMHS is eligible, the state-administered educational WET programs are primarily focused on steering people into specific positions within the PMHS workforce. When the percentage of respondents rating programs favorably was juxtaposed with the percentage of the workforce that each target position comprised, a loose correlation became evident. Generally, the higher the proportion of the workforce that a position comprised, the higher was the perceived effectiveness of the program that targeted that position.

⁸ These were MHSA directors, WET Coordinators and other county mental/behavioral health department officials who were deemed by the counties as qualified to discuss the impact of state-administered WET programs.

Figure 1: Program Effectiveness and Workforce Distribution, 2013



The PMHNP Stipend Program emerged as an exception to the pattern, rating far more favorably than the prominence of Nurse Practitioners in the workforce would predict. PMHNPs comprised only 1% of the workforce, but the PMHNP Stipend Program was rated effective by 39% of respondents. It should be noted that University of California, San Francisco reported that their PMHNP Stipend Program ended due to lack of interest, which may correspond to the low proportion of the PMHS workforce that the position comprises.

Based on the pattern apparent in the other positions, where the approval rate ranged between 1.5 and 2 times the position’s workforce proportion, the Clinical Psychologist Stipend Program rated lower than might be anticipated, with an approval rating of only 13% (roughly equal to its workforce proportion). This may be explained in part by some difficulties the program administrators reported in placing program graduates in post-doctoral positions. For MHLAP, which is designed to increase capacity across direct and indirect service positions, program visibility and perceived impact are high, while for a program like the Song-Brown Residency Program, which is very specifically aimed at improving the vacancy rate for PAs, who only occupy 0.095% of the licensed direct service workforce, both visibility and approval are low. It should be noted that the proportion of the workforce that a position comprises was a better predictor of approval than was the number of program participants that state-administered WET programs have served in that position.

Program-by-Program View of Progress to Date

Each of these state-administered programs—Stipend Programs, MHLAP, the Song-Brown Residency Program for Physician Assistants in Mental Health, and the Psychiatric Residency Program—is reviewed here, to provide a program-by-program view of progress to date.

Stipend Programs

To build the future PMHS workforce, in 2008, DMH also implemented a series of Stipend Programs to attract more individuals to the PMHS and groom them for competency and effectiveness in the field. The Stipend Program incentivizes graduate students in Social Work, Marriage and Family Therapy, Clinical Psychology, and Psychiatric Mental Health Nurse Practitioner programs to commit to work in the PMHS for 12 months in exchange for monetary stipends.

The Stipend Programs were provided across a total of 21 California schools from FY 2008-09 through FY 2012-13, awarding a total of 2,205 individuals. Given that the Stipend Program for social workers began earlier (in 2005), that program has produced the majority of the recipients (67%) received stipends for social work, while 17% received stipends to become MFTs, 13% received stipends to become Clinical Psychologists, and 3% received stipends to become Psychiatric Nurse Practitioners. Among the recipients, 61% identified with one or more under-represented demographic groups, and 53% spoke at least one language in addition to English. This information is detailed by discipline in Table 9.

Table 9: Stipend Program Recipients, FY 2008-09 through FY 2012-13*

Discipline	Individuals Awarded	Awardees of Under-Represented Backgrounds	Awardees that Speak a Language in Addition to English
Social Workers**	1,486	59%	50%
Marriage and Family Therapists	367	73%	65%
Psychiatric Nurse Practitioners	63	46%	59%
Clinical Psychologist	283	58%	52%
Total/Average	2,205	61%	53%

*Data compiled by OSHPD

**The Stipend Program for Social Workers was implemented in 2005. The data shown is inclusive of participants from 2005.

The Stipend Programs are intended to feed providers into the PMHS in positions that have been most hard-to-fill/retain. All four disciplines rank among the top 12 hardest-to-fill/retain positions reported by counties in 2008 (see Table 6). Of all the Stipend Program recipients, 70% have been employed in California’s PMHS. The majority of employed recipients have been placed in the Los Angeles and Greater Bay Area Regions (see Table 10 for further details).

Table 10: Stipend Recipients by Discipline and Region Employed, 2008 – 2013*

Discipline	Central Region	Greater Bay Area Region	Los Angeles Region	Southern Region	Superior Region	Total
Social Workers**	209	307	365	303	74	1,258
Marriage and Family Therapists	14	43	42	42	13	154
Psychiatric Nurse Practitioners	9	32	7	5	3	56
Clinical Psychologist	1	43	34	8	0	86
TOTAL	233	425	448	358	90	1,554

*Data compiled by OSHPD

**Data from 2007 through 2011

Counties reported that the Stipend Programs were generally effective in helping them fill hard-to-fill/retain positions, rating the four programs at a combined average of 2.30 on a scale of 1-4 in which 1 indicated that the program was “not at all effective” and 4 indicated that the program was “very effective.” Of these programs, counties reported that the Stipend Program for Social Workers was most effective whereas the Clinical Psychologist Stipend Program was least effective (see Table 8). This low program rating for clinical psychologists was surprising given that in 2008, counties identified the clinical psychologist position as one of the hardest-to-fill/retain. Further review of the program data suggests that the insertion rate of clinical psychologists into the field still does not meet the level of need in the PMHS. Comments from a doctorate program contractor in Clinical Psychology offer a potential insight into the problem—she explained that once stipend recipients have finished their studies, they encounter a roadblock in the pursuit of a PMHS post-doctoral placement:

“The record [for program completion] is pretty good, but the major gap is that there is a lack of post-doc funding for psychologists in public mental health. [Graduates] are in an awkward position that those post-doc positions are very hard to find...They get post docs that do pay, but they are not in a qualified [public sector] program. Some have said, ‘if only I could get my post doc somewhere else I would go back to Public Sector Mental Health. If I could get the degree and have a year grace period to do the post doc before going to get the license.’...They pound the pavement and get discouraged and we lose them because of this crucial gap. These are folks who we are training to transform systems, but they have no PMHS entry point at that stage. These are skills that are distinct from other disciplines, so we need the system to facilitate their success.”⁹

These findings suggest that greater recruitment and accessibility efforts need to be made to draw more individuals to pursue graduate studies in Clinical Psychology, and that a solution should be found to ensure that program graduates who need them can find post-doctoral

⁹ Obtained by Evaluators via phone interview conducted in September 2013.

positions in the PMHS. Program contractors reported that program cost can present a major financial burden for students, especially those who come from disadvantage backgrounds. Additionally, the education required for clinical psychologists takes more time to complete, in comparison to obtaining an MSW for example, which adds another hindrance to producing greater numbers of Clinical Psychologists.

Mental Health Loan Assumption Program

The Mental Health Loan Assumption Program (MHLAP) was developed to incentivize providers to pursue hard-to-fill/retain positions in the PMHS. MHLAP provides up to \$10,000 in loan assumption in exchange for a minimum of 12 months of service in the PMHS. Since its launch during FY 2008-09 through FY 2012-13, MHLAP has awarded 2,841 providers across 58 counties. The year-to-year award breakdown is shown in Table 11.

Table 11: MHLAP Applications FY 2008-09 to FY 2012-13*

Fiscal Year	Applica- tions Rec'd	Indivi- duals Awarded	Funds Requested	Educational Debt	Funds Awarded	Counties Supported
FY 2008-09	1,236	288	\$15,454,813	\$60,729,395	\$2,285,277	44
FY 2009-10	1,498	309	\$12,683,961	\$80,331,133	\$2,469,239	52
FY 2010-11	1,009	474	\$10,030,983	\$71,177,144	\$4,523,757	50
FY 2011-12	1,659	661	\$16,581,901	\$111,533,342	\$5,365,680	55
FY 2012-13	1,823	1,109	\$17,968,953	\$122,828,475	\$9,383,649	53
Total	7,225	2,841	\$72,720,611	\$446,599,489	\$24,027,602	58

*Data compiled by OSHPD

Of those awarded, about 53% were Marriage and Family Therapists (MFTs and Interns combined), 37% were Clinical Social Workers (LCSWs and Interns combined), and 10% were Psychiatrists.

Table 12: MHLAP Participant Placement, 2009-2012*

Top Positions Filled	Total # of Participants	% of All Participants
MFT Intern	780	28.7%
Associate Clinical Social Worker	629	23.1%
Licensed MFT	471	17.3%
Licensed Clinical Social Worker	255	9.4%
Licensed Psychiatrist	228	8.4%

*Data compiled from program contractor reports (n=2,719)

Of the 1,743 MHLAP awardees between FY 2008-09 and FY 2010-11, about 32% provided services in the Southern Region, 29% provided services in the Los Angeles Region (wholly inclusive of Los Angeles County), 19% provided services in the Greater Bay Area Region, 15% provided services in the Central Region, and 5% provided services in the Superior Region. This distribution of MHLAP recipients is shown in Figure 2.

Additionally, 56% of MHLAP recipients spoke at least one language in addition to English and 55% had consumer/family member experience in mental health.¹⁰

As shown previously (see Table 8), counties felt that MHLAP has been the most effective state-administered program in helping them retain personnel in hard-to-fill/retain positions, with 92% of responding counties rating the program as “somewhat” or “very”

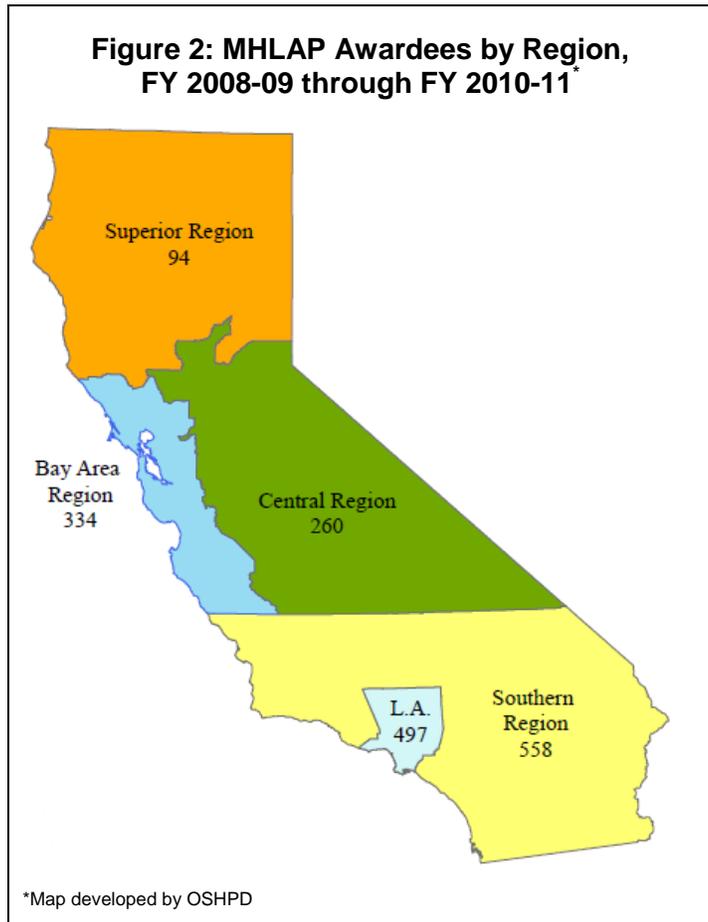
effective. The following open-ended survey response echoes and expands on this finding:

“The MHLAP program has been one of the more effective state administered programs in our county, however, based on the number of staff who apply and are awarded, it seems that [our county] is not maximizing the potential of what’s available. Not sure if there should be changes on the local level to encourage more staff to apply who are appropriate for the award.”

These findings suggest that OSHPD should continue administering MHLAP in addition to providing some program information and guidance as a “refresher” to counties.

Song-Brown Residency Program for Physician Assistants in Mental Health

The Song-Brown Residency Program for Physician Assistants (PAs) in Mental Health (henceforth referred to as “Song-Brown Residency Program”) was established to ensure that PA students perform rotations in rural and underserved communities including the PMHS. It is intended to build PAs’ competency in mental health, and especially to strengthen the number of



¹⁰ Data analyzed by OSHPD.

individuals who can oversee psychiatric treatment plans and administer medication to mental health patients in the PMHS workforce. From FY 2008-09 through FY 2012-13, the state awarded PA program participants with grants from \$15,000 to \$167,000 to accommodate this education and workforce preparation.

The program was contracted through six universities with PA programs. The programs were required to incorporate MHSA values and principles in their curriculum, including community collaboration, cultural competence, client and family-driven services, wellness, recovery, and resiliency, and provision of integrated service experience for clients and their families. Across the six contractors, the Song-Brown Residency Program enabled 1,382 PA students to be trained in MHSA principles, performing a total of 6,046 hours of mental health rotations.¹¹ Among the rotation sites were the Fresno County Department of Behavioral Health, Riverside County Department of Mental Health, and Stanislaus County Health Services Agency.

While the programs instilled MHSA values and principles into the future PAs, counties reported that the Song-Brown Program was not effective in helping them place or retain personnel in hard-to-fill/retain positions (see Table 8). Further, only five counties reported using the Song-Brown Program to build the local PMHS workforce, making it the least utilized state-administered WET program.¹² The program contractors reported that there was a sense of disinterest among providers in the PMHS in utilizing the Song-Brown Program, and that it was difficult to engage PMHS collaborators to place and supervise PAs. Notably, in the 2013 county needs follow-up survey, county mental/behavioral health department reported that PAs were used to substitute for shortages in Psychiatrists only 7% of the time. County agencies expressed concerns about PAs having enough advanced training in Psychiatry, resulting in further concerns around HIPAA-compliance and liability. Instead, PMHS agencies reported giving placement priority to medical students with a required psychiatric clerkship.

Psychiatric Residency Program

The Psychiatric Residency Program was developed to ensure that the Psychiatric Residents receive training in the county-level PMHS, working with the populations prioritized by their respective communities. Psychiatric Residents are encouraged to continue working in the California PMHS at the end of their rotations. The program has been contracted through two universities.

The programs did not consistently record participant demographic information, but reported serving a total of 81 participants, 50 (62%) of whom spoke at least one language in addition to English. The programs graduated 41 participants, 32 (78%) of whom were employed in the public mental health system

Given that counties reported Psychiatrists as the most hard-to-fill/retain PMHS position, it was surprising that only eight counties reported using in the Psychiatric Residency Program to enhance their local PMHS workforce.¹³ Further, only 13% of responding counties indicated that

¹¹ Data analyzed by OSHPD.

¹² Data retrieved from 2013 County-Reported Needs Assessment.

