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

Report 2 – Analysis of Stakeholder Feedback on Public Mental Health Workforce Needs

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RDA

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Executive Summary

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

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

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

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

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

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

[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

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 2 – Analysis of Stakeholder Feedback on Public Mental Health Workforce Needs*, provides analysis of direct feedback from stakeholders regarding California's public mental health workforce needs and perspectives on how to improve public mental health workforce education, training, recruitment and retention. The report presents RDA's analysis and findings from OSHPD-led stakeholder engagement efforts during the development of the WET Five-Year Plan 2014-2019 which included 14 community forums, 13 focus groups, 13 key informant interviews, and an online survey. OSHPD engaged in these efforts to better understand priority issues, best practices, and challenges that stakeholders believe should be considered in the next MHSA WET Five-Year Plan for 2014-2019.

Stakeholder Engagement Feedback Report

In order to obtain more in-depth feedback on public mental health workforce needs, best practices, challenges, and recommendations, OSPHD conducted 14 community forums, 13 focus groups, 13 key informant interviews, and an online survey with a wide variety of diverse stakeholder groups. This series of engagement efforts, which represents OSHPD's primary data source from stakeholders, included representatives from community-based organizations, counties, educators, consumers and family members, direct service providers, health care administrators, and other mental health policy makers. Over 600 stakeholders attended the community forum events and over 300 stakeholders participated in the online survey.

This report first examines the elements that stakeholders identified as necessary to constitute a strong public mental health workforce, which included the kinds of personnel and training that are needed to support the state's public mental health system over the coming five years. The discussion then examines the challenges that stakeholders identified to increasing and sustaining the public mental health workforce, along with recommendations for addressing those challenges.

In addition to seeking feedback on the public mental health workforce, OSHPD also facilitated breakout sessions during the community forums to allow for more in-depth discussion of specific topics. OSHPD sought input on the following topics: 1) Diversity, 2) Integration, 3) Training and Education, 4) Recruitment and Retention, and 5) Consumer and Family Member Employment. The second part of the report examines stakeholder feedback from these five topic-specific breakout sessions. Finally, the report concludes with an overview of the recurring challenges and recommendations that emerged in analyzing stakeholder feedback across all eight general topics.

Methodology

OSHPD provided RDA with eight datasheets based on the feedback received across the various engagement events. RDA used these datasheets as the basis of the analysis. Each

datasheet reported on eight primary topics: 1) Public Mental Health Workforce Needs: Competencies, Education/Credentials, and Professions, 2) Public Mental Health Workforce Challenges, 3) Public Mental Health Workforce Recommendations, 4) Recruitment and Retention, 5) Training and Education, 6) Consumer and Family Member, 7) Diversity, and 8) Integration.

Analyses were performed on all four data sources: 1) community forums, 2) focus groups, 3) key informant interviews, and 4) online survey. This effort included a qualitative analysis of the overarching themes found across each method of stakeholder engagement, followed by quantitatively cataloguing the frequency with which each theme was noted. The themes and issues that emerged most often throughout the data are discussed in this report.

Key Findings

Across California, MHSA stakeholders offered a variety of feedback and suggestions for improving the state's public mental health workforce needs. The following key findings emerged from an analysis of these discussions.

- ***Diversify the public mental health* workforce.** Stakeholders discussed the importance of building a linguistically and culturally diverse public mental health workforce over the next five years in order to better address communities' mental health needs. In addition, stakeholders also recommended expanding the definition of cultural competence beyond race and ethnicity to include proficiency in working with other communities such as the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) and disability communities, along with a trained sensitivity to working with individuals living in poverty and/or homelessness. As such, shifting the definition of cultural competency towards a client-centered perspective that recognizes and is attuned to the social *and* cultural issues that impact clients' daily lives might be beneficial.

- ***Develop a formalized infrastructure for training and employing consumers and family members.*** The majority of stakeholders recognized the value of a mental health workforce that includes consumers and family members, and many expressed the need for a certification program. Stakeholders across all 14 community forums reported a need to increase staffing in consumer-led peer positions. Accordingly, several strategies suggested by stakeholders that might aid in furthering this goal: 1) establish a standardized peer certification program at the statewide level for consumers and family members, 2) institute a standardized hiring guideline to support administrative staff in the recruitment of consumers and family members, and 3) expand training for the current mental health staff on consumer and family member workforce, which will increase knowledge around mental health issues in the current public mental health workforce and reduce stigma.

- ***Increase educational resources and employment in rural counties.*** Recruiting and sustaining a strong mental health workforce in rural communities is a persistent

challenge. Stakeholders recommended the use of telepsychiatry as well as distributed learning programs to address this issue.

- *Expand opportunities for partnership and collaboration with the aim of promoting integrated care.* Stakeholders reported a need for more opportunities to dialogue across disciplines and sectors of the community in order to break down silos that currently exist in the public mental health workforce. In particular, stakeholders identified a strong need for more partnership between primary care, behavioral/mental health, and substance abuse professionals. To accomplish this goal, stakeholder feedback indicated that it might be beneficial to allocate resources towards curriculum development around integration as well as training on substance abuse/treatment of co-occurring disorders across mental health professions.

Frequently Used Acronyms and Abbreviations

Table 1 lists the frequently used acronyms and abbreviations used in this report, as well as their definitions.

Table 1: Frequently Used Acronyms and Abbreviations

Acronym	Definition
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
CalHR	California Department of Human Resources
CalSWEC	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
IPEDS	Integrated Post-Secondary Education Data System

Acronym	Definition
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
WET	Resource Development Associates

Acronym	Definition
WF	Workforce
WIC	Welfare and Institutions Code
WRAP	Wellness Recovery Action Plan
WWT	Working Well Together Training and Technical Assistance Center

Introduction

This report identifies and summarizes key themes and findings from qualitative data that the California Office of Statewide Health & Planning Development (OSHPD) collected from 14 community forums, 13 focus groups, 13 key informant interviews, and an online survey that received over 300 responses. These stakeholder engagements were conducted to obtain more in-depth feedback on priority issues, best practices, and challenges that stakeholders believed should be considered in the next Mental Health Services Act (MHSA) Workforce Education and Training (WET) Five-Year Plan, 2014-2019.

This report presents information in five distinct sections. The first section outlines stakeholder feedback regarding the type of public mental health workforce required to meet county and regional mental health needs in the coming five years. Three key areas are discussed: (1) Competencies, (2) Education/Training, and (3) Mental Health Personnel. The second part of the report discusses stakeholders' input pertaining to the challenges and recommendations for building a more sustainable public mental health workforce. OSHPD asked stakeholders to describe challenges and recommendations specific to training and education, recruitment and retention of public mental health professionals, and the employment of consumers and family members.

The third section of this analysis reports on the "sub-issues" that constituted the second part of the community forum meetings. Five sub-issues are discussed: (1) Training and Education, (2) Recruitment and Retention, (3) Consumer and Family Members, (4) Diversity, and (5) Integration. Combining the three issues pertaining to workforce needs with the five "sub-issues," a total of eight issues relating to public mental health workforce education and training are analyzed and discussed.

The fourth section of the report offers a "big picture" overview of the stakeholders' feedback. Given the volume of responses provided by participants, this section synthesizes the data into key themes and issues that emerged across the eight subject areas. Lastly, the report concludes with an overall summary of key findings.

Data Sources

The data sources for this report include OSHPD-led community forums, focus groups, key informant interviews, and an online survey conducted by OSHPD in 2013. OSHPD compiled a total of eight data sheets (for each category discussed above) comprised of raw and coded notes.

Community Forums

From April to June 2013, OSHPD conducted community forums in 14 counties across the state.[2] Of the 14 community forums, three were held in the Bay Area region, three in the Central region, four in the Southern region, three in the Superior region, and one in the Los Angeles region. In total, over 600 stakeholders attended MHSA WET Five-Year Plan Community Forums.

The objective of the community forums was to obtain stakeholder feedback on priority issues, challenges, and recommendations that might be considered in the next WET Five-Year Plan.

Additional Outreach Activities

OSHPD supplemented community forum data with 13 focus groups, conducted from February to May 2013. Stakeholder focus groups were carried out with the following groups:

- California Coalition for Mental Health
- California Health Workforce Alliance/California Health Professions Consortium,
- California Healthcare Workforce Policy Commission
- California Mental Health Directors Association All Directors Committee
- California Mental Health Directors Association Policy Committee
- California Mental Health Planning Council
- Greater Bay Area WET Collaborative
- Health Professions Education Foundation Board of Trustees
- MHSA Partners Forum
- MHSA WET Coordinators
- Older Adult Population Stakeholder Group
- WET Regional Partnership Coordinators
- Working Well Together

To maximize outreach, OSHPD also conducted 13 key informant interviews and a survey. OSHPD engaged 13 stakeholders in phone and in-person interviews. Recognizing that numerous stakeholders are unable to attend community forums and focus groups, or participate in an interview, OSHPD administered an online survey to increase opportunities for stakeholders to share their thoughts and concerns; over 300 survey responses were received.

Using these stakeholder engagement methods, OSHPD solicited feedback from a wide variety of stakeholder groups, including representatives from community based organizations, educators, consumers and family members, direct service providers, administrators, and mental health policy makers.

[2] Participating counties included: Alameda, Butte, Humboldt, Los Angeles, Monterey, Napa, Orange, Sacramento, San Bernardino, San Diego, Shasta, Stanislaus, Tulare, and Ventura.

Methodology

OSHPD provided RDA with eight datasheets based on the feedback received across the outreach activities, from which RDA formed its analysis. Each datasheet reports on eight primary topics: (1) Public Mental Health Workforce Needs: Competencies, Education/Credentials, and Professions; (2) Public Mental Health Workforce Challenges; (3) Public Mental Health Workforce Recommendations; (4) Recruitment and Retention; (5) Training and Education; (6) Consumer and Family Member; (7) Diversity; and (8) Integration.

For datasheets 1-3, data was provided for community forums, focus groups, key informant interviews, and surveys. For the remaining datasheets 4-8, data was provided for community forums, focus groups, and surveys.

Analyses were performed on all four data sources: (1) community forums, (2) focus groups, (3) key informant interviews, and (4) online survey. This effort included a qualitative analysis of the overarching themes found across each method of stakeholder engagement, followed by quantitatively cataloguing the frequency with which each theme was noted. The themes and issues that emerged most often throughout the data are discussed in this report.

Limitations

A primary limitation in the analysis is that RDA did not collect the data from the various stakeholder engagement methods. As a result, RDA did not have an opportunity to develop an understanding of OSHPD's process for coding and categorizing stakeholders' responses, which posed constraints in the analysis. Some of the responses were very general, which left room for multiple interpretations and assumptions when looking for emerging themes and key findings.

Workforce Needs in the Public Mental Health System

One aim of the stakeholder meetings was to better understand the mental health workforce elements required to support the public mental health system's needs in the coming five years. Stakeholders were asked to specify public mental health workforce needs in three general areas: (1) competencies, (2) education and credentials, and (3) workforce personnel needs. To maintain consistency, this report organizes stakeholders' feedback along with key themes and findings pertaining to workforce needs, using these three categories.

Competencies

Among the 62 competencies reported as workforce needs, the top five key competencies are: (1) cultural competency, (2) bilingual staff, (3) integrated care, (4) substance abuse training across the mental health professions, and (5) dual diagnosis.

Table 2: Key Competencies

Competency	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Cultural Competency	12	3	2	26	43
Bilingual	12	4	1	17	34
Integrated Care	12	3	0	9	24
Substance Abuse Training across Professions	3	2	0	19	24
Dual Diagnosis	2	0	2	16	18

Source: OSHPD Stakeholder Engagement Data (2013)

As Table 2 illustrates, these five key competencies support two of the five MHSA values: (1) Cultural Competence and (2) Integrated Services. Along with increasing bilingual staff and public mental health providers proficient in sign language in order to provide culturally appropriate services, participants suggested expanding the definition of cultural competency beyond race and ethnicity. Cultural competencies noted by stakeholders included proficiency with other communities such as the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) and disability communities, a trained sensitivity to working with individuals living in poverty and/or homelessness, and other social issues that impact clients' daily lives. Overall, stakeholders recommended a broader shift towards a more client-centered culture.

Integrated care is another key competency that is needed in the public mental health workforce. Specifically, participants cited the ability of clinical staff to provide dual diagnosis and substance abuse training across the mental health professions as core competencies.

The five general areas of core competency are: (1) clinical competencies, (2) service delivery, (3) wellness, recovery, and resilience, (4) community collaboration, and (5) administration/management. The majority of the competencies raised by participants fell under

clinical competencies and service delivery. For service delivery, key themes raised were the need for integrated services between mental health, primary care, and substance abuse fields as well as across sectors such as mental health, law enforcement, and the justice system. Other key areas of service delivery competence include trauma management, specifically the intersection of trauma with cultural issues, and telemedicine. For clinical competence, participants recommend expanding the notion of cultural competence to be client-focused. As such, a need for clinical competency was identified with a number of populations, including the LGBTQ community, veterans, and those with developmental and physical disabilities, in addition to those populations across the life span (e.g. children, older adults).

Education/Credentials

Of the 12 education/credential needs identified by participants, the top five are: (1) peer certification program, (2) dual diagnosis credential, (3) associate and bachelor's degree for mental health field, (4) credentials for non-licensed professionals, and (5) alcohol and other drugs certificate.

Table 3: Educational/Credential Need

Educational/ Credential Programs	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Peer Certification	14	2	1	1	18
Dual Diagnosis Credential	1	0	0	4	5
AA and BA for Mental Health	1	0	0	3	4
Credentials for non-licensed professionals	2	0	1	1	4
Alcohol and Other Drug Abuse (AOD) Certificate	1	0	0	2	3

Source: OSHPD Stakeholder Engagement Data (2013)

Attendees at all 14 community forums reported a need for more peer certification programs, including a certificate for family members of consumers, indicating a significant workforce educational need. Stakeholders further suggested standardizing peer certification programs at the state level.