¹³ Data retrieved from 2013 County-Reported Needs Assessment.

the Psychiatric Residency Program was “somewhat” or “very” effective in helping them fill hard-to-fill/retain positions (see Table 8). Given that all the counties that participated in the Psychiatric Residency Program were medium or large counties, it may be that only larger counties have the capacity to take advantage of the program. Making the program more accessible to smaller counties may improve usage rates and bring more Psychiatrists into the PMHS workforce.

Regional Partnerships

In 2008, MHSA funded five Regional Partnerships to support the advancement and development of the PMHS workforce. Each Regional Partnership’s role and responsibilities varied based on the needs within the region. In this section the evaluation presents a discussion of how the five Regional Partnerships have attempted to address the identified gaps between workforce education and regional need, including quantifiable need for: first responder training, formal degree programs to prepare practitioners to work in the PMHS, high school academies, other career pathways, cultural/linguistic competency-building, distance-learning, and wellness and recovery-oriented training.

Central Regional Partnership

The Central Regional Partnership serves 20 inland counties located in the center of the state: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, and Yuba. Fifteen of these counties were considered small counties with populations fewer than 200,000 residents.

Among the prioritized MHSA WET needs in this region were:

1. Developing MHSA-aligned distance learning for staff, providers, and volunteers;
2. Creating PMHS pathway programming for underserved youth;
3. Implementing psychiatric education and career pathways for Nurse Practitioners; and
4. Generally improving workforce skills and cultural competency to meet the needs of the region’s mental health consumers.

The Central Regional Partnership completed its core competency project, but was unsuccessful in implementing the project at the regional level as each of its county mental health and human resources departments operated differently from one another. The partnership was able to revise the project to be implemented at the county level. Additionally, the Central Regional Partnership facilitated the following outcomes:

- Collaborated with California State University (CSU) Fresno to provide a PMHNP Online Program to increase the number of PMHNPs, a hard-to-fill position, in the Central Region. Since 2008, the program enrolled 32 students, 43% of whom were Central Region residents. By March 2013, three students have graduated and obtained employment, however, it was unclear if employment was in the region’s PMHS.

- In 2009, collaborated with several counties to launch MSW Rural Mental Health Program at CSU Sacramento to address the shortage of MSW mental health service providers in rural areas. Courses were offered during weekends to increase ease of access. The program has since enrolled 32 students, 26 of whom have graduated, and 14 who were employed as of March 2013. Nine of those who gained employment worked in the PMHS and at least one is currently providing MSW-level services in rural areas of the region.
- Provided training to about 700 individuals on topics such as suicide prevention intervention; Seeking Safety; Screening, Brief Intervention, and Referral to Treatment (SBIRT); and motivational interviewing
- Provided Mental Health First Aid training, a mental health literacy and stigma reduction program, for instructors. This resulted in about 100 active and certified instructors in the Central Region who have, in turn, trained approximately 2,500 other individuals in the region.
- In 2009, the Partnership identified and hired a Central Regional Partnership Coordinator to facilitate and manage all of the Partnership's projects and program. The implementation of the role has led to numerous agency meetings, several regional trainings, and a handful of contracts for school-based programs. The implementation of this position continues to be refined as the needs of the region are defined.
- In addition to the above, the Central Regional Partnership has several other ongoing and in-progress projects to improve the WET components of PMHS in their region. These include:
 - Roving Clinical Supervisor Program aimed at increasing the number of licensed hard-to-fill clinical positions of staff and providers in PMHS. This program has been implemented and is still in progress.
 - Online Psychosocial Rehabilitation Programs intended to increase access to recovery-based education for staff, providers, volunteers, consumers, and family members. These programs have been implemented and are still in progress.
 - Financial Incentive Program proposed to provide financial incentive administration for counties to more easily implement their local financial incentive plans. This program has not yet been developed.

Greater Bay Area Regional Partnership

Otherwise known as the Greater Bay Area Mental Health & Education Workforce Collaborative, the Greater Bay Area Regional Partnership served 12 counties and one municipality: Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma Counties and the City of Berkeley. The Regional Partnership is coordinated by a Project Manager from CiMH and receives oversight from a local steering committee, the Greater Bay Area Mental Health Directors.

The Greater Bay Area Regional Partnership organized its activities around six major goals:

1. Develop regional training resources that integrate MHSA philosophy and values: promoting education, training and re-training of the mental health workforce to increase the practice of culturally competent, recovery oriented services.
2. Increase County Human Resources/Civil Service responsiveness to and operational support of public mental health employment needs.
3. Strengthen and expand educational partnerships to increase the viability and accessibility of the mental health workforce pipeline.
4. Increase the number of consumers and family members hired, retained and offered opportunities for career pathway development throughout the PMHS.
5. Develop a diverse and culturally- and linguistically-competent PMHS workforce serving unserved, underserved and inappropriately served consumers and their families.
6. Increase public awareness of and interest in pursuing PMHS careers.

The Greater Bay Area Regional Partnership is in the process of completing its core competency project, which will enable a deeper understanding the region's current workforce strengths, needs, and opportunities for integration and collaboration. Concurrently, the Greater Bay Area Regional Partnership took on a supportive role, providing technical assistance, arranging inter-county resources, and coordinating large training efforts. The Partnership's key activities included the following:

- Launched a new MSW Program at CSU Monterey Bay in August 2010. Partnership funding has shifted from directly supporting operation to augmenting student scholarships. The program has since enrolled 103 diverse students, with the first cohort graduating in the spring of 2013. The program is still in the process of obtaining accreditation from the Council on Social Work Education.
- Started new Psychosocial Rehabilitation Program at Contra Costa College in all 2010. In spring 2013, the program had 17 students enrolled. Data for the cumulative number of students enrolled was not provided and information about employment outcomes were in the data collection phase.
- Provided High School Pathways Technical Assistance and Workshops to support county efforts in high school recruitment and exposure to the PMHS.
- Established the South Bay as a sub-region, launching the Southern Bay Area Regional Partnership in 2009. This partnership included Santa Cruz, San Benito, and Monterey Counties.
- In addition to the above, the Greater Bay Area Regional Partnership expanded their collaboration in the following activities:
 - Supported "Can We Talk?" one-day consumer and family member employment conference with San Mateo County Behavioral Health and Recovery Services to highlight best practices, lessons learned, and areas to continue exploring in the topic of consumer and family member employment in PMHS.
 - Coordinated Bay Area Community College Consortium and Health Workforce Initiative that brought together community colleges and employers to review the role of community colleges and mental/behavioral health workforces needs (e.g., curriculum choices, internships, training).

- Provided training and web-based curriculum support to the Bay Area MFT Educators Consortium.
- Hosted Conference on Primary Care Integration/Health Care Reform for graduate faculty in Social Work, MFT, Psychology, and Nursing.

Los Angeles Regional Partnership

The Los Angeles Regional Partnership encompasses all of Los Angeles County, accounting for nearly a third of the state's population.

In 2009, the Partnership identified four major goals and priorities:

1. Promulgation of Evidence-Based Practices (EBPs) that are clearly tied to significant outcomes for individuals and their families;
2. Adaptation of EBPs to culturally-diverse populations;
3. Implementation of EBPs in mental health, physical health, and other human service sectors; and
4. Expanding collaborative efforts with local higher educational institutions in order to promote translational research.

Like the Greater Bay Area Regional Partnership, the Los Angeles Regional Partnership took on a supporting role in assisting and facilitating WET expansion initiatives among its counties and CBOs. The Partnership shared its perceptions regarding the qualitative outcomes it has facilitated in the region. Due to the anecdotal nature of the findings, the magnitude of impact in terms of the numbers of individuals reached and served remains unclear. Since 2008, the Los Angeles Regional Partnership accomplished the following:

1. Implemented the Translational Research Program Project to leverage other resources in support of PMHS alignment with the mission of the Los Angeles County Department of Mental Health mission.
2. Supported the Older Adult Research Project in the standardization and validation of the Milestones of Recovery: Older Adult Version (MORS-OAV). This instrument for statewide use with older adults with severe and persistent mental illness is now available to the larger community.
3. Coordinated the Child STEPS project under the direction of a local training institution to engage the mental health provider community in developing an effective intervention for children with emotional/behavioral problems.
4. Worked with CalSWEC on the Aging Initiative to expand the capacity of the workforce to provide interventions for the older adult population in the LA Region.
5. Established the Olive View Psychiatric Residency Program, which has supported the education of Psychiatric Residents in a local training institution, thereby contributing to the expansion of the mental health workforce. However, the Partnership did not report how many Residents were enrolled in the program and whether they were placed in the PMHS.

Southern Regional Partnership

The Southern Regional Partnership served nine counties and the Tri-City Mental Health region in the south-most part of the state: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura.

In 2009, the Southern Regional Partnership identified the following major goals and priorities:

1. Workforce, education, and training coordination to provide a development and project management leadership infrastructure in the “lower” southern counties.
2. Technical assistance and project management support to the smaller “upper” Southern counties that lack existing staff resources to support additional projects.
3. Development of creative projects that support regional workforce innovations.
4. Development of local general behavioral health competencies.
5. Outreach to educational institutions and programs to build on the success of many counties in the region.
6. Development of Career Pathways in Behavioral/Mental Health to support activities that the counties are all participating in at a county level, such as high school career fairs, engaging Regional Occupation Programs (ROP), and additional work with both secondary and postsecondary education.
7. Support all counties in the process of developing and maintaining internship and/or volunteer programs.
8. Share best practices and training information to allow interns to be universally hired by other southern counties as a means to expand the PMHS workforce.
9. Support all counties in providing financial incentives to increase workforce diversity and facilitate ways for counties to share best practices and strategies for navigating county systems to create a more inclusive workforce.

The Southern Regional Partnership actively supported its counties’ implementation and expansion of WET activities. The Partnership focused many of its efforts in education and curriculum projects as a means to improve its PMHS workforce. The Southern Regional Partnership collaborated with Loma Linda University to conduct its core competencies project in which they have performed extensive data collection to develop 12 core competencies that are expected to be used not only in education and training efforts, but also in employment settings, including recruitment, orientation, supervision, training, and evaluation. The project was planned for complete implementation by 2014. The Southern Regional Partnership reported in 2013 that 12 core competencies have been developed and vetted among focus groups of professional Clinical Staff, Supervisors, Managers, WET Coordinators, Ethnic Services Managers, the Regional Coordinator, Mental/Behavioral Health Directors, and Peer Specialists. Additionally, the Southern Regional Partnership facilitated the following WET outcomes:

- Contracted with the American Association for Marriage and Family Therapy to facilitate 10 Transformed Supervisor Trainings throughout the region. The trainings were targeted for what had been a gap in workforce expansion efforts: supervisors of interns and

trainees within the PMHS. Over 150 participants learned how to adopt the recovery-oriented approach to their clinical supervision work.

- Published a career activity booklet called “Mental Health Careers: Pathways to Success” for use with WET Coordinators and other PMHS recruiters to facilitate recruitment among high school students to the PMHS. Anecdotally, the Partnership reported that thousands of these booklets have been distributed throughout the region and that it has been an effective recruitment tool.
- Developed a Job Description Crosswalk across all the different job titles and descriptions within the PMHS across all 10 counties. Designed for high schools, adult education, regional occupational programs, community college, and the general public, the purpose was to promote understanding of the similarities between jobs and offer a “career ladder” across the region. The Crosswalk is accessible online which indirectly exposes users to other topics in PMHS.
- Launched JobsInSoCal.com in September 2013, an online job board that lists all open positions in behavioral health in the Southern Region counties. The job board was also marketed to those outside of the public behavioral health field to build greater awareness of the types of careers available that might not be commonly recognized as related to mental health. The intentional selection of the website name was a calculated step to reduce stigma against mental health and boost the desirability of careers in behavioral and mental health.

Superior Regional Partnership

The Superior Regional Partnership served 16 counties in the northern-most part of California, a large proportion of which are small or rural: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity.

The Superior Regional Partnership identified the following three WET priority areas:

1. Support the planning, development and implementation of a distance learning system, accessible throughout the Superior Region including articulating agreements between two- and four-year institutions.
2. Encourage the strengthening of curricula in the Superior Region to support wellness and recovery principles and assure that mental health departments support and encourage career paths through the higher education system.
3. Identify resources to support training and technical assistance that is accessible, wellness- and recovery-focused, and available in distance education formats.

The Superior Regional Partnership worked primarily with local educational institutions in implementing and expanding WET activities throughout the region’s counties. In 2010, the Superior Regional Partnership held a Community College Summit in which four of the seven community colleges in the region participated in identifying the needs of the mental health workforce and enlisted the Partnership’s assistance in the creation of mental health workforce competencies. Additionally, the Southern Regional Partnership facilitated the following WET outcomes:

- Funded the creation of the Social Work Distributed Learning Programs at CSU Chico and Humboldt. These programs are now fully operational. Since 2009, the MSW programs enrolled about 100 students and graduated 37 students, 34 of which were Superior Region residents. However, employment information was not yet available. Since 2011, the BSW programs have enrolled 46 students, the majority of whom were Superior Region residents.
 - Additionally, the Partnership funded the mentorship components for these students, a practice that contributes to the success of geographically isolated and first-generation students.
- Offered Mental Health Wellness and Recovery multi-disciplinary courses to Social Work, Marriage and Family Therapy, social science, and other graduate students.
- Coordinated week-long Wellness Recovery Action Planning training in 2010 for county wellness center staff. Twelve staff members throughout the region became certified.
- In addition to the above WET enhancement efforts, the Superior Regional Partnership has the following projects in development:
 - Approved proposal to create Behavioral Career Pathways at College of the Redwoods to stimulate interest in behavioral health careers among high school and community college students by introducing them to mental health education and internship opportunities.
 - The Superior Region Resource Mapping Project is in progress and is intended to develop a database that identifies existing expertise and training resources within the region.

Comparative Overview of Regional Partnership Focus Areas

Each of the five Regional Partnerships supported their counties based on needs within the region. Some Regional Partnerships played more interactive roles than others. The activities Regional Partnerships engaged in to fill the gaps within the WET components of their local PMHS generally fell into eight categories:

1. Cultural competency trainings for PMHS providers, staff, Peer Specialists, and volunteers;
2. Curriculum-focused efforts with academic institutions, including the implementation of distance learning techniques in rural counties;
3. High school mental health career pathway programs to recruit young people into the PMHS workforce and reduce stigma associated with mental health;
4. Region-wide core competencies project in which the Partnership worked with various colleges and PMHS employers throughout the region to identify the essential competencies a PMHS professional needs to be effective;
5. Efforts to move mental health education, training, and practice toward a recovery-oriented model;
6. Creation, implementation, or assistance in administering programs targeting the underserved that are not otherwise provided by counties and other PMHS service providers;
7. Programs that are explicitly aimed at reducing stigma around mental health; and

8. Facilitation, coordination, or implementation of mental health training for first responders and Mental Health First Aid training.