Participants at one community forum and four online survey respondents identified the need for a Dual Diagnosis credential. A total of three participants identified the need for an Alcohol and Other Drug certificate. As such, a key educational need for the public mental health workforce seems to be programs that support an integrated, interdisciplinary approach to service delivery and care.

Similarly, one community forum event and three online survey respondents identified a need for associate and bachelor's degrees in mental health. This supports one of the key themes across

the various issues, which is the need to develop a career pathway in the mental health profession earlier in the educational process. Similarly, a total of four participants reported a need to establish a credential for non-licensed professionals.

Two key types of certifications were identified: (1) single certification and (2) multi-disciplinary certification. Single certifications provide training for a particular population, such as peers, or for particular skills, such as language interpreters. Multi-disciplinary certificates, such as for psychosocial, AOD, and dual diagnosis purposes, support the need in the public mental health workforce for educational programs that work across multiple disciplines and sectors.

Workforce Personnel Needs

Of the 43 workforce personnel needs identified, data indicates highest shortages in the following five mental health professions: (1) Psychiatrists, (2) consumer peer positions, (3) Marriage and Family Therapists (MFT), (4) Alcohol and Other Drug Abuse Counselors, and (5) Psychiatric Mental Health Nurse Practitioners.

Table 4: Public Mental Health Workforce Personnel Need

Mental Health Profession	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Psychiatrists	11	5	3	19	38
Consumer (Peer) Positions	14	2	1	20	37
Marriage and Family Therapists (MFT)	6	2	0	28	36
Alcohol and Other Drug Abuse Counselors	7	0	0	23	30
Psychiatric Mental Health Nurse Practitioner	11	5	1	13	30

Source: OSHPD Stakeholder Engagement Data (2013)

Psychiatrists were cited as the highest workforce need in the public mental health workforce. Participants specifically reported a need for psychiatrists specializing in infant/child/adolescent mental health issues as well as older adult/geriatric mental health issues. Some participants identified telepsychiatry as a growing need. Secondly, data indicated the need for more consumer-led peer positions across all age groups and clientele, including youth in the transitional age, parents and caregivers of youth, and family members of adult consumers.

Marriage and Family Therapists were identified as the third highest workforce need, specifically therapists with a specialization in childcare settings. Additionally, there is a stakeholder identified need for Alcohol and Other Drug Abuse Counselors as well as Psychiatric Mental Health Nurse Practitioners in the public mental health system.

Based on community forum data alone, participants at nine out of the 14 forums identified lived experience as an important factor in enhancing the public mental health workforce personnel. A majority of stakeholders from the OSHPD WET community forums recognized and saw a significant added value to lived experiences amongst public mental health providers and support staff. Nonetheless, stakeholders also identified the challenges of hiring more mental health workers with lived experience. These challenges, along with recommendations for addressing these challenges, will be discussed in subsequent sections.

Challenges to Increasing and Sustaining the Public Mental Health Workforce

To obtain a more accurate understanding of how to develop and support a more sustainable public mental health workforce, OSHPD asked stakeholders to comment on challenges pertaining to the following issues: (1) training and education, (2) recruitment and retention, and (3) employment of consumers and family members. This report is structured according to the same three issues to maintain consistency. A discussion of key challenges is provided for each of the three topics.

General Challenges

This section presents stakeholders' feedback regarding challenges specific to the training and education of the public mental health workforce, recruitment and retention of public mental health employees, and increasing employment of consumers and family members in the public mental health workforce. Additionally, OSHPD solicited *general* feedback on the challenges to increasing and sustaining the public mental health workforce. As Table 5 demonstrates, of the 40 issues cited by participants, the top five general challenges to increasing and sustaining the public mental health workforce are: (1) lack of funding, (2) geographic limitations, (3) reimbursements, (4) lack of a technology infrastructure, and (5) difficulties encountered in community clinics related to working with consumers.

Table 5: General Challenges to Increasing and Sustaining the Public Mental Health Workforce

General Challenges	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Lack of funding	6	1	0	27	34
Geographic limitations	5	0	0	8	13
Reimbursements	8	1	0	0	9
Lack of technology infrastructure	3	3	0	1	7
Community clinics do not know how to work with consumers	1	0	0	6	7

Source: OSHPD Stakeholder Engagement Data (2013)

Stakeholders reported the primary challenge to developing and maintaining a productive public mental health workforce was the lack of funding. Stakeholders remarked that more funding is needed to support the current infrastructure *as well as* to promote more innovative programs. Sustaining current funding was another closely related challenge noted by stakeholders.

Geographic limitations were the second biggest general challenge. As one large county reported, there is a shortage of employment programs in rural areas. As noted previously, difficulties in training and education and the recruitment and retention of public mental health providers in rural areas are significant challenges, as well. Reimbursement, particularly for peers, was cited as a challenge by two medium-sized counties. Finally, lack of a technology infrastructure and issues between community clinics and consumers seem to reflect general operational challenges and the need for increased cultural competence around client-driven services, respectively.

Training and Education Challenges

OSHPD solicited feedback from stakeholders on the current barriers to the training and education of mental health providers in the public mental health system. The five key challenges to training and education programs are: (1) lack of training and education programs, (2) lack of a clear career pathway/ladder, (3) lack of integration/collaboration, (4) lack of supervision, and (5) lack of mentorship/internships. The need for more training and education programs was noted about twice as many times as the needs for a more defined mental health career pathway and for more integrated services between primary care and mental health.

Table 6: Training and Education Challenges

Key Challenges	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Lack of training and education programs	9	4	1	30	44
No clear career pathway/ladder	7	3	1	11	22
Lack of integration/ collaboration	7	6	2	6	21
Lack of supervision	10	2	1	3	16
Lack of mentorships/ internships	6	0	0	3	9

Source: OSHPD Stakeholder Engagement Data (2013)

Stakeholders reported a lack of training and education programs for all public mental health providers, but specifically highlighted the need to expand training programs for consumers and family members/caregivers. Location was another issue; participants expressed a shortage of training and education programs in rural counties as well as noting that existing training

programs are too far away. Finally, stakeholders from one large county at a community forum meeting reported a need for education and training programs at the bachelor's level.

A second key challenge was the lack of a clear career pathway or career ladder. As one stakeholder reported, there is no opportunity for growth within agencies. Data indicates "lack of a clear career pathway or career ladder" is a recurring response throughout each topic of discussion. Based on participants' responses, this phrase is interpreted to mean two things: (1) for *prospective* people considering a mental health career, there is an absence of clearly defined roles and expectations for various mental health occupations, and (2) for *current* public mental health workforce, there is little room for growth and promotion within agencies.

The third significant challenge pertaining to workforce education and training is the lack of integration and collaboration across all health professions, specifically between primary care and mental health providers. As several stakeholders reported, early in their educational programs, students are not taught integrated care. And one of the larger counties stated that when collaborations are attempted, it feels forced. Some stakeholders noted that perhaps organizational differences between primary care and mental health providers might contribute to the lack of collaboration between the two health fields.

Finally, lack of supervision and internships were cited as key training and education challenges. Specifically, a larger county reported a need for interdisciplinary supervision, which reflects the need for more integration and collaboration. In addition to lack of supervision, participants cited a shortage of paid internships as well as internships available at the bachelor's level.

The need to revise and strengthen the supervision program is supported by county-reported needs, documented in the 2013 County Reported Needs Assessment. In the assessment county respondents also requested additional supervisors to build program capacity. Further, in the State-Administered WET Program Evaluation of the stipend programs, contracting colleges and universities reported a shortage in the availability of qualified public mental health providers to supervise practicums and field placement activities. Song-Brown Residency Program for Physician Assistants (PA) in Mental Health program contractors also reported a lack of interest among public mental health providers in collaborating with physician assistant placement programs, placing a priority on medical students instead.

Recruitment and Retention Challenges

OSHPD also solicited feedback on challenges pertaining to the recruitment and retention of professionals in the public mental health workforce. Of the 27 issues identified by participants, the five issues that emerged as central challenges in recruiting and retaining employees in the public mental health workforce included: (1) low wages, (2) stigma around mental health, (3) burnout, (4) lack of jobs, and (5) general recruitment issues.

Table 7: Recruitment and Retention Challenges

Key Challenges	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Low wages	11	6	1	19	37
Stigma	8	5	3	10	26
Burnout	10	2	1	11	24
Lack of jobs	8	4	1	10	23
General recruitment issues	9	5	0	8	22

Source: OSHPD Stakeholder Engagement Data (2013)

Low wages was cited as the primary challenge to the recruitment and retention of providers in the public mental health workforce. As one stakeholder agency reported, students become specialists because of the low pay offered by general care professions. Stigma was identified as the second key challenge to the recruitment and retention of mental health professionals in the public mental health system. Stakeholders identified two general issues specific to stigma: (1) stigma related to cultural issues and within cultural communities, and (2) self-stigma. Self-stigma is associated with the stigma that consumers perceive when disclosing their mental health status and use of mental health services to peers and colleagues. “Burnout” was a third challenge to recruiting and retaining mental health professionals in the public mental health workforce. Several counties, including three large counties, stated, “Mental health providers have a huge workload.” Furthermore, a smaller county reported isolation as an issue that contributes to burnout among providers of public mental health services.

The lack of jobs within the public mental health field was identified as a fourth key challenge to the recruitment and retention of providers in the pubic mental health system. More specifically, stakeholders from various counties noted a shortage of promotion opportunities and lack of permanent peer positions. The issue of low growth potential reflects one of the key challenges that also came up as a key training and education challenge. As described in the prior section, the absence of a clearly defined public mental health career pathway results in little opportunity for growth within agencies.

Overall, participants cited the following as general recruitment challenges: (1) the recruitment of peers and Psychiatrists and (2) recruitment of public mental health staff in rural areas. Participants additionally cited the need for additional training of county staff in recruiting public mental health staff. Finally, another reported general challenge is the recruitment of diverse populations. It seems this might be a significant challenge as seven community forums (both

large and small) as well as three stakeholder agencies noted this as a challenge to recruiting people into the public mental health workforce.

Consumer and Family Member Employment

OSHPD also solicited feedback from stakeholders on challenges for recruiting and engaging consumers and family members into the public mental health workforce. This section identifies and discusses the key challenges reported by participants. As demonstrated in

Table 8, of the 13 issues expressed by participants, the five top challenges to employing consumer and family members are: (1) lack of support and job opportunities for consumers and family members, (2) lack of a clear career pathway, (3) issues with counties internal process of hiring, (4) employers don't see value in peers, and (5) barriers with criminal records.

Table 8: Challenges to Employing Consumers and Family Members

Key Challenges	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Lack of support and job accommodations for consumers	4	0	0	11	15
No career track/ pathway for peers	4	2	2	1	9
Issues with counties internal process of hiring	0	1	1	3	5
Employers don't see value in peers	1	1	2	0	4
Barriers with criminal records	0	1	0	2	3

Source: OSHPD Stakeholder Engagement Data (2013)

Stakeholders reported the most significant challenge to hiring consumers and family members is the lack of support and job accommodations for consumers. In other words, as several counties explained, consumers fear losing their social service benefits once they are employed. One county also described an issue related to union response to these new positions. The second challenge, closely related to a lack of support and job accommodations, is the need for a more clearly defined career pathway for peers. Participants cited the current absence of upward mobility for consumers and family members, which makes it difficult to recruit consumers and family members into the public mental health workforce.

Another key challenge to consumer and family member employment has to do with hiring logistics and support. Specifically, participants reported an issue with counties' internal hiring process and barriers with criminal records.

Table 8 indicates these are two of the top five challenges to increasing consumer and family member employment.

Finally, a larger challenge to employing consumers and family members emerged which speaks to the need for a broader cultural change in the public mental health system. This fourth key challenge cited by participants was that "employers do not see value in peers." Closely related to this challenge are issues around stigma and lack of awareness of the consumer movement among county staff as well as in the general public. These issues will be discussed in greater detail in the sections that review stakeholder feedback on consumer and family member employment. What is important to note is the need for a knowledge shift within the public mental health system as it pertains to the consumer movement and lived experience – public mental health staff need additional training in the consumer movement and the value of peers, which will then help address the challenges to hiring and employment support for consumers and family members.

Recommendations for Increasing and Sustaining the Public Mental Health Workforce

Along with identifying challenges to increasing and sustaining employment in the public mental health workforce, OSHPD also solicited feedback on how to address these challenges. Once again, stakeholders provided recommendations pertaining to the following issues: (1) training and education, (2) recruitment and retention, and (3) employment of consumers and family members. To maintain consistency, this report structures the data according to the same three issues.

General Feedback on Recommendations

Thus far, this section has reviewed stakeholders' feedback regarding the recommendations specific to the training and education of the public mental health workforce, recruitment and retention of public mental health employees, and increasing employment of consumers and family members in the public mental health workforce. Additionally, OSHPD solicited *general* feedback on recommendations to increasing and sustaining the public mental health workforce. Over 40 recommendations were identified. Table 9 lists the top five general recommendations: (1) increase partnerships/collaboration, (2) revise the mental health workforce categories, (3) change culture to promote integration of mental health, primary care, and substance abuse, (4) increase funding, and (5) create more job opportunities.