These activities and supports included the provision of funds for PMHS programming, technical assistance to enable county and agency collaborations, and direct skill development training to staff, providers, volunteers, consumers, and family members on topics such as suicide prevention, motivational interviewing, Seeking Safety, and other EBPs. The matrix below provides a snapshot of the categories of activities and supports provided by each Regional Partnership.

Table 13: Regional Partnership Activities and Supports, 2008 – 2013*

Regional Partnership	Cultural competency trainings	Curriculum-focused efforts w/ academic institutions	High school mental health career pathways	Core competencies project	Movement toward recovery orientation in WET	Programs targeting the underserved	Explicit stigma reduction efforts	First responder training and MH First Aid trainings
Central	X	X		X	X	X	X	X
Greater Bay Area	X		X	X	X		X	
Los Angeles	X	X				X		
Southern	X	X	X	X	X			
Superior		X	X		X			

*Data compiled from Regional Partnership reports.

The Regional Partnerships were in varying stages of implementing a core competencies project in which they aimed to: learn about the existing regional demands for workforce readiness; establish a list of core competencies for public mental health employees; develop ways to improve training and education to ensure that these core competencies are met; devise methods to supervise, recruit, train, and evaluate those currently in the workforce; and codify procedures to assess these competencies. The Regional Partnerships are also working with one another to compare core competency projects and continuing gaps and to share ideas, services, and approaches to fill those gaps.

Additionally, several Regional Partnerships have collaborated with local community-based organizations (CBOs), universities, and government entities to expand education and training in PMHS to help meet those county needs not fully addressed by the stipend, loan assumption, and residency programs. The Regional Partnerships have also partnered with the stipend and residency program operators to expand their capacity to prepare a competent and capable workforce through formal education. For instance, the Superior Regional Partnership worked with Loma Linda University on a core competency project in which they surveyed the PMHS to identify a set of core competencies; list of knowledge, skills, and abilities; and criteria for measuring performance necessary to define the knowledge, skills, and abilities expected of those serving in the PMHS workforce. The Superior Regional Partnership intends to use this

core competencies package in their support of curriculum alignment with MHSA and in providing technical assistance to counties and CBOs as they revamp staff supervision, recruitment, training, and evaluations. In another example, the Central Regional Partnership collaborated with UC Davis Extension Center for Human Services in 2013 to deliver a one-year course on the study of leadership in mental health services that is intended to develop the leadership skills of staff, providers, volunteers, and especially consumers and family members. In the first segment of this course, 60 program evaluations were collected in which all scores related to the course content and instructor's abilities earned an average score of four out of five.

Client and Family Member Statewide Technical Assistance Center

Baseline

The 2008 workforce assessment that included 28 counties could not provide a conclusive quantification of the representation of people with lived experience as consumers or family members in the PMHS workforce. But it does provide a general impression of the extent to which the workforce was in need of consumers and family members at various levels of the PMHS workforce in 2008 (including but not limited to explicitly designated positions such as peer support specialists).

Overall, counties reported that 6.8% of total authorized FTE were in positions specifically designated for individuals with consumer or family member experience. Among unlicensed direct service staff, the proportion was 15.9%, with 73% of this number concentrated in two positions: Consumer Support Staff and Family Member Support Staff.

In 2008 most counties¹⁴ had some specifically designated positions for individuals with consumer or family member experience, although only a few¹⁵ could identify the proportion of consumers or family members working in a variety of positions, based on self-disclosure. The largest category of positions was advocacy or support positions for fellow consumers. Positions to support family members, outreach, crisis response, and working at wellness centers were mentioned as well. Obstacles to consumer and family member employment that were emphasized by counties in 2008 included:

- Absence of focused recruitment;
- Required criminal background clearances;
- Education (e.g., clinical training) and experience requirements; and
- Tradition or organizational culture resistant to change.

¹⁴ The number of counties with designated positions was not recorded in a way that categorized for unduplicated counts. Therefore, the actual number of counties that have designated positions for consumers or family members could not be determined. Given the probability of unduplicated counts, the evaluation approximates that 16 of the 28 responding counties (57%) had designated positions for consumers and family members. This extrapolates to about 33 counties statewide that may have designated positions for consumers and family members.

¹⁵ Information from the 2008 needs assessment (Shea, 2009) was not specific about the number of counties that could identify the proportion of PMHS staff who were consumers or family members.

Fifty-four percent (54%) of county work plans in 2008 mentioned an intention to address greater consumer and/or family member employment. The report from 2008 county data (Shea, 2009) estimated that the number of designated positions would need to nearly double to meet the need, with greater increases among unlicensed direct service personnel. The data in Table 14 was gathered from that report.

Table 14: Need for Consumer and Family Member Staff at Various Levels of PMHS, 2008 – 2013*

Major Group, Position	2008 Specifically Authorized FTEs for Consumer/ Family Members	Number of additional FTE estimated to meet need	Target % increase from baseline in 2013
A. Unlicensed Mental Health Direct Service Staff:	2,366	2,509	106.0%
Consumer Support Staff	1,113	1,336	120.0%
Family Member Support Staff	614	670	109.1%
Other Unlicensed MH Direct Service Staff	39	502	78.6%
B. Licensed Mental Health Staff (direct service)	353	225	63.7%
C. Other Health Care Staff (direct service)	104	72	69.2%
D. Managerial and Supervisor	211	119	56.4%
E. Support Staff	285	129	45.3%
TOTAL (all major groups and positions)	3,319	3,054	92.0%

*Data compiled from Shea, 2009 Report

Progress

As part of the state-administered WET strategy, the California Institute for Mental Health (CiMH) was funded to run a technical assistance center to promote the recruitment, hiring, retention and support of people with lived experience as mental health clients and family members within the PMHS workforce. CiMH works with three subcontracting agencies, United Advocates for Children and Families, National Alliance on Mental Illness (NAMI), and a partnership between the California Association of Mental Health Peer Run Organizations (CAMHPRO) and Peers Envisioning and Engaging in Recovery Services (PEERS)—together the effort is called Working Well Together (WWT).

Since receiving funding in 2008, WWT has developed assessment tools for agencies to recognize where they are in terms of engaging consumers and family members in the workforce. WWT put together several curricula for training individuals who identify as consumers and family members for employment in the PMHS, preparing the workforce for employing consumers and family members, and for hiring and retaining consumers and family members. They also have:

- A toolkit for recruiting, hiring and retaining employees with lived experience within the public mental health workforce;

- A white paper on how to successfully employing people with lived experience within public mental health; and
- Peer Certification standards and recommendations for a statewide plan.

WWT has also worked more directly with counties to advance their objectives. WWT conducted 159 site visits to county mental health departments to help them build their capacity to recruit, hire and retain consumer and family members in their workforce, and offered 34 trainings in communities, engaging a total of 3,677 (duplicated) individuals. It should be noted that some of the other state-administered WET programs also succeeded in supporting individuals with lived experience in the PMHS workforce. For example, MHLAP provided loan repayment to four designated consumer and family member positions, 55% of MHLAP awardees had a consumer/family member background, two of the Regional Partnerships have engaged in stigma reduction activities, and in fiscal year 2012-13 40% of MFT and PMHNP, and 26% of Clinical Psychologist stipend recipients had a consumer and family member background.

WWT does not track the number of positions that have been created or filled as a result of the technical assistance they provide to counties, or any of the other work they have done to build capacity, so this evaluation is not able to make any statements about increased representation of people with lived experience in the PMHS workforce. Since WWT is essentially an intermediary organization working to support counties in their development, rather than an agency directly involved in placing consumers and family members within the PMHS workforce, the lack of tracking is not surprising. CiMH noted in interviews that several consumer and family member designated positions were created in 2007-2009 as a result of MHSA in general. Despite the state-administered WET launch and county-led efforts for greater consumer and family member involvement, many counties reduced or eliminated those positions shortly thereafter when the California economy fell into crisis. Nevertheless, it can be presumed that the effort has resulted in an increase in the number of trainings and training curricula that have been developed with input and leadership from people with lived experience as consumers and family members, as all WWT training curricula were developed with consumer and family member leadership.

Impressions of Impact: Case Studies

Fifty-two percent (52%) of counties who responded to the survey felt that WWT has been either “very” or “somewhat” effective. Approximately 30% felt WWT had not been effective, and approximately 17% simply did not know. Because the survey findings did not provide conclusive evidence on whether or not WWT has been effective, the case studies below were constructed to complement the analysis. These case studies are meant to provide in-depth views of how WWT efforts affected counties.

The two case studies are based on telephone interviews that evaluation team members conducted with two counties in December 2013, one from the Central Region and one from the Southern Region. The counties were selected based on their responses to the county survey in which they indicated that they had either a favorable or unfavorable impression of WWT’s impact. To create conditions conducive to a candid conversation, interviewees were assured

that their counties would not be named in the report and will henceforth be referred to as *County X* and *County Y*.

County X

The MHTA Program Manager from *County X* did not have a favorable impression of the value offered by WWT. Her frustration stemmed from what she perceived as WWT's inability to convey how they could support her county. As she did not feel the program value was clearly communicated, she did not see a reason to engage WWT further. She put it this way in an interview with the evaluators:

"I've always had a difficult time trying to figure out what WWT had to offer counties.... I've had a very hard time and I've tried to figure out the value, to figure out what can they do for counties and I've never gotten a concise answer about what their product is. So that has been my biggest frustration. I need to know. We wear many hats, and if you are asking for my time I need to know what you can do for me—train my staff? Work with my managers? Provide a training? Work with my consumers? The answer to all of that was, 'no, no, no.' It was all very conceptual and ambiguous—none of it was of concrete value to counties."

Initial Contact

WWT utilized multiple methods to contact the MHTA Program Manager, including email requests and brochures, but she never felt WWT's mission or the measurable objectives that WWT aimed to achieve with counties were clearly conveyed.

"I kept getting requests to talk and meet, and I kept asking, 'what value will you bring?' and I could never get a straight answer. I've seen the brochures and they also don't provide a clear message about what they offered counties."

Technical Assistance

County X did not benefit from any technical assistance offered by WWT. Because the benefit of working with WWT was never clear to the MHTA Program Manager, she did not feel she could justify carving out time from her other duties to explore the assistance WWT might be able to offer.

Engaging Counties in Peer Certification

WWT has been working to establish a process by which Peer Specialists can be certified in the State of California. The success of this effort is dependent on input from various stakeholders, including county-level MHTA Program Managers and WET Coordinators.

County X had very limited involvement in the peer certification process. The *County X* MHTA Program Manager was not impressed with WWT's communication on this matter, and felt greater efforts should have been made to engage counties directly in the peer certification process. She put it this way:

“...I’m on the WET Coordinator calls, the MHTA coordinator calls, the cultural competency calls, and I had not heard that WWT was working on peer certification. I think getting peers certified is a really good idea, but they were not involving the counties in this. It was doing a disservice to the whole process because you need counties involved.... At some point I started getting vocal and counties got involved, but it was pretty far down the line.”

Ideas for Improved Effectiveness

County X offered some ideas for how WWT could be more effective, primarily focused on communication with counties:

“If they had a clear and concise product that could be offered to counties, like training modules, or if they worked with counties to create core competencies for consumer positions, something that added value to counties that would be beneficial. A menu of options for counties would be great. I wouldn’t even know how to evaluate what they are doing because I don’t even know what their products are. I don’t know what their effectiveness on the peer certification process is because we weren’t invited to be a part of it. If they are going to continue to receive funding, it should be concrete what they’re doing and very clear to the counties.”

County Y

County Y had a favorable view of WWT and felt the organization had offered valuable assistance on matters that were very specific to their county, including providing curriculum, consultation on staff management issues, and putting in place policies and procedures.

“We have had a good experience with them. They’ve helped us with a couple of different situations. [Our TA provider] helped us find a curriculum for our county consumer staff. We have an annual code of conduct and she went through that to help us with some of our boundary issues...she helped us put some policies in place.”

Initial Contact

County Y had identified some questions and needs around how to support a workforce that incorporated consumers and family members, so the WET Manager was very responsive to WWT’s initial outreach. The WET Manager from *County Y* described WWT as having a firm understanding of consumer culture and how to incorporate it into the workplace:

“There is a big adjustment for Clinicians to make when they start seeing consumers as clients and then as co-workers. The [WWT staff] understand that transition and have been helpful in providing TA to help with that adjustment.”

Technical Assistance

County Y has benefitted in particular from the on-site technical assistance that WWT offers, but not from WWT’s regional trainings. WWT provided this county with very hands-on assistance with staff issues, and more.

“The on-site TA has been particularly helpful...they have helped us with specific problems that have come up. [Our WWT TA provider] has also participated in the Regional Partnership, helped make sure we have consumer voice as we go forward with that.”

This county has not, however, been able to take advantage of the regional trainings:

“The regional training approach hasn’t worked that well, because for us trying to send staff to another county is not practical – our county is large and the trainings have been far away...I don’t know that a lot of counties have taken advantage of those regional trainings because they are not that easy to attend. And they [WWT] have not done a good job selling those trainings, trying to get the word out on what the topics are going to be so that they get the right people to those. They announced a training and it wasn’t that clear who should attend so we sent our consumer staff, and it would have been useful to send someone else.”

Engaging Counties in Peer Certification

County Y has engaged in the WWT effort to establish a peer certification process, although the WET Manager from *County Y* does acknowledge that greater county involvement is called for:

“We have participated in their peer certification process. The biggest suggestion I would have there is there is not enough county participation in that. The counties are claiming that they didn’t know about it, although there were a million emails about it. It goes back to how you communicate what you’re doing.”

Ideas for Improved Effectiveness

The WET Manager from *County Y*, having found it difficult to participate in regional trainings, had some suggestions for how WWT could make their trainings more accessible:

“[WWT should] focus on the TA and convert the trainings to webinars or web-based training so that people can access them. Or if the trainings were recorded so that we could integrate them into our county learning system, that would be good. If it’s a training that’s offered one day and our staff can’t go to the training in person, that’s not as useful.”

WET Programs Addressing Priority Areas

This evaluation finds that the state-administered WET programs have helped advance progress toward several of the priority areas stated in the 2008 WET Five-Year Plan. A number of program limitations were identified during the course of this evaluation. Just as important to note are the limitations of the study—because of incomplete data, several methodological assumptions were made that must be recognized as stipulations to any findings or conclusions contained in this report. The findings and limitations are discussed below.

Addressing Cultural and Linguistic Competency

A key objective of the state-administered WET programs is to help balance the discrepancies between the cultural composition of consumers and the composition of the workforce, including ethnic identification, linguistic competency, lived experience as a client or family member, and lesbian, gay, bisexual, transgender, or questioning (LGBTQ) identification. While it has been impractical for most of the education/workforce preparation programs to track the latter two of these diversity categories, all of the programs explicitly reported that increasing diversity was a part of how they designed and implemented their programs. Below is a discussion of the aggregate impact of programs on the cultural and linguistic competency of the PMHS workforce.

Baseline

In 2008, counties were asked to quantify the number of personnel falling into key ethnic categories and having proficiency in a language other than English. The report based on counties' responses (Shea, 2009) provided data that are arranged in Table 15 and Table 16. According to the report, filled full-time equivalent (FTE) figures were extrapolated from size/density totals, and "Targeted MH Population" was based on weighted average percentages by county population.

Table 15 presents the ethnic and multilingual representation among *direct service personnel* within the PMHS workforce from the 2008 survey. These figures included both county and contracted agency personnel.

Table 15: Ethnic Representation within Workforce Categories Reported in 2008*

Race	White	Latino	Black	Asian	Native American	Multi/Other	Total
Unlicensed Direct	5,256	4,056	2,099	965	119	1,026	13,521
Licensed Direct	6,938	2,417	1,072	1,342	110	1,076	12,955
Other Direct	1,095	170	393	414	8	479	2,558
TOTAL	13,289	6,643	3,564	2,721	237	2,581	29,034
Percentage	46%	23%	12%	9%	1%	9%	100%

*Data compiled from Shea, 2009 Report

Table 16 aligns the statewide target mental health population alongside the overall 2008 public health workforce, and the 2008 direct service workforce to show the discrepancies in workforce representativeness.

Table 16: Differences between PMHS Workforce and Target Mental Health Population 2008*

Race/Ethnicity	Target MH Population	Public MH Workforce	% Point Difference	Direct Service Only	% Point Difference
White/Caucasian	33.0%	44.8%	-11.8	45.8%	-12.8
Hispanic/Latino	37.7%	24.2%	+13.5	22.9%	+14.8
African American/Black	17.3%	12.9%	+4.4	12.3%	+5.0
Asian/Filipino/Pacific Islander	7.0%	9.6%	-2.6	9.4%	-2.4
Native American	0.9%	0.8%	+0.1	.8%	+0.1
Multi Race or Other	4.1%	7.7%	-3.6	8.9%	-4.8

*Data compiled from Shea, 2009 Report

The greatest discrepancy in terms of ethnic representation in the workforce was among Latinos, who are shown in this table to be underrepresented in direct service positions, and in the PMHS workforce in general. African Americans are also underrepresented, and White and Asian ethnicities are overrepresented in the workforce. It should be noted that the Asian category is not broken down in the source document (Shea, 2009), to allow a discernment of specific Asian populations such as Chinese, Filipino, Japanese, Vietnamese, etc., whose cultural backgrounds and corresponding competencies would vary substantially.

In terms of language competencies, in 2008 there was a clear gap between the number of employees in the PMHS who were proficient in a non-English language and the number required to meet community need. At that time, an approximate 65% increase in bilingual staff was called for, the vast majority of whom would need to be proficient in Spanish.

Table 17: Workforce Gaps in Linguistic Proficiencies Reported in 2008*

Non-English Language	Total staff said to be proficient	Additional numbers need to be proficient	% by which baseline needed to be increased to meet need
Spanish	9,792	6,092	62.2%
Chinese	155	357	230.3%
Korean	141	353	250.4%
Tagalog	571	330	57.8%
Vietnamese	303	273	90.1%
Cantonese	400	138	34.5%
Russian	123	118	99.2%
Farsi	180	103	57.2%
Cambodian	115	18	15.7%
Mandarin	187	18	9.6%
TOTAL	11,967	7,800	65.2%

*Data compiled from Shea, 2009 Report

The state-administered WET programs were designed to address the disparities in ethnic representation and language proficiencies found in the 2008 Needs Assessment. Programs

have targeted underrepresented populations according to ethnicity, linguistic ability, and identification as LGBT.¹⁶ By including these factors in the selection of program participants, it was anticipated that state-administered WET programs could help more people of color and bilingual persons to be prepared for or incentivized to work in the PMHS workforce. In fact, for the 3,950 WET program participants for whom ethnic identity data are available, 2,617 (66%) were from non-White ethnic groups.

Progress

Nearly all of the state-administered WET programs aimed to support licensed direct service positions (even MHLAP, which is more open, has tended to attract individuals in direct service positions). Table 18, therefore, lists both baseline and progress figures for licensed direct service positions only. On the left half of the table, the number and percentages of the 2008 PMHS licensed direct service workforce (obtained from the 2008 county survey) are broken down by ethnic category, as are the percentage differences from the target (if the workforce were proportionate to the population). On the right side of the table are listed the number of individuals served by all state-administered WET programs,¹⁷ provided by program contractors in 2013, added to weighted baseline numbers to create a numeric impression of the increase under each ethnic category that the WET programs may be advancing.¹⁸ The resulting figures represent an approximation of the progress that WET programs have helped to effect by targeting under-represented populations. These figures should be recognized as somewhat theoretical in that they rest on the assumptions that each of the individuals served will go toward filling the gaps identified in 2008, and that those gaps have otherwise remained static.

¹⁶ Since identification as LGBT is not commonly noted among employees in any public or private employment system (in California employment discrimination on the basis of sexual orientation, actual or perceived, is not legal, but it is also illegal to ask employees at the time of employment about their sexual orientation), there are no baseline data on LGBT representation. While some WET programs do track LGBT identification, it was too inconsistent for inclusion. This section is therefore limited to discussing progress on cultural competency in terms of ethnic representation and linguistic capacity.

¹⁷ Numbers served by WWT are not included in this table. The demographics of WWT participants were not tracked, nor does WWT focus specifically on increasing the representativeness of licensed direct service personnel, while the other programs do.

¹⁸ Please see appendix for how baseline numbers were weighted in Tables 17 and 18.

Table 18: Ethnic Breakdown of Licensed Direct Service Providers in PMHS Workforce, 2008 – 2013

	Baseline 2008**			Progress 2013		
	Licensed Direct	%	Difference from Target	Licensed Direct	%	Difference from Target
Caucasian/White	6,938	54%	-20.6%	15,650	51%	-18.00%
Hispanic/Latino	2,417	19%	+19.0%	6,558	21%	+16.70%
African American/Black	1,072	8%	+9.0%	2,538	8%	+9.30%
Asian/Filipino/Pacific Islander	1,342	10%	-3.4%	3,252	11%	-4.00%
American Indian/Alaska Native	110	1%	+0.1%	261	1%	-0.10%
Multiple/Other*	1,076	8%	-4.2%	2,637	8%	-3.90%
TOTAL	12,955	100%	--	30,896	100%	--

*Includes those with unspecified ethnicities

**Baseline data were obtained from Shea, 2009 Report; Progress data are an extrapolation based on numbers served gathered from program contractor reports in 2008-2013. Details on how extrapolations were calculated are provided in the appendix.

The theoretical impact of state-administered WET programs, represented in Table 18, shows the following indicators of progress: the degree to which Caucasians/Whites are overrepresented in the licensed direct service workforce could be slightly reduced, and the degree to which Latinos are underrepresented could be slightly reduced. The impact on other ethnic groups appears to be negligible at this point.

It must be noted that there are some assumptions and methodological drawbacks to the data presented in this table. First of all, the baseline data are founded upon results from only 28 counties, or approximately 48% of the state’s counties. To add the number of individuals served by WET programs to a baseline that only represents 48% of the actual statewide workforce would overstate the impact of the programs (which should in theory be serving workers in all counties). To compensate for this potential overstatement, the baseline numbers were weighted before numbers served were added and a new ethnic breakdown of the workforce was calculated.¹⁹ This seemed the most practical method of extrapolating state-administered WET program impact, although it admittedly relies on the probably flawed assumption that the baseline ethnic breakdown is truly representative of the statewide ethnic breakdown at the time. Second, these numbers rely on an assumption that 100% of the state-administered WET program participants will in fact be placed in and remain in the PMHS workforce. Since many of the programs only require a short-term commitment to PMHS work, it is reasonable to assume that a number of the individuals represented in the progress figures will eventually vacate their positions.

In terms of linguistic competencies, the 2008 assessment data point to a deficiency of 7,800 bilingual individuals in the 28 counties included. State-administered WET program participant

¹⁹ The mathematical process used here is further described in the Appendix.

data shows that 2,419²⁰ bilingual individuals were served, thereby potentially increasing or helping to ensure the retention of the bilingual PMHS workforce. Specific language proficiencies of state-administered WET stipend, MHLAP, and residency participants are listed in Table 19, along with an estimate of their potential impact on the deficiency in bilingual staff.

Table 19: Linguistic Capacity of 2008 Workforce and 2013 WET Progress toward Targets*

Non-English Language	Number of public sector staff needed in 2008	Adjusted estimate of need ²¹	Number served by statewide education/workforce preparation WET programs	% of need potentially met by state-administered WET programs ²²
Spanish	6,092	12,671	1,708	13%
Chinese	513	1,067	109	10%
Other Asian	974	20,26	283	14%
Other	221	460	319	69%
TOTAL	7,800	16,224	2,419	15%

*Baseline data were obtained from Shea, 2009 Report; Progress data are an extrapolation based on numbers served gathered from program contractor reports in 2008-2013. Details on how extrapolations were calculated are provided in the appendix.

Based on the weighted estimate, it appears that by increasing (or helping to ensure the retention of) the PMHS workforce by 2,419 bilingual workers, state-administered WET programs may meet approximately 15% of the need identified at baseline.

County survey findings, as demonstrated in Table 20, show that a majority of the county officials who responded to the survey felt that the statewide educational/workforce preparation WET programs are helping to move the workforce toward greater cultural competency, diversity, and representativeness. The largest number of respondents felt the programs have been “somewhat effective” and a smaller but substantial number felt they were “very effective.”

²⁰ As language proficiency was tracked based on the number of non-English languages spoken, this number duplicates individuals who spoke more than one non-English language.

²¹ The mathematical process used here is further described in the Appendix.

²² Number served divided by the adjusted estimated need.

Table 20: Perceptions of WET Effectiveness in Increasing Cultural/Linguistic Competency, 2013*

Survey Question	n	Not at all/ Not very effective	Somewhat effective	Very effective	Don't know
How effective have state-administered WET programs been in increasing the cultural and linguistic competency of the workforce in your county?	26	11.5%	50.0%	34.6%	3.8%
How effective have state-administered WET programs been in increasing the diversity of the workforce in your county so that the workforce is more representative of the population served in terms of ethnicity, cultural tradition, religion, LGBT identification, etc.?	26	26.9%	38.5%	19.2%	15.4%

*Data from county survey 2013

The following anecdotal feedback was offered by a WET Coordinator from a large, diverse county. This statement demonstrates an impression of progress so far, with a sense that more impactful program results are yet to come.

“I think the diversity of staff is in progress, so although we checked ‘somewhat effective’ I believe the programming and funding is going to show results in the next couple of years that are quite impressive. Already, we are developing a much more diverse and well-trained workforce.”

Alignment of Curricula and Requirements to the Needs of a MHSA-Driven PMHS

An aim of the state-administered WET programs is to help ensure that mental health curricula at educational institutions include practical skills that would prepare graduates for work in the PMHS. This evaluation is able to provide a general discussion of how programs have promoted greater alignment of curricula and requirements to the needs of an MHSA-driven PMHS based on a review of reports by university program contractors and interviews with counties and program contractors.

Baseline

The evaluation pulls from a community mental health provider survey conducted in 2008 by the California Council of Community Mental Health Agencies (CCCMHA, 2008a) to establish a baseline impression of educational curricula before the implementation of the WET Five-Year Plan. Only 26 agencies were represented among CCCMHA survey respondents, but due to the size of the agencies, CCCMHA reports that the survey represents the workforce preparedness of approximately 5,485 employees. There were several competencies that emerged as areas for

which the 2008 workforce was deemed insufficiently prepared, the identification of which helped to inform a set of recommendations for the revision of statewide MFT curriculum requirements (CCCMHA, 2008b). Several of the top competency needs revolved around specific therapeutic modalities such as knowledge of trauma, dual diagnosis and professional ethics, which would apply within both the private and public sectors. Other competencies pertained very specifically to skills needed to work in the PMHS and to the values and approaches that characterize the MHSA, including being recovery-focused, familiar with evidence-based practices (EBPs), and being more client and family-centered. Table 21 presents survey results only on these public sector and MHSA-related competencies, along with the percentage of survey respondents who indicated that the current (2008) community mental health workforce had a need for training around that competency.

Table 21: Preparedness of Workforce As Reported in CCCMHA Survey

Competency Listed on 2008 CCCMHA Workforce Survey		%
Public Sector Skills	Ability to write chart notations that accurately reflect the intervention, goal and result, assist in making future decisions, support billing, reflect the role of the client in the treatment process and choices of goals and treatment activities	65%
	Assist clients and family members to understand and navigate the PMHS	46%
	Understand Medi-Cal, Medicare and Social Security eligibility	46%
	Complete billing procedures and charting documentation to support billing	42%
Recovery-Focused	Provide psychoeducation to clients and families whose members have SMI or other disorders, including information about wellness and recovery	73%
	Recognize strengths, limitations and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit	65%
	Understand recovery-oriented behavioral health services	58%
	Knowledge of the principles underlying recovery supportive practice	46%
EBP	Understand the concept of evidenced based treatment; development of evidence to evaluate promising practices	73%
	Develop with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans	62%
More Client and Family-Centered	Understand the developmental, intergenerational and life cycle approach to community mental health practice transculturally	62%
	Understanding of the impact of mental illness and substance abuse on the consumer and family members at all stages of the life cycle	62%
	Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan	58%
	Empower clients and their relationship systems to establish effective relationships with each other and larger systems	58%
	Respect multiple perspectives (e.g., clients, family, team, supervisor, practitioners from other disciplines involved in the case)	46%
	Work collaboratively with stakeholders, including family members, other significant persons and professionals who are significant to the client	42%

Progress

Those educational institutions that were contracted to provide state-administered WET programs supported workforce development not only by supplying the PMHS workforce with committed personnel, but also by implementing curricula that promoted cultural competency and the MHSA values of wellness, recovery, and resilience. The universities demonstrated their incorporation of these principles and values in their program mission and course syllabi.