Table 9: General Recommendations to Increasing and Sustaining the Public Mental Health Workforce

General Recommendations	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Increase partnerships/ collaboration	9	3	1	3	16
Revise mental health workforce categories	3	1	0	4	8
Change culture for integration of MH/SA/PC	3	1	0	3	7
Increase funding	2	0	0	5	7
More job opportunities	0	2	2	3	7

Source: OSHPD Stakeholder Engagement Data (2013)

The primary recommendation for strengthening the public mental health workforce is to increase partnerships and collaboration with the goals of fostering dialogue and breaking down silos. Stakeholders advocate more partnerships across a number of fields and levels. In other words, participants reported a need for more collaboration between state and counties, between agencies, and between the mental health profession and education institutions (including community colleges, California State Universities, and University of California system). Along with who to partner with, strategies for increasing partnership were also suggested, including: (1) creating a consortium for educational programs, (2) funding pilot projects that foster collaboration, and (3) establishing workgroups and forums to increase communication among the various groups and sectors.

The second general recommendation is to review mental health workforce occupations and roles. More specifically, participants reported a need to have jobs that reflect the different levels of education as well as a need to standardize job descriptions.

Stakeholders also recommended a need to change the organizational culture so as to foster more integration between mental health, substance abuse, and primary care providers. This supports what was identified in prior sections as a need for increased competency in integrated service care, more education/credentials that offer a multi-disciplinary certificate, as well as one of the key training and education challenges and recommendations for enhancing the public mental health workforce. This general recommendation suggests the need for a larger systemic change in order to foster integrated services and collaboration between mental health, primary care, and substance abuse professions.

Finally, the fourth and fifth general recommendations for increasing and sustaining the public mental health workforce are related – create more financial and job opportunities. Stakeholders' suggestions for expanding funding and employment opportunities include: (1) sponsoring innovative programs, (2) increasing money to sustain clinics due to low reimbursements, (3) providing state grants to sustain successful programs, and (4) funding regional workforce

activities. Suggestions for providing more job opportunities include: (1) creating more promotional opportunities and (2) fostering growth potential within the public mental health workforce.

Training and Education

Broadly speaking, key recommendations for the training and education of the public mental health workforce aligned to key challenges. These recommendations were: (1) expand training and education programs, (2) establish a clear career pathway, and (3) promote integrated treatment and care. Of the 44 recommendations cited by participants, the top five recommendations for training and education are: (1) expand topics for training, (2) develop career pathways for mental health occupations, (3) expand training in the integration of primary care and mental health, (4) continue education and training for the current workforce, and (5) increase funding for education and training.

Table 10: Training and Education Recommendations

Key Recommendations	Community Forum	Focus Group	Key Informant Interview	Survey	Total
Expand topics for training	12	6	7	1	26
Develop career pathways/ladder for Mental Health occupations	13	3	2	3	21
Training for integration of primary care and mental health	8	6	3	0	17
Continuing education and training for workforce	8	3	4	0	15
More funding for education and training	7	4	2	1	14

Source: OSHPD Stakeholder Engagement Data (2013)

In addition to allocating more money for education and training, a key recommendation was to enhance the content of the training programs. An overwhelming number of community forums (12 out of 14) suggested expanding the topics for training. Data indicates that trainings in cultural competency and service delivery are the primary areas for further education. More funding is needed for local and roving training programs as well as for a number of specific mental health professions, including: (1) Psychiatrists, (2) Psychologists, and (3) Nurse Practitioners.

Thirteen out of 14 community forums recommended developing a more defined career pathway for several mental health occupations, indicating a significant need. Stakeholders from two of the larger counties specified the need to articulate a clear career ladder for non-traditional

mental health occupations and for Marriage and Family Therapists looking to become Licensed Clinical Social Workers. Additionally, to help create a more developed mental health career pathway, participants from several counties suggested creating a stronger connection between high school and higher education (e.g. community college, California State Universities, and University of California institutions).

The third key recommendation for enhancing training and education is to increase training in primary care and mental health. Stakeholders' key suggestions include: (1) develop incentive programs for integrated care, (2) train primary care physicians on mental health, (3) create a wellness tool to assist in integrated care, and (4) combine family medicine and psychiatric programs. In addition, participants also noted the importance of ensuring that consumers are included in these activities.

Finally, stakeholders recommended support for continuing education and training for the current workforce. Several stakeholders highlighted the need for cultural competency training, professional development, and more on-the-job training. In addition, stakeholders proposed that agencies might benefit from having management increase efforts in retraining staff to stay up-to-date on the latest models of care and treatment methods.

Recruitment and Retention

OSHPD also solicited stakeholders' feedback on recommendations to improve the recruitment and retention of staff and providers in the public mental health workforce. A total of 42 recommendations were identified. The top five key recommendations were: (1) provide more financial incentives, (2) increase career awareness/recruitment efforts, (3) increase stipends, (4) increase reimbursements, and (5) increase outreach efforts in diverse and underserved communities.

Table 11: Recruitment and Retention Recommendations

Key Recommendations	Community Forum	Focus Group	Key Informant Interview	Survey	Total
More financial incentives	9	2	6	4	21
Conduct career awareness/recruitment efforts	12	5	3	0	20
Increase stipends	8	4	0	1	13
Increase reimbursement	10	1	1	0	12
Conduct outreach to diverse and underserved communities	6	3	2	0	11
Higher salaries	2	0	2	7	11

Source: OSHPD Stakeholder Engagement Data (2013)

The provision of more financial incentives was the primary recommendation for enhancing recruitment and retention efforts. In particular, participants recommended targeting financial

incentives to recruit members of multicultural communities, attracting providers to work in rural areas, and to high school students for their service hours in the PMHS. Financial incentives are also needed to help retain Psychiatrists in the PMHS and to strengthen the public mental health workforce in community health centers.

Closely related to the provision of more financial incentives are increasing stipends, reimbursements, and salaries. Stakeholders suggest expanding each of these areas to include more people and professions (e.g. expand reimbursement beyond traditional categories, offer stipend program for both years). Specifically related to the stipend program, participants recommend increasing the stipend for Psychologists, Nurses, retirees to come back and mentor, for consumers with lived experience, students interested in older adult population, and undergraduates. Several participants from the community forums and online survey suggested offering higher salaries, in particular, to those mental health providers working in rural areas.

Finally, a significant key recommendation for increasing the recruitment and retention of providers in the public mental health workforce is to increase career awareness/recruitment efforts. In particular, participants suggested increasing recruitment efforts in middle and high schools as well as rural areas. Strategies for enhancing recruitment efforts in the community include working with consumers to conduct outreach in high schools, working with interns at mental health departments to connect with local communities, as well as using community role models, parents, and community and faith-based organizations to recruit and effectively outreach in the community. Overall, participants from several counties reported a need to raise public awareness and knowledge about mental health careers, particularly in the educational setting. One way to enhance general awareness might be to develop a mental health career curriculum for teachers working in K-12 education.

Consumer and Family Member Employment

OSHPD also solicited stakeholder feedback on recommendations for increasing consumer and family member employment in the public mental health workforce. Participants offered a total of 27 suggestions. The top five recommendations are: (1) provide more support for consumers, (2) increase trainings for consumers, (3) offer a peer certification program, (4) train staff in the consumer movement, and (5) train management on the consumer workforce.

Table 12: Recommendations for Increasing Employment of Consumers and Family Members

Key Recommendations	Community Forum	Focus Group	Key Informant Interview	Survey	Total
More support for consumers	11	4	3	0	18
More training for consumers	10	3	2	0	15
Peer Certification	8	2	3	0	13
Train staff in consumer movement	7	2	4	0	13
Train management on consumer workforce	2	3	4	0	9

Source: OSHPD Stakeholder Engagement Data (2013)

The primary recommendation for increasing consumer and family member employment in the public mental health workforce is to provide more financial and logistic support. Regarding financial support, participants' suggestions include (1) providing a livable salary, (2) offering benefits, (3) offering financial incentives for education, and (4) providing stipends to be part of advisory boards. Logistical support includes suggestions such as: (1) increasing access to transportation, (2) providing mentoring and peer-to-peer programs, (3) having retired providers support peers, and (4) offering support groups. Some participants identified Wellness Recovery Action Plan (WRAP) and the 20/20 program as beneficial supports for consumers.

Addressing training needs was the second key recommendation for increasing consumer and family member employment. Suggested trainings include: (1) training to work in primary care settings, (2) peer-to-peer training, (3) practicum training for peers, (4) training in medical billing, (5) evidence-based practices, and (6) geriatric training. Additionally, a peer certification program will also help increase consumer and family member employment. A peer certification program was also cited as the number one key education/credential need in the public mental health system.

The fourth and fifth key recommendations – train staff and management in the consumer movement – pertain to the need to train staff and management in the value of lived experience and issues around stigma and mental health so that there is greater parity between consumers and other mental health staff/providers in the workforce.

Break-Out Sessions

As mentioned in the Introduction section, the OSHPD-led community forums were three hours in duration and comprised of two parts. The first part involved a larger discussion with all the stakeholders on public mental health workforce needs as well as challenges and recommendations. The second part of the community forums consisted of smaller break-out sessions where each group was given a particular topic to discuss. OSHPD came up with five "sub-issues": (1) diversity, and (2) integration, were discussed across breakout groups, and (3) training and education, (4) recruitment and retention, and (5) consumer and family members had their own individual breakout groups.

This section of the report analyzes and discusses key findings from these breakout sessions and findings from the focus groups and surveys that were specific to feedback received on the five aforementioned sub-issues. To maintain consistency, the analysis is organized according to the topics of the five break-out sessions. Three stakeholder engagement methods comprise the data sources for this analysis: (1) community forums, (2) focus groups, and (3) online surveys.

Diversity

OSHPD solicited stakeholder feedback on how to increase the diversity of the public mental health workforce. Participants were asked to identify barriers to increasing diversity and for suggestions to address identified barriers.

Barriers to Increasing the Diversity of the Public Mental Health Workforce

Table 13 provides a comprehensive list of all the barriers reported by participants. In this instance, three barriers clearly emerged, with the remainder receiving just one comment each. The top three barriers are: (1) lack of knowledge on how to outreach to diverse communities, (2) stigma, and (3) high cost of education.

Table 13: Barriers to Increasing the Diversity of the Public Mental Health Workforce

Key Barriers	Community Forum	Focus Group	Survey	Total
Lack of knowledge on how to outreach to diverse communities	0	3	0	3
Stigma	0	2	0	2
High cost of education	0	2	0	2

Source: OSHPD Stakeholder Engagement Data (2013)

The primary challenge to increasing the diversity of the public mental health workforce is the lack of knowledge about how to effectively outreach to the diverse number of cultural communities. Issues regarding the number of cultural communities, language barriers, ensuring culturally appropriate outreach, as well as barriers to forging strong partnerships in each

community all affect the ability to increase diversification of the public mental health workforce. The intersection of culture and stigma around mental health/mental illness serves an additional significant challenge.

Recommendations to Increase Diversity of the Public Mental Health Workforce

Participants provided a total of 39 recommendations for increasing the diversity of the public mental health workforce. Table 14 lists the top five key recommendations: (1) provide financial incentives, (2) strengthen marketing and outreach campaigns, (3) expand recruitment in various communities and locations, (4) increase partnerships and collaboration, and (5) increase awareness of available programs.

Table 14: Recommendations to Increase the Diversity of the Public Mental Health Workforce

Key Recommendations	Community Forum	Focus Group	Survey	Total
Provide financial incentives	7	3	19	29
Strengthen marketing and outreach campaigns	5	7	16	28
Expand recruitment in various communities and locations	12	6	8	26
Increase partnerships and collaboration	5	3	8	16
Increase awareness of available programs	1	0	13	14

Source: OSHPD Stakeholder Engagement Data (2013)

Stakeholders' feedback on increasing the diversity of the public mental health workforce fall into two general categories: (1) financial support and (2) increase outreach efforts. Financial assistance programs for educational programs, such as scholarships, fee waivers, and stipends, will help incentivize people from various communities to join the public mental workforce. Along with financial incentives, participants propose strengthening marketing and outreach campaigns. Strategies for strengthening outreach varied from implementing culturally competent marketing techniques to using social media and partnering with community leaders and celebrities. Stakeholders also proposed expanding locations for recruitment to Kindergarten (K)-12th grade education, job fairs, conferences, places of worship, rotary clubs, civic groups, boys and girls club, and other popular locations in local communities. Overall, these suggestions for expanding recruitment locations and marketing strategies speak to the broader need to increase partnerships/collaborations and raise awareness of mental health careers in the various communities.

Integration

For the breakout session that included integration, OSHPD requested that participants provide more in-depth feedback on the delivery of integrated services. OSHPD asked the group to identify the current barriers to integrated services and what can be done to expand multi-

disciplinary and inter-disciplinary training that integrates behavioral health, mental health, substance abuse, and primary care. This section reviews participants' identified barriers and recommendations for fostering integrated services.

Challenges to Promoting Integration of Behavioral Health, Mental Health, Substance Abuse, and Primary Care

Participants identified five challenges to integrating behavioral health, mental health, substance abuse, and primary care. Table 15 lists the five key challenges, which are: (1) lack of connection between primary care and mental health providers, (2) reimbursement, (3) lack of curriculum, (4) cultural differences between primary care and mental health providers, and (5) professional silos.

Table 15: Challenges to Multi-Disciplinary Integration

Key Challenges	Community Forum	Focus Group	Survey	Total
Lack of link between primary care and mental health providers	0	1	10	11
Reimbursement	0	2	2	4
Lack of curriculum	0	1	3	4
Cultural differences between PC and MH providers	0	1	2	3
Professional silos	0	1	0	1

Source: OSHPD Stakeholder Engagement Data (2013)

As Table 15 above demonstrates, the primary challenge to integrated services is a disconnect between primary care and mental health providers. Factors that shape the disconnect are cultural and communication differences. Stakeholders stated, "Doctors only want to talk to doctors." Additionally, the absence of an educational and financial infrastructure – lack of an integrated care curriculum as well as absence of a reimbursement system that aligns with integrated services – create further challenges.