Given that there was no uniform procedure for reporting alignment to MHSA principles, how programs incorporated cultural competency and wellness, recovery, and resilience was not always explicit, nor would it be methodologically sound to present a definitive quantification of the programs that made curricular changes when program contractors were not asked to report on such changes in a systematic way. However, it is possible to report that each funded university (100%) reported providing at least one course targeted toward cultural competency and at least one course that incorporated or embodied the MHSA values of wellness, recovery, and resilience. Among the courses that demonstrated alignment with MHSA principles were those titled Gender and Sexuality in Clinical Practice, Family and Community Care, Cross-Cultural Counseling, and Mental Care of Special Populations. Coursework that aligned with MHSA principles commonly targeted the themes of family, community, race/ethnicity, poverty, immigrants, the elderly, and substance abuse. For example, the Psychiatric Residency program operators have also introduced coursework that targets other underserved populations such as veterans, the homeless, LGBTQ-identified, people with HIV/AIDS, spirituality and religion, and rural populations.

Below are some examples of how university-based program contractors adapted curricula and requirements:

- Upon their inclusion in the Psychiatric Residency Program, program contractors revised their curricula to include MHSA values and principles in community collaboration, cultural competence, client/family-driven mental health system, focus on wellness, recovery, and resilience, and integrated service experience for clients and their families. The programs partnered with their local county departments of mental/behavioral health and community-based organizations to ensure that Residents would be able to perform rotations in the county-level PMHS. These rotation sites included Sacramento Mental Health Treatment Center, UC Davis Medical Center, Kern County Mental Health, and Kern County Department of Corrections.
- In the 2009-2010 school year, one PMHNP Stipend Program began integrating its resources to establish MHSA-aligned curriculum changes. Among its considerations for program integration and improvement were faculty participation in the Psychiatric Nurses Association's Recovery to Practice program, a program that develops ways to implement recovery components into psychiatric nursing education and practice.
- While nearly all programs explicitly documented their efforts to align coursework with MHSA values and principles, and/or developed courses specifically aimed at promoting MHSA values and principles as cited above, one of the Stipend Program operators simply stated in its program report that, "the philosophy of recovery models and the

Mental Health Service Act are core beliefs of the faculty and as such are simply a part of every class, every day.”

Additionally, educational program contractors implemented specific standards for workforce preparation that helped to ensure that participants were prepared with practical skills for work in a PMHS that is guided by MHSA principles. In the Stipend Programs, for example, recipients are required to complete a practicum at a qualified mental health service site under the supervision of an experienced clinician who later evaluates the recipient in terms of practical and theoretical competency in addition to cultural and linguistic competency. Substantive work on curriculum development and alignment also happened at the Regional Partnership level, which is discussed in the Regional Partnership section, below.

Finally, the passage of California Senate Bill (SB) 33 in 2009 represents a major change in education and training. The bill mandated that MFT programs provide curricula focused on public mental health topics that incorporate the core principles of the MHSA. As early as 2011, MFT Stipend Programs began adopting new curricula in adherence to SB 33. For example, Alliant International University shifted their focus from private practice to public mental health, incorporating several courses that focused on (1) the use of EBPs, (2) cultural competency across gender, race, religion, sexual orientation, etc., and (3) the principles of wellness and recovery among adults and resiliency among youth.

One of the struggles cited among the MFT programs in making this curricular switch was the professional development of faculty members to effectively deliver instruction, training, and supervision in these areas. To address these challenges, in 2012, MFT Stipend Program contractors including Alliant and the MFT Consortium collaborated with each other and county agencies to provide training opportunities to faculty on recovery-oriented care. Schools reported that the collaborative training efforts yielded great success in increasing their faculty’s capacity and expertise in mental health practices, and that faculty gains facilitated gains in preparing an MFT workforce that was competent to work in the PMHS.

The work toward curriculum advancement at the Regional Partnership level should also be acknowledged, as the majority of the Regional Partnerships (four of five) have worked with their local institutions of higher education to advance curricula that correspond to the workforce.

Employing Consumers and Family Member Participation in the PMHS Workforce

A clear goal of MHSA in general, and the WET vision specifically, is to increase the number and proportion of people with lived experience as consumers and/or family members in the PMHS workforce. While work toward this goal has been happening to a certain extent within Stipend Programs as well as at the Regional Partnership level, the Client and Family Member Statewide Technical Assistance Center (WWT), operated by CiMH and three subcontractors, assumed the bulk of this burden. The WWT accomplishments have been largely in the realm of:

- Providing individualized technical assistance to counties as they make the move toward increasing the representation of consumers and family members in their workforce.

- Developing training curricula and offering trainings to support the recruitment, employment, and successful integration of consumers and family members in the workforce; and
- Creating tools and reports for use by professionals working in the PMHS;

While all of these accomplishments are noteworthy, it is difficult to measure the extent to which they have had an impact on the actual number or proportion of individuals with lived experience within the PMHS workforce. This is largely because WWT has been designed to serve as an intermediary body, providing technical assistance, rather than direct involvement in placing employees in workforce positions. It can be said that about half of the counties perceived that the work of WWT has been effective in supporting greater and more successful representation of consumers and family members within the workforce. Fifty-two percent (52%) of counties who responded to a survey felt that WWT has been either “very” or “somewhat” effective. Approximately 30% felt WWT had not been effective, and approximately 17% simply did not know. As described in the case study with County X (p. 32), counties noted that their ability to work with WWT could be enhanced if WWT were more clear about what specific programming or assistance WWT was offering to counties, and if WWT could use multiple modes of communication to enlist county participation. Finally, while there are no specific numbers that demonstrate the extent to which individuals with lived experience occupy positions within the various levels of the PMHS workforce, there is a perception that the positions that they occupy generally tend to be low-level, low-paid peer-support positions. Counties vary in the methods employed to increase consumer and family member representation—most simply have created designated peer-support positions, though some give priority to candidates who choose to disclose lived experience.

Other state-administered WET programs also succeeded in supporting individuals with lived experience in the PMHS workforce. MHLAP provided loan repayment to four designated consumer and family member positions; 55% of MHLAP awardees had a consumer/family member background; two Regional Partnerships engaged in stigma reduction activities; and in fiscal year 2012-13, 40% of MFTs and Psychiatric NPs, and 26% of Clinical Psychologist stipend recipients had a consumer and family member background. While all of these accomplishments are noteworthy, it is difficult to measure the extent to which all state-administered programs had an impact on the actual number or proportion of individuals with lived experience within the public mental health system workforce.

Other Accomplishments

The five Regional Partnerships have also 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 PMHS workforce. Additionally, each of the Regional Partnerships has addressed region-specific gaps and needs. 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. It would be useful, however, as a way to promote cross-regional learning, to have a way to inventory various approaches, accomplishments, and

lessons from the Regional Partnerships in a more systematic way. The evaluation attempts to line up areas of focus based on what each Regional Partnership has reported as their accomplishments, but because the list of categories was constructed post-hoc, rather than according to specific categories on which each Regional Partnership was asked to report, the matrix is likely to be missing some of the accomplishments or areas of focus.

Discussion

In terms of increasing general capacity, the programs addressed many of the personnel gaps identified by counties in 2008. The Stipend, MHLAP, and Residency Programs were utilized by individuals serving in some of the hardest-to-fill/retain positions in the county systems. The Social Worker, and MFT Stipend Programs, and MHLAP were rated as effective by a majority of county survey respondents. Several of the programs are perceived by only a minority of respondents as being effective—it should be noted that some of these programs' impact may not yet be noticed, as a large portion of students in the Stipend and Residency Programs have not matriculated through the program all the way to placement in county-funded PMHS positions.

There are some inconsistencies between the list of positions identified at baseline and the list of positions targeted by state-administered WET programs. For instance, while the vacancy rates for support, managerial, and supervisory staff were comparable to direct service staff, the thrust of state-administered WET programs was almost entirely on supporting licensed direct service positions. Also, there were several positions that were identified in 2008 for which there are no corresponding state-administered WET programs (e.g., Registered Nurse, Supervising Clinician, Analysts, quality assurance, top-level managers, etc.), and one position that was not identified in 2008 but for which there is a WET program (Physician Assistant).

Addressing Cultural and Linguistic Competency

Regarding cultural and linguistic competency, the state-administered WET programs appear to have worked in an effective way to recruit and support people of color and people with linguistic abilities. Sixty-six percent (66%) of the individuals served in statewide Stipend, MHLAP, and Residency Programs were from groups currently underrepresented in the PMHS workforce, and it is estimated that over half were competent in a language other than English. It should also be noted that at the Regional Partnership level, efforts have also been undertaken to increase the cultural and linguistic competency of the workforce, including delivering cultural competency trainings, providing support for existing staff to enroll in language institutes, and partnerships with universities to expand the focus on cultural competency. In interviews, state-administered WET program contractors mentioned that they have also worked conscientiously to recruit and engage individuals who identify as LGBT and/or as consumers or family members. However, because programs did not systematically track these efforts, the evaluation cannot document the extent to which these efforts may have resulted in increased representation of these two groups in the PMHS workforce.

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 PMHS that aligns with MHSA principles. Although the exact impact of state-administered WET efforts is difficult to isolate because educational and training institutions are vast and operate largely independently, it is clear that each of the institutions that directly contracted to provide a state-administered WET program has made a conscientious effort to add courses and adapt degree requirements so that program graduates have pertinent skills and competencies. In particular, funded universities have made efforts to expand cultural competency training, knowledge of EBPs, and recovery principles into teaching approaches. Involvement in MFT licensure requirements also appears to have advanced key competencies in the preparation of licensed professionals so that they may be more prepared to work in the public sector. The work toward curriculum advancement at the Regional Partnership level should also be acknowledged, as the majority of the Regional Partnerships (four of five) have worked with their local institutions of higher education to advance curricula that correspond to needs within the public mental health workforce.

Program Limitations

Below is a listing of program limitations that were discovered during the course of the evaluation process. This list is not exhaustive, but it does provide an inventory of areas that stood out during data collection and analysis.

- In several instances, it was challenging for Stipend and Residency Programs to place participants because of shortages in field supervisors or a lack of positions into which program graduates could be placed. Participants in some of the Stipend Programs who could not find adequate placements had to repay their obligations. A specific difficulty was encountered in the Clinical Psychologist Stipend Program. While attracting candidates to the program was not difficult, and while it is generally perceived that there are positions within the PMHS for Clinical Psychologists, program contractors reported a severe shortage of post-doctoral placements for program graduates, a critical piece of the process of moving participants through the program and into PMHS positions.
- Some inconsistencies appear to exist between identified need and program focus. In some cases this may be intentional and strategic, while in others it may prompt a closer examination of how resources have been allocated. For example, while the Song-Brown Residency Program for PAs has been very effective in attracting and graduating participants, it rated very low in terms of perceived effectiveness at the county level, and PAs were not listed as a hard-to-fill/retain position, nor do they comprise a large portion of the current PMHS workforce.
- Several of the programs did not rate very high in terms of county perceptions of effectiveness. Some of this may change over time as more program graduates have an opportunity to join a county workforce, but there may be other reasons. The nuanced reasons for these shortcomings should be investigated further.
- The peer and family member role in the PMHS appears to be limited to lower-level positions.

Limitations of the Study

There are several limitations to the data collection and analysis methods used in this evaluation. In many cases, inconsistent reporting structures led to potential duplication and/or missing data. To the extent possible the evaluation team gathered information that would enable a fair assessment of state-administered WET program impact, but an honest disclosure of limitations must be considered as the findings in this report are reviewed.

- While California has 58 counties, 2008 baseline survey data were only available for 28 counties, and 2013 County follow-up survey data were only available for 26 counties. Only 12 counties were represented in both the baseline and follow-up county lists, and there were 16 counties for which no data were collected at all. To accommodate this limitation, some mathematical adjustments were made, although even these are likely to have produced a flawed estimate of impact as they assumed representativeness of the convenience samples of counties surveyed.
- A full assessment of current county shortages using tools that mirror those used in 2008 was not conducted. This would be the most reliable way to evaluate changes in the workforce between 2008 and 2013. The impracticality of this approach, however, was two-fold: one, it would have put a significant burden on counties, and two, it may well be premature to conduct such an assessment when a number of the programs' impacts may not yet have been felt at the county workforce level. In place of this, the evaluation relies on county reported perceptions of effectiveness for each of the state-administered WET programs. It should be acknowledged that, while this approach provides a general sense of perceived program penetration, it is not the most scientific method for evaluating program impact.
- There were no clear systematic methods in place to track a large number of the outputs and outcomes that are inherent in the goals of the state-administered WET approach; for example, there were no requirements for WWT to track training participants, no systematic and standardized ways to track Regional Partnership progress, and no methodological way to monitor curriculum improvements. To the extent practical, RDA conducted interviews to solicit anecdotal information of program activities and perceived impacts. It must be acknowledged, however, that for the most part, information was culled from reports that were not completed in a truly standardized way, which means that there may well be program activities and accomplishments that are not recognized in the report.

Conclusions and Recommendations

The evaluation aims not only to document progress-to-date, but also to provide a discussion of challenges, successes and lessons learned that should be considered as future WET implementation is planned.

Recommendations

This evaluation points to a number of provisions that should be made in the future by OSHPD, state-administered WET program contractors and counties to improve program effectiveness:

- **Ensure that program offerings correspond to current workforce needs:** The next round of program funding should be guided by the 2013 needs assessment.
- **Ensure that the pipeline to employment is considered so that programs can succeed in placing all graduates in the PMHS workforce:** Interviews with program operators show that even if there are vacancies within the workforce, and even if there are programs that support the creation of licensed, qualified individuals to fill the vacancies, for many of these positions, intermediary steps must be taken before those individuals can fill the vacant positions. Future programs should be designed in a way that addresses bottlenecks that may exist in the pipeline to joining the workforce, including qualifying supervised internships and post-doctoral placements.
- **Ensure a strategic and consistent approach to consumer and family member workforce development:** If it continues to be a state-administered WET priority that consumers and family members are employed “at all levels” of the PMHS workforce (and not simply in a number of specifically-designated peer-support positions), efforts must be made to provide consistent messaging and guidance around how counties should work to accomplish this, and corresponding support to counties should be put in place.

To enhance future evaluation capacity, additional measures should be taken. These include:

- **Track participation consistently:** In the end, RDA was able to obtain participant counts, including demographic and linguistic competency breakdowns for most of the state-administered WET programs, although for several this required multiple follow-up contacts and conversations. To ease the process in the future, a single data repository could be created at the state level that would document, for each program whose purpose is to train, place, and/or retain individuals in PMHS positions, participants’ enrollment and graduation information, demographics, program completion, and placement details (including county).
- **Track LGBTQ and consumer/family member identification:** Programs were, understandably, very inconsistent in whether and how certain participant attributes were tracked. Because it is not appropriate to ask sexual orientation or consumer and/or family member status during an application process, these characteristics were not tracked by most programs. Nevertheless, increasing the representation of these groups in the workforce continues to be a key goal of MHS’s WET component. Creative methods for ascertaining participants’ LGBT identification should be investigated, and, if possible, replicated throughout programs. For example, MHLAP includes an open-ended question that asks applicants to describe any relevant personal experience that might enable them to be responsive to the needs of consumers and family members—program operators described this as an effective way to capture lived experience without asking directly. They then went through applications and coded for lived experience so that they

could provide a count. A similar method could be developed to capture LGBT-identification.

- **Track progress of Regional Partnerships with more consistent tools:** While the evaluators recognize that each region is unique, as are the efforts of each Regional Partnership, it would be useful to create a matrix similar to the one constructed for this report. The Regional Partnership matrix, however, should be based on Regional Partnership input rather than an evaluator's post-hoc interpretation.
- **Monitor curricula with checklist:** It is clear that several changes were made to the educational curricula at the universities and institutions where state-administered WET programs took place. It would be useful to develop a matrix or checklist of competencies that could be used to create a cross-program picture of the extent to which funded (and perhaps non-funded) relevant degree-bestowing university programs align with the needs of a PMHS workforce that aligns with MHPA principles.

Conclusion

In conclusion, this evaluation, based on reports from program contractors, interviews conducted by the RDA evaluation team, a county-level survey, and additional data provided by OSHPD, finds that progress is indeed being made toward WET priorities. Some programs are perceived as more effective in addressing workforce gaps and needs than others—differences in perceived effect appear to be associated not only with the number of individuals served by the program, but also with the level of need for specific positions and program contractors' communication strategies. The evaluation found several limitations to state-administered WET programs, although these were outnumbered by program strengths and accomplishments and should be considered alongside the methodological limitations of the study. A common theme that emerged in this evaluation was the notion that long-term program impacts have yet to be felt. Subsequent evaluation is needed to demonstrate the true effect of many of the WET programs reviewed here. The recommended improvements in data collection procedures are meant to help ensure that those subsequent evaluations can speak more accurately and, perhaps, persuasively to the difference made by state-administered WET programs.

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Appendices

Appendix 1: Draft Regional Partnership Survey

Survey Questions

Regional Partnerships

Please answer the following questions about partnership-operated or -owned programs and activities. Programs and activities run by or owned by counties and contractors who do not report to the regional partnership should not be included in this assessment.

1. Please indicate the workforce gaps, shortages and deficiencies that were the most pressing problems when the Regional Partnership began (check all that apply):

- Psychiatrist shortage (M.D.)
- Physician Assistant shortage (P.A.)
- Masters level therapist shortage (MFT/LCSW)
- Clinical Psychologist shortage (Ph.D.)
- Cultural competency gap
- Linguistic capacity gap
- Ethnic representation gap
- Need for first responder competencies
- Need for personnel specializing in services for Older Adult
- Need for personnel specializing in services for Transitional Age Youth
- Poor representation of consumers and family members in workforce
- Lack of career pathways for high school students
- Lack of career pathways for public sector employees
- Training/education programs that did not teach competencies needed for public sector work [skip logic – include question 3]
- Training/education programs that were not aligned with MHA principles [skip logic – include question 4]
- Other _____

Other _____

2. Please list the WET programs developed to **meet regional needs** during 2008-2013. Such programs may include capacity building in cultural/linguistic competence, first responder training, technology-based learning, career pathways, etc. (partnerships with formal educational institutions not included on this list)

Need [field populated from Question 1 responses]	Program Name [open-ended]	Implementation Date [date format]	Status [drop down menu: currently running, complete, canceled, postponed]	Number of individuals served [number format]	Other accomplishments [open-ended]

3. Please list any **education or training programs** with which the Regional Partnership has worked ensure that relevant **public mental health system skills** (such as billing, evidence-based practices, etc.) are included in curricula. Please list the numbers per program if you are reporting on more than one program.

Educational Institution	Program Name	Type of Training	Total number of individuals trained	Other Accomplishments

4. Please list any **education or training programs** with which the Regional Partnership has worked ensure that **MHSA principles** (including resiliency, recovery and wellness)

are reflected in curricula. Please list the numbers per program if you are reporting on more than one program.

Educational Institution	Program Name	Type Training	of Total number of individuals trained	Other Accomplishments

- How many of your regional programs use web-based technology and/or distance learning techniques to enhance the workforce education and training efforts? Please list these programs and the estimated number of individuals reached through the web-based or distance learning techniques.

Program Name	Technology Used	Total reached	individuals

- Among the [automated total from listed approximations of individuals served] these programs have served, please estimate the percentage for each of the following categories:

Program Name	% of Participants
African American	
American Indian/Alaska Native	
Asian/Filipino/Pacific Islander	
Hispanic/Latino	
Indian/Pakistani	
Middle Eastern/Arab	

White	
Other Ethnicity	
Multilingual Competency (Spanish)	
Multilingual Competency (Chinese)	
Multilingual Competency (Other Asian)	
Multilingual Competency (Other)	
Transitional Age Youth (ages 16-25)	
Older Adult (ages 60+)	
LGBTQQI	
Deaf/Hard of Hearing	
Blind/Visually Impaired	
Other Physical Disability	
Veteran/Military Family	
Personal/Familial Experience with Mental Health	

7. Please describe any notable successes the Regional Partnership has seen

[Open-ended field]

8. Please describe any notable challenges or barriers the Regional Partnership has seen

[Open-ended field]

9. Please list any recommendations you have for how OSHPD can better support the Regional Partnership

[Open-ended field]

Appendix 2: Proposed Abridged County-Level Needs Assessment Form

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)
A. Unlicensed Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist										
Case Manager/Service Coordinator										
Employment Services Staff										
Housing Services Staff										
Consumer Support Staff										
Family Member Support Staff										
Benefits/Eligibility Specialist										
Other <i>Unlicensed</i> MH Direct Service Staff										
<i>Sub-total, A (County)</i>				(Unlicensed Mental Health Direct Service Staff, Sub-Totals Only) ↓						
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist										
Case Manager/Service Coordinator										
Employment Services Staff										
Housing Services Staff										
Consumer Support Staff										
Family Member Support Staff										
Benefits/Eligibility Specialist										
Other <i>Unlicensed</i> MH Direct Service Staff										
<i>Sub-total, A (All Other)</i>				(Unlicensed Mental Health Direct Service Staff, Sub-Totals and Total Only) ↓						
Total, A (County & All Other):										



EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	
B. Licensed Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general.....				(Licensed Mental Health Direct Service Staff; Sub-Totals Only) ↓						
Psychiatrist, child/adolescent.....										
Psychiatrist, geriatric.....										
Psychiatric or Family Nurse Practitioner										
Clinical Nurse Specialist										
Licensed Psychiatric Technician										
Licensed Clinical Psychologist.....										
Psychologist, registered intern (or waived)										
Licensed Clinical Social Worker (LCSW)										
MSW, registered intern (or waived)										
Marriage and Family Therapist (MFT).....										
MFT registered intern (or waived).....										
Other Licensed MH Staff (direct service)										
<i>Sub-total, B (County)</i>										
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general.....				(Licensed Mental Health Direct Service Staff, Sub-Totals and Total Only) ↓						
Psychiatrist, child/adolescent.....										
Psychiatrist, geriatric.....										
Psychiatric or Family Nurse Practitioner										
Clinical Nurse Specialist										
Licensed Psychiatric Technician										
Licensed Clinical Psychologist.....										
Psychologist, registered intern (or waived)										
Licensed Clinical Social Worker (LCSW)										
MSW, registered intern (or waived)										
Marriage and Family Therapist (MFT).....										
MFT registered intern (or waived).....										
Other Licensed MH Staff (direct service)										
<i>Sub-total, B (All Other)</i>										
Total, B (County & All Other):										



EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	# FTE filled (5)+(6)+(7)+(8)+(9)+(10) (11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician										
Registered Nurse										
Licensed Vocational Nurse										
Physician Assistant										
Occupational Therapist										
Other Therapist (e.g., physical, recreation, art, dance).....										
Other Health Care Staff (direct service, to include traditional cultural healers).....										
<i>Sub-total, C (County)</i>										
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician										
Registered Nurse										
Licensed Vocational Nurse										
Physician Assistant										
Occupational Therapist										
Other Therapist (e.g., physical, recreation, art, dance).....										
Other Health Care Staff (direct service, to include traditional cultural healers).....										
<i>Sub-total, C (All Other)</i>										
Total, C (County & All Other):										

(Other Health Care Staff, Direct Service; Sub-Totals Only)



(Other Health Care Staff, Direct Service; Sub-Totals and Total Only)



EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....				(Managerial and Supervisory; Sub-Totals Only) ↓						
Supervising psychiatrist (or other physician)										
Licensed supervising clinician.....										
Other managers and supervisors.....										
Sub-total, D (County)										
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.....				(Managerial and Supervisory; Sub-Totals and Total Only) ↓						
Supervising psychiatrist (or other physician)										
Licensed supervising clinician.....										
Other managers and supervisors.....										
Sub-total, D (All Other)										
Total, D (County & All Other):										
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....				(Support Staff; Sub-Totals Only) ↓						
Education, training, research										
Clerical, secretary, administrative assistants										
Other support staff (non-direct services).....										
Sub-total, E (County)										
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance.....				(Support Staff; Sub-Totals and Total Only) ↓						
Education, training, research										
Clerical, secretary, administrative assistants										
Other support staff (non-direct services).....										
Sub-total, E (All Other)										
Total, E (County & All Other):										

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE (A+B+C+D+E)

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)
<i>County (employees, independent contractors, volunteers) (A+B+C+D+E).....</i>										
<i>All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E)</i>										
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)										

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

(1)	(2)	(3)	(4)	Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	All individuals (5)+(6)+ (7)+(8)+ (9)+(10) (11)
F. TOTAL PUBLIC MH POPULATION	Leave Col. 2, 3, & 4 blank									



EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions (1)	Estimated # FTE authorized and to be filled by clients or family members (2)	Position hard to fill with clients or family members? (1=Yes; 0=No) (3)	# additional client or family member FTEs estimated to meet need (4)
A. Unlicensed Mental Health Direct Service Staff:			
Consumer Support Staff.....			
Family Member Support Staff			
Other Unlicensed MH Direct Service Staff			
Sub-Total, A:			
B. Licensed Mental Health Staff (direct service)			
C. Other Health Care Staff (direct service)			
D. Managerial and Supervisory			
E. Support Staff (non-direct services).....			
GRAND TOTAL (A+B+C+D+E)			

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English (1)	Number who are proficient (2)	Additional number who need to be proficient (3)	TOTAL (2)+(3) (4)
1. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
2. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
3. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
4. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
5. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

IV. REMARKS: Provide a brief listing of any improvements that have been noted since the implementation of MHSA WET programs. You may also note any persistent shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III.

A. Shortages by occupational category:

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

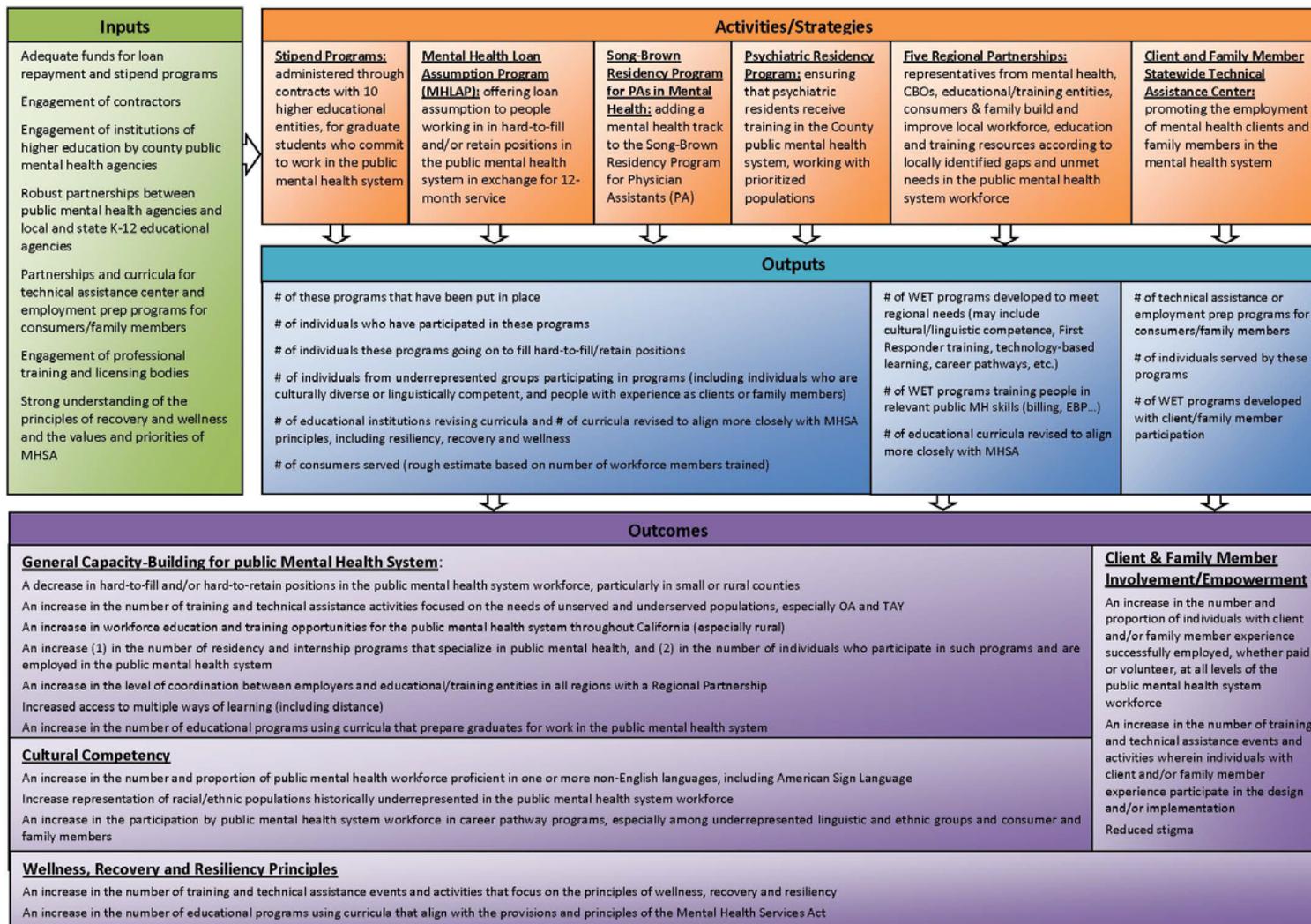
C. Positions designated for individuals with consumer and/or family member experience:

D. Language proficiency:

E. Other, miscellaneous:

Appendix 3: Logic Model

WET Logic Model



Appendix 4: Weighting for Tables 17 and 18

In Table 11 and Table 12, the baseline numbers were weighted by multiplying original figures by 2.08, representing the inversion of 48%, which was the portion of the universe that the baseline survey represented ($1/.48=2.08$). This created a new theoretical statewide baseline from which to add the numbers served and calculate the potential impact of state-administered WET programs.