Recommendations for Promoting Integration of Behavioral Health, Mental Health, Substance Abuse, and Primary Care

Stakeholders offered a total of 11 recommendations for promoting the integration of behavioral health, mental health, substance abuse, and primary care. The top five recommendations are: (1) provide more training for integration, (2) increase collaboration, (3) ensure reimbursement aligns with integration, (4) include Substance Abuse Counselors in integration, and (5) develop multi-disciplinary training teams.

Table 16: Recommendations to Multi-Disciplinary Integration

Key Recommendations	Community Forum	Focus Group	Survey	Total
Provide more training for integration	0	2	12	14
Increase collaboration			8	8
Ensure reimbursement aligns with integration	0	1	6	7
Include Substance Abuse Counselors in integration	0	1	5	6
Develop multi-disciplinary training teams	0	0	4	4

Source: OSHPD Stakeholder Engagement Data (2013)

The primary recommendation for promoting integrated services is to offer more training on integration. This also emerged as a key recommendation in addressing workforce training and education needs. In addition to offering more training on integration, stakeholders also proposed making it a requirement to offer periodic trainings in integrated services. And to build an infrastructure for promoting integrated services, stakeholder feedback included increased collaboration with universities and local nonprofits, working with education institutions to develop a curriculum on integrated services, conducting a policy review, and identifying successful programs that can be replicated.

Training and Education

OSHPD hosted a breakout session to solicit further feedback on training and education needs within the public mental health workforce. Participants were asked to identify barriers to expanding the capacity of training and education programs, along with associated recommendations. Additionally, OSHPD asked participants to provide feedback on training and education needs as they pertain to cultural competency, early prevention and intervention services, the use of web-based techniques, additional supports needed by the county to place interns in public mental health settings, and finally ways to ensure consumers and family members' viewpoints are included in training and education. This section reviews key findings from each of these topics.

Barriers to Expand Training and Education Capacity

Participants listed four key barriers to expanding training and education programs. These are: (1) lack of funding for training, (2) lack of time to take training courses, (3) lack of clinical sites, and (4) conflict between social and medical model.

Table 17: Barriers to Expand the Capacity of Training and Education Programs

Barrier	Community Forum	Focus Group	Survey	Total
Lack of funding for training	0	1	0	17
Lack of time to take training courses	0	1	0	2
Lack of clinical sites	0	1	0	1
Conflict between social and medical model	0	1	0	1
TOTAL	0	0	0	**21**

Source: OSHPD Stakeholder Engagement Data (2013)

Funding emerged as the number one barrier to expanding training and education. In addition to financial barriers, other resource constraints pose challenges. Participants cited a shortage of clinical sites and lack of time (as training takes time away from providing services) as factors challenging training and education capacity. Finally, the fourth challenge – conflict between the social and medical model – speaks to a broader issue around differing approaches to service delivery and care.

Recommendations to Expand Training and Education Capacity

Participants provided 43 different recommendations for expanding training and education capacity. The top five recommendations are: (1) expand training on various topics, (2) increase partnerships/collaboration, (3) provide more financial incentives, (4) expand training for various occupations, and (5) strengthen supervision.

Table 18: Recommendations to Expand the Capacity of Training and Education Programs

Recommendations	Community Forum	Focus Group	Survey	Total
Expand training on various topics	12	3	5	20
Increase partnerships/ collaborations	7	1	8	16
Provide more financial incentives	9	0	6	15
Offer training for occupations outside the mental health profession	7	0	0	7
Strengthen supervision	4	0	2	6

Source: OSHPD Stakeholder Engagement Data (2013)

Participants' recommendations centered on areas where training and education are needed. Suggested topics for training fell under three general categories: (1) wellness and recovery, (2)

models of care, and (3) clinical competency working with various populations, such as older adult and low-income individuals. In addition to expanding topics for training, participants suggested expanding training beyond the public mental health workforce to include K-12 faculty, peer specialists, families, teachers, police officers, county quality improvement officers, and primary care providers.

The second key recommendation is to increase partnerships and collaborations. Stakeholders specified the need for more collaboration between counties, agencies, and academic institutions, between community colleges to reduce duplication, between counties and agencies, as well as with workforce investment boards. One stakeholder suggested creating mental health ambassadors to foster partnerships with non-profits, schools, hospitals, and businesses.

The third recommendation that emerged was to provide more financial incentives. For prospective students, stakeholders from various counties proposed increasing scholarships and stipends, fee waivers, and providing financial assistance for all students (not only Master's students). Stakeholders in several counties also proposed offering financial incentives for continuing education to the current workforce.

Finally, based on stakeholder feedback, there is a need for strengthening supervision for current students and Residents in training. A number of stakeholders from large counties reported the need for adequate supervision, multilingual supervisors, designated supervisor positions, and lowered expectations related to supervisor productivity.

Recommendations to Promote Cultural Competency in Training and Education

OSHPD solicited stakeholder feedback on how to promote cultural competency in public mental health training and education programs. Participants provided a total of 32 recommendations. The top five recommendations for promoting cultural competency in training and education are: (1) increase recruitment of cultural groups, (2) increase collaboration and partnerships, (3) develop curriculum, (4) provide training for mental health practitioners and supervisors, and (5) expand the definition of diversity.

Table 19: Recommendations to Promote Cultural Competency in Training and Education

Key Recommendations	Community Forum	Focus Group	Survey	Total
Increase recruitment of cultural groups	6	0	6	12
Increase collaboration and partnerships	4	0	6	10
Develop curriculum	3	0	6	9
Provide training for Mental Health practitioners and supervisors	3	1	4	8
Expand definition of diversity	6	0	1	7

Source: OSHPD Stakeholder Engagement Data (2013)

The primary recommendation for promoting cultural competency in training and education programs is to increase outreach and recruitment efforts among cultural communities. Suggestions for accomplishing this task include: (1) having a more diverse group of individuals participate in outreach, (2) using cultural brokers, (3) having community college interns recruit from their own communities, and (4) implementing a "grow your own" model. Closely related to increasing recruitment of cultural groups is to increase collaboration and partnership. This could involve networking with local resources and closely working with local organizations that are building proficiency in cultural competency. Stakeholders from one county and six online survey respondents proposed it might be helpful to develop a curriculum on cultural competence for K-12 education.

In addition to increasing cultural competency training for current students, stakeholders also suggested the importance of providing cultural competence training for the *current* public mental health workforce through continuing education and on-the-job training. Finally, and more broadly, the fifth recommendation for promoting cultural competency in education and training is to expand the definition of diversity beyond race and ethnicity. Several stakeholders from small counties recommended including the LGBTQ community, proficiency in the culture of those in recovery, and the culture of those people experiencing poverty and homelessness. Stakeholders from one county also suggested that cultural humility be emphasized in the promotion of cultural competence in training and education programs.

Recommendations to Promote Training in Prevention and Early Intervention

OSHPD solicited stakeholder feedback on how to promote staff training and education on prevention and early intervention services to consumers. Participants provided a total of 27 recommendations. Table 20 lists the top five most frequently cited recommendations: (1) increase recognition of prevention and early intervention, (2) provide appropriate funding for training, (3) expand training for current workforce, (4) expand training in interview skills, public speaking, and delivery modalities, and (5) provide web-based training in Prevention and Early Intervention (PEI) as well as promote training for non-clinical staff in the public mental health workforce.

Table 20: Recommendations to Promote Training in Prevention and Early Intervention Services

Key Recommendations	Community Forum	Focus Group	Survey	Total
Increase recognition of prevention and early intervention	1	0	10	11
Provide appropriate funding for training	1	0	10	11
Expand training for current workforce	1	0	6	7
Expand training in interview skills, public speaking, and delivery modalities	2	0	4	6
Provide Web-based training in PEI	2	0	3	5
Promote training of non-clinical workforce	1	0	4	5

Source: OSHPD Stakeholder Engagement Data (2013)

Based on participants' feedback, the primary recommendation is to raise awareness of PEI services. The second key recommendation is to provide funding for training in PEI services. Stakeholders reported training would be helpful not only for current students and Residents, but also for the current public mental health workforce. Finally, participants suggested budgeting Web-based training in PEI when planning resources for training.

Recommendations to Promote Web-Based Technologies/Distributive Learning Techniques in Training and Education

OSHPD asked participants for feedback on how to promote web-based technologies and distributive learning in training and education. A total of 29 recommendations were collected. Table 21 lists participants' top five recommendations for promoting web-based technologies/distributive learning techniques: (1) offer a variety of technology options, (2) increase partnership with higher education and private businesses, (3) offer interactive trainings, (4) train staff on using technology tools, and (5) develop more intuitive technology software.

Table 21: Recommendations to Promote Web-Based Technologies in Training and Education

Key Recommendations	Community Forum	Focus Group	Survey	Total
Offer a variety of technology options	1	0	11	12
Increase partnerships with higher education and private businesses (e.g. Comcast)	1	0	5	6
Offer interactive trainings	1	0	5	6
Train staff on using technology tools	2	0	3	5
Develop more intuitive technology software	1	0	4	5

Source: OSHPD Stakeholder Engagement Data (2013)

Generally speaking, participants' recommendations for promoting web-based technologies in training and education seem to follow two broad themes: (1) provide the resources, and (2) train staff on how to use the resources. Key recommendations for increasing resources include offering a variety of technology options and developing more intuitive technology software. In addition to providing the tools, participants' also recommend a need for training staff in the use of these tools as well as telehealth more generally. Stakeholders specified interactive trainings in the use of web-based technologies as particularly beneficial. Finally, a broader key recommendation is to increase partnerships with higher education and businesses in order to create more distributive learning programs. However, as stakeholders from one county stated, quality must remain a top priority, even as the number of web-based/distributive learning programs increase.

Recommendations for County and CBO Support to Enhance Intern Placements in the Public Mental Health Workforce

OSHPD solicited feedback on what kinds of supports might be needed by counties, county contractors, and training programs in order to place students as interns in pubic mental health settings. A total of 26 support needs were identified. Table 22 lists the top five support needs: (1) strengthen supervision, (2) provide financial support, (3) increase funding to support intern retention, (4) increase availability of stipends, and (5) strengthen internship programs.

Table 22: County Support to Enhance Intern Placements in the Public Mental Health Workforce

Key Recommendations	Community Forum	Focus Group	Survey	Total
Strengthen supervision	11	0	15	26
Provide financial support	5	0	5	10
Increase funding to support intern retention	2	0	8	10
Increase availability of stipends	4	0	4	8
Strengthen internship programs	6	0	2	8

Source: OSHPD Stakeholder Engagement Data (2013)

Stakeholders from 11 out of 14 counties recommended the need to strengthen supervision, making this a significant recommendation. Specific suggestions for improving supervision include increasing the number of supervisors, exploring dual or shared supervision across the professions, offering stipends or funding to supervisors, providing technical assistance for supervisors, addressing supervisor burnout, and creating opportunities for supervisors to receive feedback. Stakeholders from several counties proposed creating a consortium of supervisors at the regional level to address some of these current issues.

A second key recommendation is to provide financial support for current programs, such as funding to run background checks and fingerprinting, and to take certificates/tests. Suggestions for additional financial support include tuition assistance for undergraduates and financial assistance for interns and the incumbent workforce. Additional suggestions for financial support focus on the retention of interns once they have completed the program. Specifically, stakeholders reported there are not enough jobs after internships are complete. Finally, stakeholders proposed revising the WET stipend program by increasing the stipend amount, creating equal distribution among the counties, and offering stipends for students and field instructors as well as students specializing in the older adult population.

Recommendations to Ensure the Inclusion of Consumers and Family Members' Viewpoints in Training and Education Programs

For the training and education break-out session, OSHPD's last question pertained to consumers and family members. Specifically, OSHPD requested feedback on how to ensure that consumers' and family members' viewpoints are included in training and education programs. A total of 19 recommendations were provided. Table 23 lists the top five key recommendations: (1) conduct consumer stakeholder forums, (2) increase consumer involvement in trainings, (3) ensure consumer involvement in academic decision-making, (4) obtain feedback from peers, and (5) ensure consumer representation on Mental Health boards and committees.

Table 23: Recommendations to Ensure Inclusion of Consumers and Family Members' Viewpoints in Training and Education Programs

Key Recommendations	Community Forum	Focus Group	Survey	Total
Conduct consumer stakeholder forums	2	0	26	28
Increase consumer involvement in trainings	5	0	12	17
Ensure consumer involvement in academic decision-making	1	0	12	13
Obtain feedback from peers	2	0	10	12
Ensure consumer representation on Mental Health boards and committees	2	0	8	10

Source: OSHPD Stakeholder Engagement Data (2013)

In order to ensure inclusion of consumers and family members' viewpoints in training and education programs in the public mental health system, participant's primary recommendation was to receive feedback from peers. Participants from one community forum proposed leading a grassroots effort to obtain input from consumers. Twenty-six respondents to the online survey suggested conducting consumer stakeholder forums.

Table 23 demonstrates another key recommendation is to increase the participation of consumers and family members in various leadership positions. Suggestions include: (1) have consumers play a central role in developing and leading training programs, (2) involve consumers in academic decision-making, and (3) raise consumer and family member representation on Mental Health boards and committees. Overall, stakeholders recommend creating more opportunities to obtain input from consumers as well as ensure more decision-making roles for consumers and family members in training and education programs.

Recruitment and Retention

For the recruitment and retention break-out session, OSHPD solicited more in-depth feedback on current financial assistance programs for students enrolled in mental health graduate programs. Specifically, OSHPD asked participants for their feedback pertaining to stipends, scholarships, and loan forgiveness programs offered to people for their commitment to volunteering and/or employment in the public mental health system. This section reviews and discusses key findings regarding current barriers and recommendations for improving financial assistance programs in order to increase the recruitment and retention of professionals in the public mental health system.

General Opinion on Financial Assistance Programs for Recruiting and Retaining People in the Public Mental Health System

OSHPD first asked participants for their general thoughts on WET stipends, scholarships, and loan forgiveness programs currently offered to students for their commitment to joining the public mental health workforce. A total of 11 general comments were identified. Table 24 provides a comprehensive list of these comments.

Table 24: General Comments on WET Stipends, Scholarships, and Loan Forgiveness Programs

General Comment	Community Forum	Focus Group	Survey	Total
Programs are effective	6	0	282	288
Needs to be an evaluation of state level stipend program	2	0	0	2
Need equal distribution of stipend across all counties	2	0	0	2
Stipends have not done a great job at retention after payback	2	0	0	2
MHLAP is a good model	1	0	0	1
Need to think about creating new types of programs not just status quo	1	0	0	1
Counties want clear guidelines on how to run stipend program	1	0	0	1
MFT consortium is a good model	1	0	0	1
Stipend program is set up inconsistently across professions	1	0	0	1
Not enough money for stipends	1	0	0	1
Stipends are more valuable than loan forgiveness	1	0	0	1

Source: OSHPD Stakeholder Engagement Data (2013)

As Table 24 illustrates, the majority of participants find the various financial assistance programs to be effective. More specifically, some stakeholders reported the WET stipend program seems to be more successful than loan forgiveness programs. Two programs were identified as key models for replication: (1) MHLAP and (2) coordination of stipends by the Marriage and Family Therapy Consortium. It should be noted that there are state-administered stipend programs and county/regionally-administered stipend programs and it is unknown which type of stipend program stakeholders were referring to as many were unaware there were different types of stipend programs.

While overall participants found the WET stipend program to be effective, this is also where the majority of recommendations were focused. Stakeholders proposed conducting an evaluation of the WET stipend program, looking at the possibility of equal distribution of stipends across counties as well as mental health professions, and possibly increasing the stipend amount. Finally, one community forum raised the idea of promoting new types of financial assistance programs.

Barriers to Using Stipends, Scholarships, and Loan Forgiveness Programs

OSHPD asked participants to identify those barriers that prevent more people from applying for the WET stipend, scholarships, and loan forgiveness programs. A total of 27 barriers were identified. Table 25 lists the top five barriers reported by participants: (1) lack of marketing/promotion of the financial assistance programs, (2) complicated application process, (3) insufficient employment opportunities for payback, (4) biased selection criteria, and (5) low wages.

Table 25: Barriers to People Using WET Stipends, Scholarships, and Loan Forgiveness Programs

Key Barriers	Community Forum	Focus Group	Survey	Total
Lack of marketing/promotion of programs	6	0	62	68
Application process is too complicated	5	0	24	29
Insufficient Employment opportunities for payback	3	0	15	18
Selection criteria is biased	1	0	10	11
Low wages	2	0	8	10

Source: OSHPD Stakeholder Engagement Data (2013)

The primary barrier to people applying for financial assistance programs is a general lack of knowledge of these financial opportunities due to a shortage of marketing and promotion efforts. Furthermore, based on stakeholders' feedback, when prospective candidates do find out about the programs, the bureaucratic requirements and complicated application processes seem to deter them from applying for financial assistance programs. The third key barrier is the selection criteria; as stakeholders from one large county reported, consumers are often excluded from applying to financial assistance programs. Finally, participants perceive that there are not enough financial rewards for students complete their training and education, largely because jobs in the public mental health system garner low wages. Additionally, stakeholders expressed the belief that there are not enough job opportunities in the public mental health system that allow for students to pay loans back within the required timeframes.

Recommendations for Making Stipends, Scholarships, and Loan Forgiveness Programs More Effective

Participants also provided recommendations for improving the WET stipend, scholarships, and loan forgiveness programs in order to attract more applicants. Participants proposed a total of

35 recommendations. Table 26 lists the top five most frequently cited recommendations: (1) increase outreach and awareness of programs, (2) increase dollar amount of stipend programs, (3) increase financial incentives, (4) increase funding for education and training, and (5) increase partnerships and collaboration.

Table 26: Recommendations for Improving Stipends, Scholarships, and Loan Forgiveness Programs

Key Recommendations	Community Forum	Focus Group	Survey	Total
Increase outreach and awareness of programs	11	0	38	49
Increase dollar amount to cover full tuition, training and living expenses	3	0	25	28
Increase financial incentives	7	1	8	16
Increase funding for education and training	1	0	9	10
Increase partnerships and collaboration	4	0	2	6

Source: OSHPD Stakeholder Engagement Data (2013)

Given that stakeholders identified a lack of awareness of the programs as the number one barrier to having more people use the financial assistance programs (see Table 25), it is not surprising that the leading recommendation for making these programs more effective is to increase marketing and outreach efforts. Stakeholders in a number of counties recommended expanding outreach to high schools, underrepresented groups, and diverse communities. Possible strategies for increasing outreach include: holding information sessions, participating in career fair days, and creating public service announcements. Participants also propose involving both recipients of the financial assistance programs and mental health department staff in outreach efforts.

The second and third key recommendations for increasing the efficiency of financial assistance programs fall under the general category of increasing financial incentives. Participants propose increasing the stipend amount to cover the full cost of tuition and living expenses as well as the possibility of extending the stipend program to both years instead of one year. This increase might further incentivize people to apply for the program. Additional suggested financial incentives include offering more scholarships at the associate and bachelor's level. Scholarships could also target particular populations such as consumers, older adults and retirees, bilingual applicants, and low-income students.

As discussed in prior sections including training and education and workforce training and education needs, the fourth key recommendation is to increase funding for education and training. Finally, participants recommend increasing partnerships and collaboration across sectors. Participants from several counties propose more partnerships with businesses, employment sites and agencies, as well as with middle schools, high schools, and community colleges. The potential to leverage the financial resources of some sectors

Strategies for Educational Institutions, Counties, and Partners to Recruit and Retain Students in a Mental Health Career Pathway

OSHPD asked participants what educational institutions, counties, and partners in the public mental health system can do to recruit and retain students in a mental health career pathway. Participants offered a total of 37 suggestions. Table 27 lists the five most frequently cited recommendations for recruiting and retaining students in a mental health career pathway: (1) diversify outreach to different communities and grade levels, (2) increase collaboration and partnerships, (3) break down stigma, (4) strengthen internship programs, and (5) develop career pathways for mental health professions.

Table 27: Strategies for Educational Institutions, Counties and Partners to Recruit and Retain Students in a Mental Health Career Pathway

Key Recommendations	Community Forum	Focus Group	Survey	Total
Diversify outreach to different communities and grade levels	10	3	12	25
Increase collaboration and partnerships	7	0	10	17
Break down stigma	4	2	8	14
Strengthen internship programs	3	1	9	13
Develop career pathway for Mental Health professions	8	1	3	12

Source: OSHPD Stakeholder Engagement Data (2013)

Table 27 indicates five large-scale, systemic actions proposed by participants to increase recruitment and retention in a mental health career pathway. The primary recommendation is to expand outreach to diverse communities and across grade levels. As mentioned in the prior section, participants suggest expanding outreach to K-12 education and engaging consumers and mental health department staff in outreach efforts. Closely related to expanding outreach is developing a more defined career pathway for particular mental health professions. Stakeholders from several counties propose that a clearer mental health career pathway for consumers and family members as well as students interested in alternative education, criminal justice and foster youth will benefit the public mental health system workforce.

Participants also recommend: increasing partnerships and collaborations between educational programs, high schools and colleges, school districts, community-based organizations located in diverse communities, and the Department of Education. Stakeholders from one community forum recommended creating a career academy partnership with the California Department of Education.

Overall, in order to increase recruitment and retention of students in a mental health career pathway, stakeholders propose holding anti-stigma trainings in middle and high schools. One respondent from the survey states, “Make it cool to work in the mental health field.”

Recommendations to Enhance Career Pathway Programs for a Career in the Public Mental Health System

Finally, OSHPD asked stakeholders for recommendations to increase career pathway programs such as career academies, adult schools, and regional occupation centers/programs, with a focus on careers in the public mental health system. Table 28 lists the five top recommendations: (1) offer higher wages, (2) define core competencies, (3) set affordable tuition, (4) offer part-time programs, and (5) increase staff to coordinate and implement ideas.

Table 28: Recommendations to Enhance Career Pathway Programs for a Career in The Public Mental Health System

Key Recommendations	Community Forum	Focus Group	Survey	Total
Offer higher wages	1	0	17	18
Define core competencies	1	0	15	16
Set affordable tuition	1	0	11	12
Offer part-time programs	1	0	0	1
Increase staff to coordinate and implement ideas	1	0	0	1

Source: OSHPD Stakeholder Engagement Data (2013)

Table 28 demonstrates four of the five recommendations are related to increasing programmatic support—offering higher wages, setting affordable tuition, increasing staff to coordinate and implement ideas, and offering part-time programs. The suggestion to define core competencies speaks to a larger, systemic issue. Stakeholders in a large county reported it could be helpful to establish core competencies at the State level as well as across the various mental health professions.

Consumer and Family Member Employment

The third break-out session focused on issues pertaining to consumer and family member employment in the public mental health system. OSHPD began the discussion asking participants whether an adequate number of consumers and family members are employed in the public mental health system. Survey data indicates that 80 respondents do not think an adequate number of consumers and family members are represented in the pubic mental health system, while 51 online survey respondents do think consumers and family members are adequately represented. Stakeholders from eight of the 14 community forums felt that consumers and family members are not adequately represented in the workforce. No data on this subject was available from the focus groups.

OSHPD asked stakeholders to elaborate on issues around increasing the employment of consumers and family members including: why stakeholders believe consumers and family members are not adequately represented in the public mental health workforce; suggestions for supports needed by consumers and family members to gain and maintain employment in the public mental health system; what can be done to reduce stigma associated with mental illness in the public mental health workforce; and what types of assistance might counties and county partners need to increase the employment of consumers and family members in the public

mental health system. This section reviews and discusses key responses for each of these questions.

Reasons for Low Employment of Consumers and Family Members

When participants expressed the belief that consumers and family members are not adequately represented in the public mental health workforce, OSHPD asked them to explain. A total of 42 explanations were provided. Table 29 lists the top five reasons: (1) stigma, (2) lack of formal training or education, (3) lack of employment opportunities, (4) lack of support and accommodation for consumers, and (5) fear of losing social service support benefits and funding.

Table 29: Reasons for Low Employment of Consumers and Family Members in The Public Mental Health System

Key Reasons	Community Forum	Focus Group	Survey	Total
Stigma	12	6	18	36
Lack of formal training or education	8	2	10	20
Lack of employment opportunities	11	3	5	19
Lack of support and accommodations for consumers	4	4	3	11
Fear of losing social service support benefits and funding	5	2	2	9

Source: OSHPD Stakeholder Engagement Data (2013)

Participants believe that the primary reason consumers and family members are not sufficiently represented in the pubic mental health workforce is stigma. Stakeholders from several counties report a high prevalence of stigma in mental health departments as well as self-stigma.

The second factor attributed to low participation is the lack of formal training and education available for consumers and family members, and the resulting lack of skills needed by employers. Participants also perceive that counties have insufficient funding to train consumers and family members.

Participants also note a lack of employment opportunities. More specifically, there are a lack of entry-level and part-time positions. Stakeholders in several large counties also report the absence of a clearly defined career pathway, along with low-growth potential.

The fourth and fifth explanations have to do with a lack of support for consumers. Overall, there appears to be a fear among some consumers that if they gain employment, they may lose social financial benefits, such as those from Medi-Cal or Social Security. This fear was also noted in the report titled, *MHSA WET Five-Year Plan Assessment: Summary of County-Reported Mental Health Workforce Needs*.

Recommended Supports for Consumers and Family Members to Gain and Maintain Employment in the Public Mental Health System

Participants were asked to identify the kinds of supports that will help consumers and family members gain and maintain employment in the public mental health system. Participants provided a total of 44 supports. Table 30 lists the top five most frequently cited support: (1) education and training opportunities, (2) support systems and groups, (3) reasonable accommodations, (4) employment support services, and (5) financial support for education and training.

Table 30: Appropriate Supports for Consumers and Family Members to Gain and Maintain Employment in the Public Mental Health System

Key Supports	Community Forum	Focus Group	Survey	Total
Education and training opportunities	12	5	28	45
Support systems and groups	9	4	15	28
Reasonable accommodations	7	3	15	25
Employment support services	7	0	16	23
Financial Support for education and training	7	3	10	20

Source: OSHPD Stakeholder Engagement Data (2013)

The primary support proposed by participants is the creation of education and training opportunities for consumers and family members. Suggested trainings include: computer skills; financial literacy; clinical skills; wellness, recovery, and resilience; evidence-based practices; grant writing; Medi-Cal billing; leadership; and documentation completion. Some stakeholders also suggest providing hands-on training in addition to book training.

Closely related to providing more educational opportunities, another key recommendation is to increase financial support for education and training. This might include creating a stipend and MHLAP program for consumers. It should be noted that consumer and family members do currently qualify for MHLAP.

Finally, the remaining supports fall into the broader category of workforce development. Participants identified several programs to strengthen support systems for consumers and family members: (1) Working on Wellness, (2) Partners in Hope, and (3) peer to peer support. Participants also suggest offering more flexible work hours and environment. One stakeholder identified the 20/20 program (working 20 hours and going to school 20 hours) as a potentially beneficial model to replicate. Finally, respondents proposed support in employment placement, such as assessing work skills and identifying the most appropriate positions within the public health system, and subsequently when consumers find employment. Stakeholders from one

community forum propose creating a Consumer Employment Coordinator position that would be charged with supporting consumer employment.