Table 22: Calculation for Table 18

Ethnicity	A Licensed Direct Service Staff Year 2008 (from report)	B Weighted (A x 2.08)	C # served by WET (from program reports)	D Theoretically enhanced workforce numbers (B+C)	E New statewide breakdown based on theoretical improvement (D/D Total)
Caucasian/White	6,938	14,431	1,219	15,650	51%
Hispanic/Latino	2,417	5,027	1,531	6,558	21%
African American/ Black	1,072	2,230	308	2,538	8%
Asian/Filipino/Pacific Islander	1,342	2,791	461	3,252	11%
American Indian/ Alaska Native	110	229	32	261	1%
Multiple/Other	1,076	2,238	285	2,523	8%
Total	12,955	26,946	3,950	30,896	100%

Table 23: Calculation for Table 19

Ethnicity	A Need in 2008 (from report)	B Weighted (A x 2.08)	C #s served by WET (from reports)	D % of need potentially met by state-administered WET programs (C/B)
Spanish	6,092	12,671	1,708	13%
Chinese	513	1,067	109	10%
Other Asian	974	2,026	283	14%
Other	221	460	319	69%
Total	7,800	16,224	2,419	15%

Appendix 5: Program Data Sources

Information about state-administered programs was gathered primarily through program contractor-submitted progress reports through, supplemented by interviews and one-on-one follow-up. Table 24 depicts the progress reports received for use in this evaluation.

Table 24: Program Progress Reports Reviewed for 2013 Evaluation

State-Administered Program	Program Contractors	Date(s) for Which Data Were Reported
MHLAP		2009 – 2012
Psychiatric Residency	UC Davis	2012 – 2013
	UCLA-Kern	2008 – 2013
Song-Brown Residency for PAs in MH	UC Davis	2009 – 2013
	Moreno Valley College	2009 – 2011
	Touro University	2012 – 2013
	Keck University	2009 – 2013
	Samuel Merritt College	2010 – 2011
	San Joaquin Valley College	2009 – 2011
Stipend for Clinical Psychologists	California Institute of Integral Studies	2011 – 2014
	California Psychology Internship Council	2008 – 2012
	Palo Alto University	2008 – 2011
Stipends for MFTs	Alliant International University	2011 – 2013
	MFT Consortium of California, Phillips	2009 – 2013
	CSU Chico State	2008 – 2013
	Loma Linda University	2009 – 2012
Stipends for PMHNPs	CSU Fresno	2009 – 2013
	UC San Francisco	2009 – 2013
	Azuza Pacific University	2009 – 2011
Stipends for Social Workers	CaISWEC	2008 – 2012
Statewide Technical Assistance Center	CiMH: Working Well Together	2008 – 2014

Appendix 6: California’s Public Mental/Behavioral Health Workforce Needs Assessment 2013

California’s Public Mental/Behavioral Health Workforce Needs Assessment

Due July 28, 2013

The Office of Statewide Health Planning and Development (OSHPD) is developing the next Mental Health Workforce Education and Training (WET) Five-Year Plan 2014-2019. To develop a comprehensive plan that meets local and regional needs, OSHPD is requesting information from counties that identifies their mental/behavioral health workforce needs. This need assessment will help inform the next WET Five-Year Plan and its funding priorities. Please fill out the following needs assessment for your County by July 28, 2013 and submit to OSHPD.MHSAWET@oshpd.ca.gov . If you have any questions on how to fill out the form please contact Sergio Aguilar at (916) 326-3699 or Sergio.Aguilar@oshpd.ca.gov

Survey completed by (name, title or position): _____

Contact Information (email and phone number): _____

County: _____

GENERAL
<p>Existing and Future Mental/Behavioral Health Workforce Shortages (Provide the top 7 mental/behavioral health workforce shortages in your county in order starting with highest need by using sample occupational categories outlined in Appendix 1 below):</p> <ol style="list-style-type: none"> 1. 2. 3. 4. 5. 6. 7. <p>Mental/Behavioral Health Workforce Demands Met (Does your county have occupational categories that are declining in need and/or demand? Provide the top 5 mental/behavioral health workforce occupational categories in your county that are declining in needs starting with the least need by using sample occupational categories outlined in Appendix 1 below):</p> <ol style="list-style-type: none"> 1. 2. 3.



- 4.
- 5.

Mental/Behavioral Health Workforce Hard-to-Fill Hard-to-Retain Positions (Provide the top 7 mental/behavioral health workforce hard-to-fill, hard-to-retain positions in your county in order starting with highest need)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Mental/Behavioral Health Workforce Diversity (Provide the top 7 mental/behavioral health workforce diversity needs in your county in order starting with highest need using sample categories outlined in Appendix 1 below):

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Language Proficiency (Provide the top 7 mental/behavioral health workforce language proficiency needs in your county in order starting with highest need using sample languages outlined in Appendix 1 below):

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Consumer and/or Family Member Designated Positions: (Provide a description of currently designated positions and specific roles for consumer and/or family member positions, if any. Provide a description of future roles consumers and/or family members could have in your county, if any.)

STATE-ADMINISTERED WET PROGRAMS
Stipends (Provide the top 5 mental/behavioral health workforce occupational categories that

should have a state-administered WET Stipend Program in order starting with highest need by using sample occupational categories outlined in Appendix 1 below):

- 1.
- 2.
- 3.
- 4.
- 5.

Stipends (Provide a description of your counties use of and recommendations to enhance this program)

Mental Health Loan Assumption (MHLAP) (Provide the top 5 mental/behavioral health workforce occupational categories that should be eligible for MHLAP in order starting with highest need by using sample occupational categories outlined in Appendix 1 below):

- 1.
- 2.
- 3.
- 4.
- 5.

MHLAP (Provide a description of your counties use of and recommendations to enhance this program)

Residency Program for Physician Assistants (Provide a description of your counties use of and recommendations to enhance this program)

Psychiatric Residency Program (Provide a description of your counties use of and recommendations to enhance this program)

Working Well Together (Provide a description of your counties use of and recommendations to enhance this program)

<p><u>Regional Partnerships</u> (Provide a description of your counties use of and recommendations to enhance this program)</p>
<p><u>State-administered WET Programs</u> (What other mental health workforce development programs should be included in the state-administered WET Program?)</p>
<p><u>State-administered WET Programs</u> (Other comments not referenced above)</p>
<p><u>OTHER</u></p>
<p><u>Other miscellaneous:</u> (Provide a description of any other critical mental/behavioral health workforce needs not identified in the sections above including but not limited to supervisor needs, succession planning needs, needs for individuals with lived experience):</p>

Appendix 7: OSHPD WET County Needs Follow-Up Survey 2013

1) What county are you completing this survey for?*

Hard-to-Fill/Hard-to-Retain Positions

2) Please list the top seven positions that your county identified as hard-to-fill or hard-to-retain (in order of difficulty) in the WET Five-Year Plan Workforce Assessment 2013. Please note that in the following pages, you will be asked follow-up questions about the top three positions.

	Hard-to-Fill/Retain Position	
1 (most hard-to-fill/retain)	<input type="text"/>	Answer Choices: Substance Abuse/Alcohol & Other Drug Counselor Occupational Therapist Licensed Clinical Social Worker Marriage and Family Therapist Licensed Professional Clinical Counselor Clinical Nurse Specialist Licensed Clinical Psychologist School Psychologist Licensed Psychiatric Technician Psychiatric Mental Health Nurse Practitioner Physician Assistant Psychiatrist Child/Adolescent Psychiatrist Geriatric Psychiatrist Consumer/Family Member/Peer Position Other (please specify in Comments box)
2	<input type="text"/>	
3	<input type="text"/>	
4	<input type="text"/>	
5	<input type="text"/>	
6	<input type="text"/>	
7	<input type="text"/>	

Comments:

3) What are some reasons why people have left these positions? (select all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Career change | <input type="checkbox"/> Lack of opportunity for advancement |
| <input type="checkbox"/> Involuntary termination | <input type="checkbox"/> Burnout |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Poor organizational fit |
| <input type="checkbox"/> Went back to school | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Location | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Pay | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Workload | |

4) What are some other agencies people in these positions go to when they leave your agency? (select all that apply)

- Other public mental health agency
- Private mental health agency
- Correctional facility
- Medical facility
- Education
- Non-mental health related organization
- Unknown
- Other: _____

5) How have you managed staff vacancies for these positions? (select all that apply)

- Temporary or locum tenens staffing
- Reassign duties to existing staff in similar/same position
- Reassign duties to existing staff in different positions
- Triage consumers
- Longer wait times
- Other: _____

Hard-to-Fill/Hard-to-Retain Position 1

6) What is the estimated number of current vacancies for this [Question #2, Response #1] position?

7) What are some potential reasons why this [Question #2, Response #1] position is hard-to-fill or hard-to-retain? (select all that apply)

- Not enough qualified individuals
- Location
- Pay
- Burnout
- Lack of opportunities for advancement
- High job demands
- High workload
- Unknown
- Other: _____

8) What professionals has your county used as substitutes to fill this [Question #2, Response #1] position when there have been vacancies? Please list the top three substitutions your county most frequently uses.

1 (most frequently)	<input type="text"/>	<p>Answer Choices: Substance Abuse/Alcohol & Other Drug Counselor Occupational Therapist Licensed Clinical Social Worker Marriage and Family Therapist Licensed Professional Clinical Counselor Clinical Nurse Specialist Licensed Clinical Psychologist School Psychologist Licensed Psychiatric Technician Psychiatric Mental Health Nurse Practitioner Physician Assistant Psychiatrist Child/Adolescent Psychiatrist Geriatric Psychiatrist Associate Clinical Social Worker (ASW) Marriage and Family Therapist Intern (MFTi) Registered Nurse Registered Psychologist Psychology Assistant Licensed Vocational Nurse Nurse Practitioner Psychiatry Resident Medical Doctor (not a psychiatrist) Other</p>
2	<input type="text"/>	
3	<input type="text"/>	

Comments:

9) Is there anything else you'd like to share about the difficulty in staffing this [Question #2, Response #1] position?

Hard-to-Fill/Hard-to-Retain Position 2

10) What is the estimated number of current vacancies for this [Question #2, Response #2] position?

11) What are some potential reasons why this [Question #2, Response #2] position is hard-to-fill or hard-to-retain? (select all that apply)

- Not enough qualified individuals
- Location
- Pay
- Burnout
- Lack of opportunities for advancement
- High job demands
- High workload
- Unknown
- Other: _____

12) What professionals has your county used as substitutes to fill this [Question #2, Response #2] position when there have been vacancies? Please list the top three substitutions your county most frequently uses.

1 (most frequently)	<input type="text"/>	Answer Choices: Substance Abuse/Alcohol & Other Drug Counselor Occupational Therapist Licensed Clinical Social Worker Marriage and Family Therapist Licensed Professional Clinical Counselor Clinical Nurse Specialist Licensed Clinical Psychologist School Psychologist Licensed Psychiatric Technician Psychiatric Mental Health Nurse Practitioner Physician Assistant Psychiatrist Child/Adolescent Psychiatrist Geriatric Psychiatrist Associate Clinical Social Worker (ASW) Marriage and Family Therapist Intern (MFTi)
2	<input type="text"/>	
3	<input type="text"/>	

		Registered Nurse Registered Psychologist Psychology Assistant Licensed Vocational Nurse Nurse Practitioner Psychiatry Resident Medical Doctor (not a Psychiatrist) Other
--	--	---

Comments:

13) Is there anything else you'd like to share about the difficulty in staffing this [Question #2, Response #1] position?

Hard-to-Fill/Hard-to-Retain Position 3

14) What is the estimated number of current vacancies for this [Question #2, Response #3] position?

15) What are some potential reasons why this [Question #2, Response #3] position is hard-to-fill or hard-to-retain? (select all that apply)

- Not enough qualified individuals
- Location
- Pay
- Burnout
- Lack of opportunities for advancement
- High job demands

- High workload
- Unknown
- Other: _____

16) What professionals has your county used as substitutes to fill this [Question #2, Response #3] position when there have been vacancies? Please list the top three substitutions your county most frequently uses.

1 (most frequently)	<input type="text"/>	Answer Choices: Substance Abuse/Alcohol & Other Drug Counselor Occupational Therapist Licensed Clinical Social Worker Marriage and Family Therapist Licensed Professional Clinical Counselor Clinical Nurse Specialist Licensed Clinical Psychologist School Psychologist Licensed Psychiatric Technician Psychiatric Mental Health Nurse Practitioner Physician Assistant Psychiatrist Child/Adolescent Psychiatrist Geriatric Psychiatrist Associate Clinical Social Worker (ASW) Marriage and Family Therapist Intern (MFTI) Registered Nurse Registered Psychologist Psychology Assistant Licensed Vocational Nurse Nurse Practitioner Psychiatry Resident Medical Doctor (not a Psychiatrist) Other
2	<input type="text"/>	
3	<input type="text"/>	

Comments:

17) Is there anything else you'd like to share about the difficulty in staffing this [Question #2, Response #3] position?



Consumer and Family Members as Paraprofessionals

18) Please identify strategies your county has used to recruit, orient, and train consumers and family members for positions within your county. (select all that apply)

- Peer/Consumer Internship Program
- Dedicated County Peer Positions
- Requirement for Contracted Agencies to have dedicated peer positions
- Contract(s) with Peer Run/Led Organizations
- Volunteer Opportunities on Advocacy and Other Boards
- Staff Mentor Program
- Vocational training program for mental health positions
- Partnership with Community College for Peer/Consumer Training
- Anti-stigma training for all staff
- Meeting or job accommodations
- Priority/Preference given to applicants with lived experience
- Other: _____

19) Is there anything else you would like to share about recruiting, orienting, and training consumers and family members in public mental health positions?

State-Administered WET Programs

20) How effective have the following state administered WET programs been in helping your county place or retain personnel in hard-to-fill or hard-to-retain positions?