Recommendations for Reducing Stigma Associated with Mental Illness in the Public Mental Health Workforce

OSHPD solicited feedback on how to reduce stigma associated with mental illness in the public mental health workforce. Participants offered a total of 28 recommendations. Table 31 lists the top five frequently cited recommendations: (1) increase knowledge of consumer movement, (2) bring consumers out of the shadow, (3) create public service announcements, (4) provide a statewide training on stigma in the workplace, and (5) educate employers about the consumer movement.

Table 31: Recommendations for Reducing Stigma Associated with Mental Illness in the Public Mental Health Workforce

Key Recommendations	Community Forum	Focus Group	Survey	Total
Increase knowledge of consumer movement	12	2	29	43
Bring consumers out of the shadows	8	0	19	27
Create public service announcements	3	0	3	25
Provide a statewide training on stigma in the workplace	1	0	24	25
Educate employers about the consumer movement	8	0	13	21

Source: OSHPD Stakeholder Engagement Data (2013)

As demonstrated in Table 31, the top recommendation for reducing stigma around mental illness in the public mental health workforce is to increase knowledge and awareness of the consumer movement. Twelve out of 14 community forums and 29 online survey respondents suggested raising awareness might help reduce stigma, indicating a significant recommendation. Ways to raise awareness include showing the business case for consumer employment, promoting what is working regarding the employment of peers, and training the current mental health workforce as well as human resources in the recovery model. Additionally, stakeholders from several counties also suggested educating employers and clinical staff in the consumer movement by having individuals with lived experience present to staff and employers.

Stakeholders also propose increasing consumer visibility by launching a statewide campaign that promotes the value of lived experience, and is endorsed by state administrators and elected officials. Creating public service announcements and training peers in how to publicly talk about their lived experience may help reduce stigma. Overall, all these recommendations speak to the need to promote the consumer movement within the current workforce as well as with the larger public.

Types of County Assistance Needed to Increase Consumers and Family Members Employment in the Public Mental Health Workforce

OSHPD requested feedback on the kinds of assistance counties need to increase consumer and family member employment in the pubic mental health workforce. Participants provided a total of 23 suggestions. Table 32 lists the top five most frequently cited recommendations: (1) increase funding, (2) help human resource staff understand the value of people with lived experience, (3) increase awareness of resources, (4) create a peer certification program, and (5) provide employers and agencies a guideline for hiring consumers and family members.

Table 32: Types of County Assistance Needed to Increase Consumers and Family Members Employment in the Public Mental Health Workforce

Types of Assistance	Community Forum	Focus Group	Survey	Total
Increase funding	6	0	15	21
Help human resource staff understand the value and importance of people with lived experience	6	1	7	14
Increase awareness of resources such as MHLAP and WWT	1	0	12	13
Create a peer certification program	4	1	6	11
Provide employers and agencies guidelines on how to hire and utilize consumers	5	1	3	9

Source: OSHPD Stakeholder Engagement Data (2013)

The primary recommendation for county assistance in order to increase consumer and family member employment in the public mental health workforce is to increase funding. Stakeholders from one community forum advocated for more funding to sustain partnerships, while stakeholders also cited more funding to smaller counties.

Based on the data presented in Table 32, two of the five recommendations speak to more programmatic and organizational development support for counties and county partners. That is, human resources and employers might benefit from guidelines to hire consumers and family members. In addition to a hiring guideline, participants suggest human resource staff could benefit from additional training on the value of the consumer movement and the participation of people with lived experience, as well as an informational training that increases awareness of resources such as MHLAP and Working Well Together. Finally, stakeholders recommend creating a peer certification program. This was also identified as a key workforce education/credential need (see section Public Mental Health Workforce Needs: Education/Credentials).

Recommendations to Ensure Consumers and Family Members' Viewpoints are Included in Training and Education Programs

Lastly, OSHPD asked participants to provide feedback on how to ensure that consumer's and family members' viewpoints are included in training and education programs. Participants provided a total of 15 recommendations. Table 33 lists the top five recommendations: (1) ask consumers for their input, (2) include consumers in significant roles, (3) organize consumer panels at trainings, (4) include consumers in county training teams, and (5) include consumers and family members in funding decisions.

Table 33: Recommendations for Ensure Consumer and Family Members Viewpoints are Included in Training and Education Programs

Key Recommendations	Community Forum	Focus Group	Survey	Total
Ask consumers for feedback	3	0	43	46
Include peers in significant roles/ Important decision-making roles			23	23
Create consumer panels at trainings	2	0	19	21
Include consumers in county training teams	1	0	19	20
Include consumers in county training teams	1	0	10	11

Source: OSHPD Stakeholder Engagement Data (2013)

Based on the data presented in Table 33, all five recommendations to ensure that consumers and family member viewpoints are included in training and education programs reflect a broader theme: to increase the feedback, roles, and participation expectations of consumers and family members. The optimal way to ensure that consumer and family member viewpoints are included in training and education programs is to build consumer feedback into all planning and development processes as well as important decision-making processes. Overall, it seems that raising the presence and visibility of consumers and family members may help ensure their viewpoints are included in workforce training and education programs.

Emergent Themes and Issues

This section provides a broader synthesis of the data reviewed in the prior sections. The objective of this section is to present an overview of recurring challenges and recommendations *across* the eight general topics on which OSHPD solicited feedback at the various stakeholder engagement events. In the prior sections, findings, challenges, and recommendations were discussed for each of the eight general topics. In this section, themes found *across* the eight topics are clustered and described. The purpose of this section is to offer an additional layer of analysis from all of the data collected during OSHPD's 2013 stakeholder engagement activities.

Six general topic areas emerged: (1) Public Mental Health Workforce Needs, (2) Public Mental Health Workforce Challenges, (3) Increasing Employment in the Public Mental Health Workforce, (4) Improving the Current Public Mental Health Workforce, (5) Diversity in the Public Mental Health Workforce, and (6) Integrated Services in the Public Mental Health System. This section is organized according to these six general categories.

Public Mental Health Workforce Needs

As described in the first section, "Workforce Needs in the Public Mental Health System," OSHPD solicited stakeholder feedback on the type of public mental health workforce that will be needed to better address the mental health workforce needs in stakeholders' county or region. OSHPD divided these needs into competencies, education/credentials, and workforce personnel. To maintain consistency with OSHPD, this section is divided according to these three needs.

Competency Needs

Participants identified competencies which fall under five general categories: (1) Clinical, (2) Service Delivery, (3) Wellness, Recovery, and Resilience, (4) Community Collaboration, and (5) Administration/Management.

The majority of competency needs provided by participants relate to the service delivery. In particular, there is a need for integrated services, where providers gain proficiency in treating co-occurring disorders. Substance abuse training across mental health professions is also an identified need.

Clinical competencies are the second major area of need. Overall, stakeholders recommend a broader shift in the public mental health workforce towards a client-centered culture. Specifically, data indicates cultural competency is most needed. This category includes the provision of culturally appropriate services, such as increasing bilingual staff and public mental health providers' proficiency in sign language. Additionally, stakeholders suggested expanding the definition of cultural competency beyond race and ethnicity to include other communities such as the LGBTQ and disability communities, and those living in poverty and/or homelessness, as well as other social issues impacting clients' daily lives.

Education/Credentials Needs

Participants identified public mental health workforce education/credential needs. These education/credential needs fall into two general types: (1) single certification and (2) multi-disciplinary certification.

All 14 community forums identified peer certification as an emerging education/credential need. Other degrees or certificates that might be helpful to consider are associate and bachelor's degrees in mental health, translator certificates, and a certificate for non-licensed professionals. The need for a translator certificate program supports the need for more bilingual interpreters in the public mental health workforce.

Multi-disciplinary certificates are the second general type of education/credential need. These certificates provide training across different health professions and sectors. For instance, participants report a need for a dual diagnosis credential, alcohol and other drugs certificate, psychosocial certificate, and Wellness Recovery Action Plan (WRAP) certificate. Some participants said it may be helpful to offer a certificate that integrates not only mental health and primary care, but also training in housing and social support benefits.

Public Mental Health Workforce Personnel Needs

Participants identified workforce occupations needed in the coming five years. These occupations were divided into two main categories: (1) Licensed Mental Health Professionals and (2) Unlicensed Mental Health Professionals. Among Licensed Mental Health professions, there is a strong need for Psychiatrists, Mental Health Nurse Practitioners, Marriage and Family Therapists, Licensed Clinical Social Workers, and Psychologists.

Among Unlicensed Mental Health professions, participants identify a need for more consumer peer positions and Alcohol and Other Drug (AOD) Counselors.

Public Mental Health Workforce Challenges

OSHPD requested stakeholder feedback on the challenges to increasing and sustaining the public mental health workforce in stakeholders' regions. Participants were asked to respond to issues specifically relating to training and education, recruitment and retention, and consumer and family member employment. To maintain consistency, analysis is structured according to the same three categories.

Training and Education

Participants identify training and education challenges within the public mental health workforce. These challenges can be divided into two general categories: (1) training and education challenges for current students and Residents, and (2) training and education challenges for the current workforce.

For both current students and Residents and members of the current public mental health workforce, there is a lack of training and education programs for specific populations as well as a lack of trainings that focus on integrated care. For students, participants also consistently identify a need for training at the bachelor's level. Geographic limitations are also a challenge to training and education programs in the public mental health system, with a particular lack of trainings in rural counties.

For current workforce members, participants note the lack of a clear career pathway in the public mental health system, with very little growth opportunity within agencies. Issues pertaining to integration have to do with communication challenges and general tensions between mental health and primary care providers. Respondents also noted the lack of training programs for peer positions and caregivers.

During the break-out session focusing on training and education, OSHPD asked participants to identify barriers to expanding the training and education capacity of the public mental health workforce. Participants identified four barriers; the primary barrier to expanding the capacity of training and education programs seems to be a lack of funding for training. Another key barrier seems to speak to a larger structural issue: the conflict between the social and medical models.

Recruitment and Retention

Participants identify challenges to the recruitment and retention of staff in the public mental health workforce. These challenges were grouped into four general categories: (1) financial, (2) program and logistics, (3) education pipeline, and (4) other.

Low wages is the most cited challenge to recruiting and retaining staff in the public mental health workforce. Key program and logistics issues reported by participants have to do with challenges in the recruitment and retention of staff in rural areas, recruiting people from diverse communities, and recruiting among peers. Participants also noted the lack of administrative, billing, and planning support to sustain the current public mental health workforce.

Education pipeline issues relate to the lack of general knowledge regarding the mental health profession and career pathways within the field. Participants note the cost of mental health education has increased, which is also a challenge to recruiting prospective mental health professionals in the public mental health workforce.

Other challenges to the recruitment and retention of staff in the public mental health system concern psychosocial dimensions, such as burnout and low employee morale. Stakeholders from several large counties stated, "Mental health providers have a huge workload." Combined with the shortage of job opportunities, low-growth potential and low wages, burnout can become a potentially significant challenge to recruiting and retaining mental health professionals in the public mental health workforce.

Consumer and Family Member Employment

OSHPD solicited stakeholder feedback on the challenges to increasing employment of consumers and family members in the public mental health workforce. These challenges fall into

three general issues: (1) hiring support, (2) professional development, and (3) awareness and value for consumer-driven culture.

The primary challenge to hiring consumer and family members in the public mental health workforce is support in hiring, specifically the lack of job support and job accommodations. Participants report the absence of sustainable employment and career pathways that promote professional growth opportunities serve as hiring barriers. Moreover, because peer positions are not permanent, consumers fear the loss of needed support services and benefits.

Finally, the third significant challenge to increasing consumer and family member employment reflects a broader cultural shift in the public mental health workforce. Stakeholders report that staff and employers lack awareness of the consumer movement as a key MHSA value and as it relates to the recruitment of consumers and family members to the public mental health workforce. As a result, stakeholders report issues around equity between current mental health staff and consumers and family members.

General Challenges to Increasing and Sustaining the Public Mental Health Workforce

After participants provided feedback on challenges to training and education, recruitment and retention, and increasing consumer and family member employment in the public mental health workforce, OSHPD followed up with a general discussion regarding the challenges to increasing and sustaining the public mental health workforce. Based on this feedback, four overall key challenges were identified: (1) financial, (2) capital and information technology, (3) classification and roles of mental health professions, and (4) the culture of the public mental health system.

Participants reported the primary challenge to increasing and sustaining the public mental health workforce is the lack of funding. There is a lack of funding to support the current infrastructure and innovative programs. Additionally, there is the challenge of sustaining current funding levels.

Capital and information technology needs also reflect resource challenges. Two key issues are: (1) challenges to increasing and sustaining the public mental health workforce in rural areas, and (2) the absence of a strong technology infrastructure, which impedes telemedicine as well as effective use of data.

Classification and roles of mental health professions speak to challenges around communication (e.g. mental health professional silos), accreditation standards, and expectations around the many diverse mental health professions. As noted in two community forums, there is a lack of knowledge and understanding of each profession and its role in the system. Additionally, some stakeholders report that county workforce needs differ from those of agencies.

Finally, the fourth general challenge to increasing and sustaining the public mental health workforce pertains to the broader culture of the public mental health system. Challenges might arise as a consequence of the rapid change in workforce needs due to the rollout of the

Affordable Care Act and cultural issues related to immigration. Participants also cite the lack of communication between different stakeholders, such as between providers or between counties and local agencies, where stakeholders are not informed of local WET strategies. Once again, challenges to integrated services emerge as a key theme.

Increasing Employment in the Public Mental Health Workforce

OSHPD also sought recommendations to address the challenges to increasing and sustaining the public mental health workforce in the different regions. Similar to the discussion regarding public mental health workforce challenges, participants provided suggestions specifically relating to training and education, recruitment and retention, and consumer and family member employment. To maintain consistency, this section is organized according to the same three categories, although the data is synthesized with that data from the smaller break-out sessions, where participants were able to provide more in-depth feedback on training and education, recruitment and retention, and consumer and family member employment.

Training and Education

Participants provide recommendations to address challenges to training and education programs in the public mental health workforce. Similar to challenges, these recommendations can be divided into two categories: (1) actions helpful to current students and Residents and (2) actions helpful to the current public mental health workforce.

For both current students and current members of the public mental health workforce, the primary recommendation is to expand training and education programs. One recommendation provided to enhance training and education programs for current students and Residents is to develop a career pathway for particular mental health occupations. Identified occupations include non-traditional mental health occupations and Marriage and Family Therapists training to become Licensed Clinical Social Workers. Participants from several counties provided a broader suggestion — strengthening the partnership between high schools and higher educational institutions (e.g. community colleges, California State Universities, and University of California system).

Stakeholders made recommendations for expanding the capacity of training and education programs in five general areas: (1) financial, (2) partnerships, (3) training needs, (4) knowledge of current training programs, and (5) program and logistical support.

Financial incentives range from increasing the amount provided in financial assistance programs to increasing funding for faculty and curriculum development. Another key recommendation is to promote more partnerships between agencies, between counties and agencies, and between academic institutions and various public and private sectors (e.g. nonprofits, businesses, and hospitals).

Participants also report expanding the topics and issues for training as well as expanding the populations who receive trainings. In addition to increasing the number of trainings, stakeholders also emphasize the need to identify quality trainings. To accomplish such a task,

another key recommendation is to raise awareness of the training programs that are currently available.

Finally, the fourth key recommendation for expanding the capacity of training and education programs is to provide program and logistical support. Key suggestions include strengthening supervisory and internship programs, creating a mentorship program, and establishing performance measures to assess continuous improvement and cultural competence.

Finally, participants in the training and education breakout session were asked what kinds of supports counties need to successfully place interns in the public mental health workforce. A discussion of this section is included here, since this is related to the larger discussion on recommendations for increasing employment in the public mental health workforce.

Across all activities, stakeholders provide a comprehensive list of types of support counties could provide to successfully place interns in the public mental health. Three broader supports were identified: (1) mentorship/leadership, (2) financial, and (3) program and logistical support.

Eleven out of 14 community forums identified the need to strengthen the supervisory system, indicating this is a significant area of need. Secondly, financial support to increase and sustain the current internship program is recommended. Finally, program and logistical support includes suggestions for strengthening the overall infrastructure of internship programs. Some of the proposed county supports include guidelines for how to use interns, creating an internship search website, and defining interns' roles and expectations for different positions (e.g. high school students, college students, consumers and family members, and volunteers).

Recruitment and Retention

Participants provided recommendations to enhance recruitment and retention efforts in the public mental health workforce. Three broader recommendations are: (1) establish a career pathway and expand outreach, (2) provide more financial incentives, and (3) offer program and logistics support for the current workforce.

Participants' primary recommendation for overcoming challenges to recruitment and retention efforts is to expand outreach to diverse communities and K-12 schools. But, to successfully accomplish this task, stakeholders from several community forums suggest establishing a clear career pathway for mental health occupations to show students what a career in the public mental health system looks like. Some participants advocate introducing mental health concepts to K-12 grades. Overall, data indicates that more community engagement could help in recruitment and retention efforts.

Offering financial incentives is the second key recommendation for improving recruitment and retention efforts. Suggestions include: increase stipends, offer interns stipends, strengthen the reimbursement system, and provide counties more funding so that they can create incentives to recruit and retain people in the public mental health workforce.

Finally, the third key recommendation – providing program and logistical support for the current workforce – focuses on strategies to retain staff in the public mental health workforce.

Participants suggest creating wellness and self-care programs. These programs might help providers with burnout and low employee morale, which are identified as key recruitment and retention challenges. Implementing "Grow Your Own" models, increasing awareness of job opportunities through job boards, and offering relocation strategies for people who are going to less desirable areas to work are additional strategies for supporting the current public mental health workforce.

Financial Assistance Programs to Recruit and Retain People in the Public Mental Health System

In the breakout session on recruitment and retention, OSHPD asked participants for feedback on the efficacy of financial assistance programs, like WET stipends, scholarships, and loan forgiveness to recruit people in the public mental health system. In addition to asking participants if these financial assistance programs are effective, OSHPD was also interested in: finding out the barriers that prevent people from using these financial assistance programs; how these programs can be improved to recruit and retain more people in the public mental health workforce; and what education institutions, counties, and partners can do to increase recruitment and retention.

An overwhelming number of respondents strongly support the financial assistance programs and find them effective. Participants report the WET stipend program helps with recruitment overall, but particularly with attracting a diverse group of students into the public mental health workforce. Some participants said the loan forgiveness program works well for students and licensed staff, while scholarships work better for peers. MHLAP and the Marriage and Family Therapist consortium were identified as model programs. It should be noted that there are state-administered stipend programs and county/regionally-administered stipend programs and it is unknown which type of stipend program stakeholders were referring to as many were unaware there were different types of stipend programs.

Nonetheless, while participants provided positive feedback, suggestions for improvement include: a statewide evaluation of the stipend program, greater consistency in the set-up of the WET stipend program across counties and mental health professions, and more focus on retention efforts which have not been as successful.

Stakeholders identified four main barriers that prevent people from using the various financial assistance programs: (1) program and logistics issues, (2) lack of knowledge of financial assistance programs, (3) financial issues that de-incentivize prospective students from considering a mental health career path, and (4) personal conflicts. The primary program and logistical barrier is a complicated application process that discourages prospective students from learning more about the programs. Stakeholder feedback indicates that financial barriers involve low wages as well as lack of job opportunities, which hinders the ability to pay back student loans. Finally, there are personal barriers that prevent people from using these financial programs, such as family or other work obligations.

Of participants' 35 recommendations for making financial assistance programs more effective, four broad recommendations for expanding efforts emerge: (1) marketing and outreach efforts,

(2) financial incentives, (3) mentoring/leadership, and (4) program and logistical support. Similar to stakeholders' recommendation to increase recruitment and retention efforts, participants also recommend increasing marketing and outreach efforts pertaining to financial assistance programs. Here too, participants suggest expanding the location of outreach efforts as well as audiences to include grade schools and diverse communities.

Similarly, offering financial incentives-a key recommendation for increasing recruitment and retention efforts-is also a key recommendation for attracting more people to use financial assistance programs. Suggested incentives include providing more scholarships, increasing the dollar amount, and extending these financial opportunities to particular populations. Strategies to specifically address the identified barriers that prevent people from using the financial assistance programs include extending the time allotted for students to pay back loans in addition to funding retention efforts.

Two suggestions that may attract more people to use the financial assistance programs include: (1) improving graduate training supervision programs and (2) establishing a mentoring program at community colleges. Program and logistical support include a variety of strategies to enhance the administration of the WET stipend program while also promoting MHSA values.

Finally, participants offered recommendations for how educational institutions, counties, and partners in the public mental health system can increase recruitment and retention of students in a mental health career. Four broad recommendations include: (1) providing advocacy and outreach, (2) developing mental health career ladder and professional development, (3) increasing collaboration, and (4) providing support for the current public mental health workforce.

The first three general recommendations focus on recruiting prospective students. That is, stakeholders suggest increasing outreach in the community and to K-12 students, which also entails increasing collaboration with high schools, colleges, and community groups. Along with increasing outreach and community partnerships, stakeholders recommend establishing a clear career ladder when conducting outreach in the community and high school settings. Specific strategies for helping develop a mental health career ladder include: integrating a mental health curriculum in high schools, educating students and children on mental health, and providing funding for high school bridge programs and stipends for high school students. Finally, the fourth general recommendation focuses on supports to retain current mental health staff in the public mental health workforce, such as more job opportunities, higher wages, and wellness and social support programs to promote self-care.

OSHPD also requested feedback on recommendations for increasing career pathway programs that focus on careers in the public mental health system. Participants provide five suggestions that ranged from financial issues to wide-scale, structural issues. Financial recommendations include considering affordable tuition and higher wages. The broader, systemic recommendation includes defining core competencies at the state-level and for all the mental health professions. One large county stakeholder suggests establishing these two sets of core competencies may help define a clearer career pathway within the public mental health workforce.

Consumer and Family Member Employment

During the breakout session discussion regarding consumer and family member employment, OSHPD asked participants if they felt an adequate number of consumers and family members are employed in the public mental health system, and to identify why there may not be. Feedback from eight community forums and 80 online survey respondents focus on a lack of adequate representation of consumer and family members in the public mental health workforce. Participants provided reasons for why they did not believe there was sufficient employment of consumers and family members. These reasons speak to three broader issues: (1) career pathway and professional development, (2) relations between staff and consumer and family members, and (3) program and logistical support. These issues reflect the general challenges identified by stakeholders in increasing employment of consumers and family members, discussed in the prior section.

The primary reasons provided for why there is insufficient representation of consumers and family members in the public mental health workforce pertain to issues around career pathway and professional development. There is a lack of employment opportunities and formal training. Participants stated there are not enough employment opportunities or career advancement opportunities currently available for peers.

The second broader issue speaks once again to the need for a cultural shift in the public mental health workforce. Data indicates that staff members lack knowledge of how to integrate and include consumers and family members in the public mental health workforce. This lack of knowledge speaks to the need for a hiring infrastructure to guide employers and human resource staff at agencies. It also pertains to the ability of the current public mental health workforce to perceive the value of having consumers and family members join the workforce. Stakeholders cite issues related to stigma and a general lack of understanding of the complex mental health issues consumers and family members confront on a daily basis. Overall, participants point to integration challenges between public mental health staff, consumers, and family members.

Finally, program and logistical issues are the third general reason cited for why consumers and family members are not adequately represented in the public mental health workforce. Program and logistical support include lack of resources (e.g. lack of transportation, lack of adequate workspace), as well as the absence of a defined hiring infrastructure which would provide a formal mechanism for employers to hire consumers and family members.

OSHPD solicited recommendations for overcoming these challenges. Participants provided 27 recommendations reflecting three broader categories: (1) education and training, (2) culture of the consumer movement, and (3) program and logistical support.

Participants' key recommendations for increasing consumer and family member employment in the public mental health workforce speak directly to the identified challenges. Stakeholders' primary recommended action is to address the lack of job opportunities and lack of professional development for peers. Additionally, more education and training opportunities for consumers

would be beneficial. Specifically, participants believe that a statewide peer certification program would be a valuable benefit.

The second recommendation addresses the challenge of staff and employers' low awareness of the consumer movement. Stakeholders suggested more staff trainings on the consumer movement so that staff better understand both the value of lived experience and the impact of stigma. On a broader level, participants propose raising public awareness around the consumer movement through public service announcements, presentations in high school, and creating city-wide anti-stigma campaigns.

Finally, other recommendations speak to program and logistical support. Developing a hiring and employment infrastructure is a key recommended action. This includes not only creating more designated peer positions, but also providing hiring guidelines as well as training counties to develop peer positions so they can subsequently hire consumers and family members.

During the consumer and family member employment breakout session, OSHPD asked participants what kinds of supports consumers and family members might need to gain and maintain employment in the public mental health workforce. A subsequent question requested participants' feedback on the types of county support needed to increase the employment of consumers and family members in the public mental health workforce.

Three general kinds of supports are: (1) education and training, (2) employment infrastructure, and (3) outreach and advocacy. In addition, a fourth key support was identified for consumers and family members – social and service delivery.

Feedback from 12 community forums and 28 online survey respondents suggest the provision of more education and training programs for consumers, making this a significant need. As has been discussed in prior sections, one recommendation is to develop a peer certification program. Additionally, financial support for education and training would be helpful. Developing a more formalized infrastructure that encourages employment of consumers and family members is the second key support.

Finally, participants propose greater outreach and advocacy support for consumers and family members. In addition to targeted recruitment and more community engagement to increase consumers and family member participation in the public mental health workforce, participants also recommend creating broader political support, such as peer representation at the state level and more statewide campaigns to raise awareness and support for mental health and the consumer movement.

An additional key support for consumers and family members is social and service delivery support. This support refers to the ability to provide flexible work accommodations for consumers and family members (e.g. transportation, childcare). A significant issue, already discussed in prior sections, is consumers' fears of losing social support benefits once they were to gain employment in the public mental health workforce. Addressing this fear seems to be a key support need for consumers and family members to gain and maintain employment in the public mental health workforce.

General Recommendations

Just as OSHPD solicited stakeholders' feedback on the general challenges to increasing and sustaining the public mental health workforce in their regions, OSHPD also requested general recommendations. These recommendations concentrate around five key issues: (1) integration and collaboration, (2) financial, (3) workforce roles and classifications, and (4) program and logistic support, and (5) advocacy and policymaking.

Participants' primary general recommendation for increasing and sustaining the public mental health workforce is to foster more opportunities for partnership and collaboration among the different mental health professions as well as across other health fields. Stakeholders believe there is a need for more forums and working groups to facilitate dialogue, identify commonalities, and share resources and best practices across varying groups. Some stakeholders also propose funding pilot projects that promote collaboration between different sectors of the public mental health workforce.

Recommendations pertaining to program and logistics support speak to resource and capital development that help in the daily functioning of the public mental health workforce. Participants' suggestions directly address key capital and resource challenges, such as strengthening the technology infrastructure, developing a repository of current resources, and increasing the overall efficiency of the current workforce.