	Not at all effective	Not very effective	Somewhat effective	Very effective	I have never heard of this program
Mental Health Loan Assumption Program (MHLAP)	●	●	●	●	●
Clinical Psychologist Stipend Program	●	●	●	●	●
MFT Stipend Program	●	●	●	●	●
Psychiatric Nurse Practitioner Stipend Program	●	●	●	●	●
Social Worker Stipend Program	●	●	●	●	●
Psychiatric Residency	●	●	●	●	●
Song-Brown Residency for Physician's Assistants	●	●	●	●	●

21) How effective has Working Well Together been in helping your county to increase the role of people with lived experience as consumers or family members in the public mental health system?

- Not at all effective
- Not very effective
- Somewhat effective
- Very effective
- I have never heard of this program

22) How effective have state administered WET programs been in increasing the cultural and linguistic competency of the workforce in your county?

- Not at all effective
- Not very effective
- Somewhat effective
- Very effective
- I don't know

23) How effective have state administered WET programs been in increasing the diversity of the workforce in your county, so that the workforce is more representative of the population served in terms of ethnicity, cultural tradition, religion, LGBT identification, etc.?

- Not at all effective
- Not very effective
- Somewhat effective
- Very effective
- I don't know

24) Is there anything more you would like to say about how effective state administered WET programs have been in helping your county address its public sector mental health workforce needs?



Thank you!

Appendix 8: 2008 County-Level Workforce Survey Tool

See attached PDF.

Appendix 9: MHSa Workforce Education and Training Evaluation Plan for OSHPD

Resource Development Associates (RDA) is proposing an evaluation structure to assess the effectiveness of WET programs in advancing the Mental Health Services Act (MHSa) Workforce Education & Training vision. The goal of the evaluation is to reveal the impact, strengths and challenges of implementation. The guiding summative (1 a-f) and formative (2) evaluation questions are as follows:

- 1) Given the vision of MHSa WET,²³ what were the needs in the public mental Health system workforce public mental health system in prior to WET program implementation, and how have they improved since the implementation of WET? More specifically:
 - a) How has the general capacity of the public mental health system increased, especially in terms of small/rural counties and hard-to-fill/retain positions?
 - b) How has WET implementation improved the cultural and linguistic competency of the public mental health system workforce in California?
 - c) How has WET implementation improved formal educational structures so that professionals being trained emerge more prepared to work in the public mental health system?
 - d) How has WET implementation improved educational curricula to ensure that the public mental health system workforce is more aligned with the principles of the MHSa, including resiliency, recovery and wellness?
 - e) How has WET implementation expanded the role that people with lived experience as clients or family members have in the public mental health system workforce?
 - f) How has WET implementation helped address specific the public mental health system workforce gaps identified in the five principal regions of California?
- 2) What are the challenges, successes and lessons learned that should be considered as future WET implementation is planned?

RDA will work with OSHPD staff, WET program leaders, and county mental health departments to answer these questions, drawing extensively from existing documents and reports.

Underlying Logic of Evaluation Design

The following logic model lays out the six primary strategies that have been implemented in accordance with the WET five-year strategic plan. These are:

- **Stipend Programs** that provide monetary stipends, in exchange for a commitment to work for one year in the public mental health system, to students pursuing: Ph.D. in Clinical

²³ “We envision a public mental health workforce, which includes clients and family members, sufficient in size, diversity, skills and resources to deliver compassionate, safe, timely and effective mental health services to all individuals who are in need and their families and caregivers, and contributes to increased prevention, wellness, recovery and resilience for the people of California.”

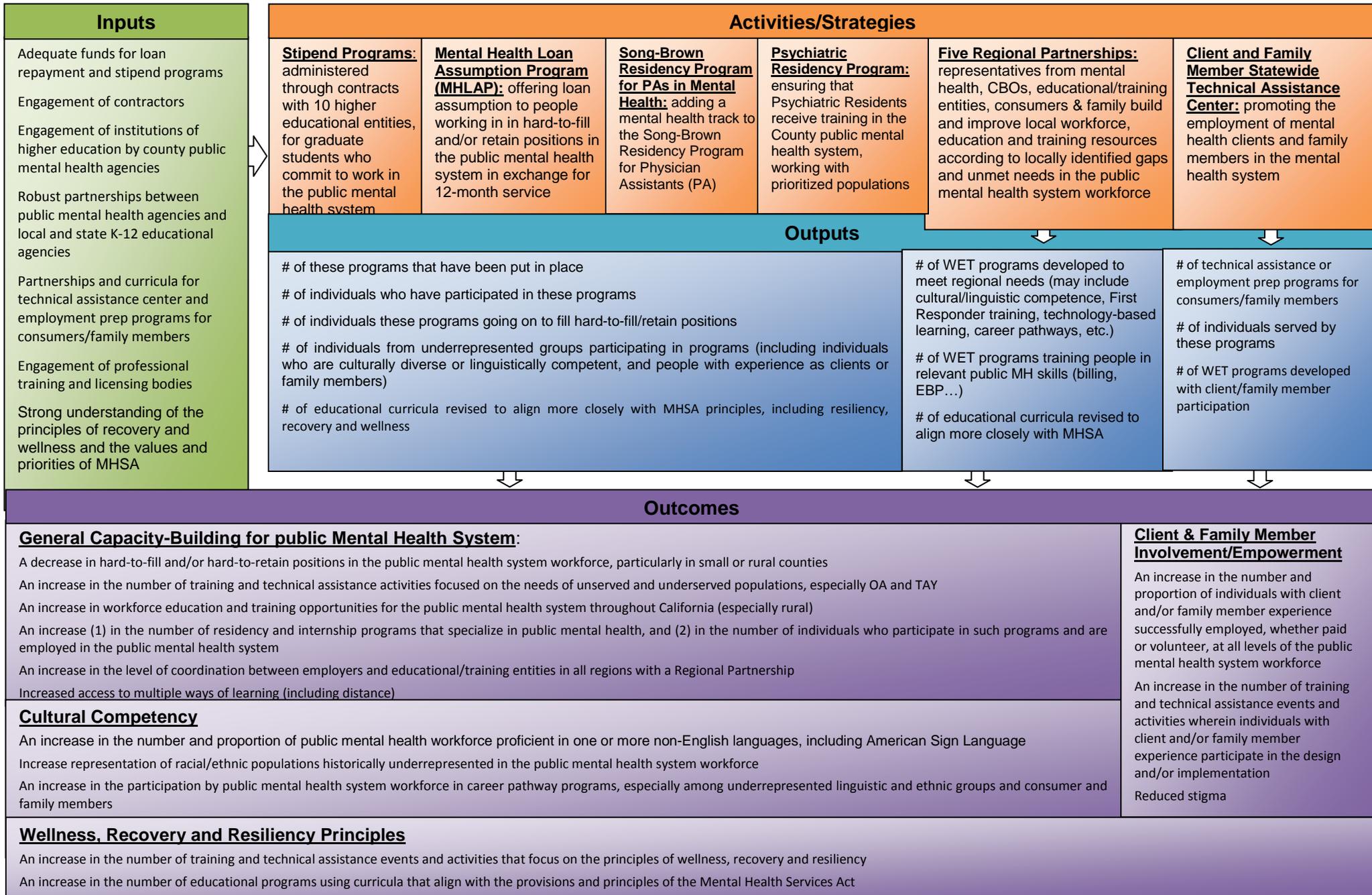
Psychology; Masters in Therapy (toward a license in Marriage and Family Therapy MFT), Mental Health Nurse Practitioner, and Masters in Social Work – in order to run a program, the education/training entity must demonstrate curriculum aligning with MHSa principles

- **Mental Health Loan Assumption Program** which provides loan repayment in the amount of \$10,000 (for some counties, applicants receive the award up to six consecutive years) in exchange for a commitment to work for one year in a hard-to-fill or hard-to-retain position in the public mental health system – counties define which positions qualify.
- **Song Brown Residency Program for Physicians Assistants in Mental Health** which adds a mental health track to the Song-Brown Residency Program, funding Physician Assistant (PA) programs that train second-year Residents to specialize in mental health
- **Psychiatric Residency Program** which funds Psychiatric Residency Programs to align curricula to the needs of the mental health sector, and encourages Psychiatric Residents to continue working in the California public mental health system after their rotations end
- **Regional Partnerships** wherein representatives from the public mental health system, CBOs, educational/training entities, and consumers and their families come together to build and improve local workforce, education and training resources according to locally identified gaps and unmet needs in the local public mental health system workforce – strategies and targets vary across the five regions (Superior, Bay Area, Central, Los Angeles, and Southern)
- **Client and Family Member Statewide Technical Assistance Center** (known as Working Well Together) which provides leadership, training, and technical assistance to promote the recruitment, hiring, retention and support of current and prospective public mental health system employees who have lived experience as mental health clients and family members

In the logic model, beneath these six strategic program areas are listed the anticipated outputs, or deliverables, that each program is expected to yield. Below that are the changes that are anticipated to occur (outcomes) as a result of implemented strategies. Laying out the conceptual elements in this way helps to clarify the logic that underlies the relationship among the outcomes and the approaches. This logic can also be stated as a theory of change:

Providing stipends and loan assumption programs, building mental health residency programs for physicians assistants and physicians that incentivize work in the public sector, offering technical assistance and training to promote a more active role for people with lived experience as consumers and family members, and promoting partnerships among public mental health systems, community-based agencies, training and education entities as well as consumers and family members, will result in a public mental health system workforce that has fewer gaps, is more culturally diverse and competent, has greater involvement from people with experience as consumers and family members, and is more closely aligned with the values of MHSa, including the principles of wellness, recovery and resiliency.

WET Logic Model



Methods of Measurement and Analysis

The evaluation questions listed above will be approached by 1) establishing a clear baseline from prior records and documents, 2) quantifying and describing the efforts and successes of WET program implementation over the past five years by culling information from programs' progress reports, 3) following up with program leaders to confirm and complete information gained from progress reports, and 4) collecting hard employment data from the counties. Below is a more detailed description of how these data will be collected and analyzed.

Establishing a Baseline

A first step in the inquiry will be to pull information from source documents, including the 2009 *California's Public Mental Health Workforce: A Needs Assessment* (Shea, 2009), which details data from 2008, and 2008 county reports, to establish baseline measures for each of the summative evaluation questions.

Evaluation Question	Baseline Data Points (from 2008)
a) How has the general capacity of the public mental health system increased, especially in terms of small/rural counties and hard-to-fill/retain positions?	Vacancy and turnover rates for key positions throughout CA public mental health system; Vacancy rates in small/rural counties
b) How has WET implementation improved the cultural and linguistic competency of the public mental health system workforce in California?	Ethnic and multilingual representation within the public mental health system workforce
c) How has WET implementation improved formal educational structures so that professionals being trained emerge more prepared to work in public mental health system?	Extent to which the mental health curricula at formal educational institutions included practical skills that would prepare graduates for work in public mental health system
d) How has WET implementation improved educational curricula to ensure that the public mental health system workforce is more aligned with the principles of the MHSa, including resiliency, recovery and wellness?	Level of alignment with MHSa principles among degree-bestowing formal educational and training institutions
e) How has WET implementation expanded the role that people with lived experience as clients or family members have in the public mental health system workforce?	Representation of people with lived experience as clients or family members at various levels of the public mental health system workforce (including but not limited to explicitly designated positions such as peer support specialists)

Evaluation Question	Baseline Data Points (from 2008)
f) How has WET implementation helped address specific public mental health system workforce gaps identified in the five principal regions of California?	What were the identified gaps between workforce education and regional need, including quantifiable need for: first responder training, formal degree programs to prepare practitioners to work in the public mental health system, high school academies, other career pathways, cultural/linguistic competency-building, distance-learning, wellness and recovery-oriented training, etc.

It is anticipated that the necessary information to build the baseline can be gleaned from the Shea 2009 and 2008 county reports. If there are any evaluation questions for which no quantitative data are available to provide a baseline, a qualitative baseline will be constructed through key informant interviews.

Alternative Impact Measurement Strategies

Sound evaluation methods point very clearly to conducting a full survey of counties' current workforce shortages. Without this sort of inquiry the evaluation will only be able to document *efforts* to fill gaps and improve workforce training and education, and will not be able to touch upon the actual *impact* these efforts have had upon the workforce itself. Nevertheless, the RDA evaluation team recognizes that conducting an in-depth assessment might prove impractical given time restrictions and the existing burden upon counties. If the Steering Committee concludes that the full survey is not feasible, RDA proposes two potential alternative impact measurement strategies. The first would be to sample the counties and administer the 7-page needs assessment form to a select group of 12-15 counties, with representation from rural, small, urban and ex-urban counties. This method would allow for a comparison, although it would offer a considerably less powerful analysis. The second alternative would be to survey all counties with an even more abridged assessment tool, which could be anticipated to take no more than 20-30 minutes for counties to complete. This sort of survey would not allow a strict comparison as counties would probably rely heavily on estimations to complete the forms. While neither of these alternatives would be as informative as the full survey, they would be preferable to an evaluation plan that did not afford any impact data at all.

Analysis, Interpretation and Recommendations

The evaluation report will be organized according to the evaluation questions, concluding with a discussion of strengths, challenges, lessons learned, and implications for the future (Question 2). Progress on each summative question (Questions 1, a-f) will center on need established at baseline, the success of programs to address that need, and the difference that can currently be measured against the baseline. Implications and recommendation will be based on persistent gaps identified in the summative inquiry, as well as specific insights offered in interviews and surveys as to why those gaps persist and what should be done to address them. All analyses of



progress and impact will be shared with the Evaluation Steering Committee prior to cementing interpretations and finalizing the report, to ensure that OSHPD perspectives inform the final analysis and the meaning that is attached to findings.

Timeline

Evaluation activities will begin as soon as OSHPD and the Evaluation Steering Committee approve the evaluation plan. Once approved to move forward, the Evaluation Team’s first tasks will include amassing all reports and gathering required data points, some of which will come from reports and data RDA already has on hand. Subsequent tasks will include revising and launching the county-level survey – some time will be anticipated in the turnaround from counties. The projected timeline is very tight and RDA will rely heavily on OSHPD support to obtain needed data and encourage county survey returns. Analysis and interpretation will follow, with review and dissemination as the final tasks.

Task	Dates
Gather baseline data from Needs Assessment Report and request additional reports	October 7-11, 2013
Gather output data points from program reports	October 7-18, 2013
Conduct follow-up interviews and/or distribute written surveys to program leaders	October 11-31, 2013
Revise county-level survey	October 14-18, 2013
Launch county-level survey	October 18, 2013
County-level survey return deadline	November 11, 2013
Analyze county-level survey results against baseline measures	November 11-15, 2013
Begin drafting report	November 15, 2013
Complete draft for Steering Committee review and interpretation session	November 22, 2013
Finalize report	November 28, 2013
Disseminate and present findings to stakeholder groups	December 2013 – January 2014