Recommendations pertaining to workforce roles and classifications and advocacy and policymaking reflect larger, systems-wide issues. Workforce roles and classifications represent a key challenge identified by participants (see section on General Challenges to Increasing and Sustaining the Public Mental Health Workforce). Specific strategies offered include: (1) have county human resource departments reclassify positions, (2) standardize some job descriptions, (3) expand the role of Unlicensed Mental Health Professionals (particularly in rural areas), and (4) expand the definition of public mental health. Finally, at the statewide level, participants suggest stronger political presence through more advocacy and legislation.

Improving the Current Public Mental Health Workforce

As discussed in a previous section, OSHPD solicited stakeholders' feedback on training and education needs, which was one of the main topics addressed among all stakeholders during the community forums. OSHPD also conducted a smaller breakout session on training and education needs. During this session, participants were asked questions pertaining to cultural competency, promotion of prevention and early intervention services, the implementation of web-based technologies/distributive learning programs, and recommendations to ensure consumers and family members' viewpoints are included in training and education programs. These questions and corresponding responses focus on improving the *current* public mental health workforce. As such, this section will review stakeholders' feedback and present key themes primarily drawn from the training and education breakout session.

Promotion of Cultural Competencies in Training and Education

OSHPD asked participants' for recommendations to promote cultural competencies in training and education programs. The recommendations reflect three broader issues: (1) workforce diversity, (2) collaboration with diverse communities, and (3) knowledge and skill-building.

Participants' primary suggestion for promoting cultural competency in training and education programs is to diversify the public mental health workforce. Suggested strategies include: increasing the recruitment of cultural groups, employing culturally competent specialists, and employing bilingual staff. On a broader level, participants propose expanding the definition of diversity beyond race and ethnicity, and, as stakeholders from one small county at a community forum suggests – including cultural humility.

To diversify the public mental health workforce, participants recommend greater levels of collaboration with diverse communities. Partnering with local organizations working on cultural competency as well as establishing relationships with cultural brokers in target communities (e.g. elders) will help build trust and rapport.

The overall general recommendation for promoting cultural competency in training and education programs is to provide opportunities for increasing knowledge and skill-building. The stakeholder engagement data indicates there is a need for public mental health staff to develop an understanding of the diverse communities and their survival skills. More field training in the various local cultural communities is one suggestion to help public mental health providers gain proficiency in cultural competence as well as cultivate strong relationships.

Promotion of Prevention and Early Intervention Services

OSHPD asked participants' to identify methods to promote the training of staff on providing appropriate prevention and early intervention services to consumers. Based on the responses collected, recommendations support three broader issues: (1) awareness and access to trainings, (2) types of training, and (3) service delivery.

Participants' primary recommendation is the need to increase clinical and non-clinical staff awareness of prevention and early intervention services. Stakeholders at one community forum also suggest expanding training to all healthcare professionals, including primary care providers. Prevention and early intervention services approach care and treatment differently. As such, participants also recommend changing the clinical language and looking to primary care models for how to incorporate prevention principles into services.

Finally, participants suggest training employees in other sectors (e.g. teachers, law enforcement) about mental health and symptoms associated with mental illness will help reduce stigma and increase the provision of prevention and early intervention services.

Promotion of Web-based Technologies/Distributive Learning Techniques

OSHPD asked for participants' recommendations to promote the use of web-based technologies and distributive learning techniques in training and education programs. Twenty-

nine recommendations were collected, which fall into four broad categories: (1) availability of resources and tools, (2) training and education infrastructure, (3) collaboration, and (4) knowledge infrastructure.

On the ground level, participants discuss a need for: (1) more technology tools and resources (e.g. the use of smart phones, technology from other statewide groups) as well as distributive learning programs and (2) more trainings on telehealth and web-based learning for public mental health staff and educators.

However, given the recent development of web-based/distributive learning programs, this is an area that requires greater support through strategic planning and program development. As such, a key recommendation for promoting the use of web-based technologies and distributive learning programs is support in developing an overall knowledge infrastructure. Suggestions include: develop a code of ethics appropriate to the use of technology tools, increase advocacy at state level, reduce stigma around online education, and increase mental health providers' knowledge of new models of care.

Inclusion of Consumers' and Family Members' Viewpoints in Training and Education

OSHPD asked participants what can be done to ensure that consumers and family members and their viewpoints are included in training and education programs. This question was raised in both the training and education breakout session and the consumer and family member breakout session. This section provides a review of the data and key themes that emerged from both discussions.

Recommendations for increasing consumer's and family members' viewpoints in training and education programs generally matched across both discussions. Participants' key suggestions to ensure greater inclusion of consumers and family members viewpoints in training and education programs are: (1) initiate a grassroots effort to seek consumers and family members input and (2) increase their participation in trainings as well as academic decision-making and leadership activities.

One additional category emerged from the consumer and family member breakout session. In addition to increasing the visibility of consumers at all levels (which reflects a key emergent theme during the training and education breakout session), participants also propose strategies that public mental health staff might take to help ensure greater inclusion of consumers' and family members' viewpoints in training and education programs. In addition to increasing consumers' and family members' visibility and involvement, a second broad recommendation involves strategies directed to county mental health staff to increase their awareness and value for lived experience. Some suggestions include: developing a training program for leaders on the consumer movement, encouraging county mental health directors to participate in the California Mental Health Directors Association, establishing policies and procedures on how to utilize peers, and sponsoring statewide webinars that include consumers and family members. As a result of these various actions, public mental health staffs' knowledge and understanding

of hiring consumers and family members will be raised, which will hopefully lead to an increase in actual hiring of consumers and family members.

Overall, stakeholders' feedback suggests that to ensure greater inclusion of consumer and family member viewpoints in training and education, more opportunities must be created to involve them in the development of these programs, and there must be efforts to increase awareness among public mental health staff of the value of bringing the lived experience of consumers and family members into the public mental health system workforce.

Recommendations to Reduce Stigma Regarding Mental Illness in the Public Mental Health Workforce

OSHPD was interested in general recommendations for reducing stigma associated with mental illness in the public mental health workforce. Participants offered recommendations for de-stigmatizing mental illness, which support three broader recommendations: (1) increase awareness of consumer movement in the current public mental health workforce, (2) increase awareness of the consumer movement in the general public, and (3) conduct research and evaluation.

Similar to the recommendations for ensuring greater inclusion of consumers' and family members' viewpoints in training and education programs, educating staff on the consumer movement is key to reducing stigma in the public mental health system workforce. Stakeholders at 12 community forums and 29 online survey respondents propose this action, making it a significant recommendation. Participants recommend educating public mental health employers and clinical staff on the value of lived experience and employing consumers and family members.

Increasing the general public's awareness of the consumer movement emerged as the second key recommendation. Participants suggest a variety of communication outreach strategies, including encouraging consumers to share their experience by participating in a statewide public campaign; creating public service announcements to be delivered via television, radio, and other media outlets; running digital stories in clinic reception areas and agency lobbies; running stories in newspapers; and creating public spaces to display consumers and family members artwork.

Participants' third general recommendation – research and evaluation – reflects the need to think of new and innovative ways to reduce stigma regarding mental illness in the public mental health workforce. In addition to funding exploratory research, participants propose identifying best practices in other communities that have successfully reduced stigma (e.g. LGBTQ community).

Overall, stakeholders expressed a desire to address stigma by increasing public discourse around the consumer movement. Such an effort could potentially promote wider acceptance of lived experience and support a fuller integration of consumers and family members into the public mental health workforce.

Diversity in the Public Mental Health Workforce

OSHPD organized a breakout session to obtain a better understanding of issues around diversity in the public mental health workforce. Key barriers to diversifying the public mental health workforce fall into three categories: (1) social, (2) program and logistics, and (3) financial. Social barriers include the challenge of conducting outreach to the many different communities. This includes language barriers. But more broadly, participants observe a general lack of understanding regarding how to perform culturally appropriate outreach in various cultural communities, which is compounded by cultural perceptions and stigma associated with mental illness.

Program and logistical barriers range from issues around regulations to resource constraints. For example, regulations around out-of-state/county licensing reciprocity can deter some people from joining the public mental health workforce. Additionally, participants noted a systematic fear that more outreach will result in the need for more services without the capacity to provide the services.

Finally, the financial barriers to diversifying the public mental health workforce include the high cost of education and billing issues.

Stakeholders' recommendations for increasing the diversity of the public mental health workforce included: (1) increase outreach and recruitment, (2) provide financial incentives, (3) increase education and training pertaining to diversity, (4) develop a mental health career pathway, and (5) increase program and logistical support.

Overall, stakeholders reinforced the importance of having a diverse public mental health workforce. Specific strategies include expanding cultural competence education and training for students and staff, and increasing outreach campaigns across diverse communities in a culturally competent manner by partnering with cultural brokers in the target communities and with agencies focusing on culturally competent services. Participants also recommend establishing a clear mental health career pathway, which could help in recruitment and outreach efforts in schools and local communities.

Integrated Services

OSHPD organized a breakout session to gain a better understanding of how to promote integrated services in the public mental health workforce. Five barriers were identified, which mainly fall into two broad categories: (1) program and logistics and (2) organizational culture. Program and logistics pertain to issues participants raised around putting integration into practice. Challenges occur around reimbursement processes and the lack of a curriculum to guide clinical staff in the provision of integrated services.

The second general challenge to integration reflects wider structural issues. In general, participants noted the cultural differences between primary and mental health providers that affect the lack of collaboration between the two health professions.

Participants also provided recommendations for promoting integrated services, which complement those key challenges raised in the discussion. These include increasing trainings on integration for current students and current workforce. The second key recommendation focuses on broader systems-level actions. Participants suggest more collaboration between universities, local nonprofits, and other local entities; conducting a policy review; and identifying best practices and model programs that exemplify successful integration programs.

Summary of Key Findings

Several key findings emerged from the analysis of feedback from the community forums, focus groups, key informant interviews, and online survey.

Types of Public Mental Health Workforce

Increase the diversity of the mental health workforce and increase training in two general competencies: (1) cultural competencies, and (2) integrated services. Overall, stakeholders believe that achieving cultural competence in the public mental health system workforce requires a shift towards a client-centered perspective. Establishing a statewide protocol of core competencies that define the mental health profession as well as each mental health occupation will be very beneficial.

Additionally, stakeholders cite the need for greater competency in integrated services, particularly substance abuse training across the mental health professions and treating co-occurring disorders. Moreover, stakeholders' comments reflect the need for broader, structural adjustments such as curriculum development around integration and fostering dialogue between primary care and mental health providers in order to promote integrated services among behavioral health, mental health, substance abuse, and primary care.

Promote lived experiences to strengthen the public mental health workforce. All 14 community forums identified a need to increase staffing in consumer-led peer positions. One factor that will help achieve this goal is to establish a statewide peer certification program. Here again, all 14 community forums identify this as a beneficial educational program.

Challenges and Recommendations to Increasing and Sustaining the Public Mental Health Workforce

Define a clear career pathway within the public mental health field. Stakeholders report that the lack of a clear career pathway contributes to the low growth potential within the public mental health workforce, and leads to a high burnout rate and low employee morale. Stakeholders specifically identify a need to establish a clear career pathway for consumers and family members, which will help to increase the employment of consumers and family members in the public mental health workforce. Additionally, stakeholders recommend expanding outreach and marketing efforts to K-12 education to better establish a career pipeline and increase recruitment of public mental health professionals.

Geographic barriers are a key challenge. Stakeholders identify the need to increase resources and employment in rural counties. However, there needs to be financial incentives to recruit public mental health providers to work in rural counties. Telepsychiatry is one suggestion for increasing access to mental health services in rural counties. Additionally, there is a need to expand trainings and educational programs in rural areas – towards this need, stakeholders recommend increasing the use of web-based technologies and distributive learning programs.

Increase partnerships and collaboration. Stakeholders report a need for more communication across disciplines and sectors (e.g. County Departments of Mental Health and Department of Education), between counties and community-based organizations, between educational institutions at all levels, and across all health professional fields. More opportunities for dialogue are needed to break down the current silos and foster an integrated approach to treatment and care. Stakeholders also identify a specific need for more partnership and collaboration between primary care, mental health, and substance abuse professionals.

Stakeholders also recommend cultivating more partnerships and collaboration among diverse cultural communities in order to strengthen the overall cultural competence of public mental health staff and diversify the public mental health workforce. Specific strategies for achieving this goal include: developing relationships with cultural brokers in target communities to establish trust and rapport, and partnering with local community groups that provide culturally competent programs and services.

Develop a hiring infrastructure for employing consumers and family members. Stakeholders' recommendations for increasing consumer and family member employment emphasize program and logistical support. Stakeholders report a need to establish a stronger hiring infrastructure to promote and assist in the hiring of consumers and family members. In addition to creating more permanent job opportunities for peers, stakeholders specifically recommend the need to establish hiring guidelines and policies, as well as training human resource staff in how to develop sustainable peer positions.

From the consumer's perspective, anxiety around losing social support benefits and services creates a significant barrier to pursuing those jobs that currently exist. Addressing this fear in combination with creating a stronger hiring infrastructure will help increase consumer and family member employment in the public mental health system workforce.

Increase public mental health system workforce and general public's awareness of the consumer movement and lived experiences. Stakeholders suggest that increasing overall awareness of the consumer movement will expand understanding, thus reducing stigma around mental illness and contributing to the hiring of consumers and family members into the public mental health system workforce.

Similarly, stakeholders also suggest increasing general public awareness of mental illness and the consumer movement. Consumers and family members can play an active leadership role in increasing public awareness around mental health, the consumer movement, and lived experiences by participating in public education campaigns and advocacy efforts. The more lived experiences are widely understood and accepted, the more success consumers and family members will have in integrating into the public mental health system workforce.