

Office of Statewide Health Planning and Development
California Workforce Investment Board
Health Workforce Development Council
Career Pathway Sub-Committee

Report

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EXECUTIVE SUMMARY

California's Emerging Mental Health Workforce Needs

There is an urgent and important need for California to expand its mental health workforce capacity to achieve the goals of healthcare reform and meet the health needs of its growing, increasingly diverse and aging population. Expansion of the mental health workforce will also offer rewarding job and career opportunities for California residents and contribute to state and regional economies

California is already experiencing shortages and mal-distribution in many critical mental health professions. Healthcare reform implementation and other key trends, such as population growth and aging, will exacerbate these challenges. In 2014, up to 5.9 million additional Californians will have access to health insurance coverage through implementation of the Affordable Care Act (ACA). The ACA includes expanded coverage for mental health, behavioral health and substance use disorders. Workforce shortages could undermine the ability of these newly insured to access services and obtain quality care. There is also a focus on integrating mental health with primary care to enhance individual and population health quality, cost and outcomes.

The expected increase in mental health workforce demand may occur simultaneously with major supply challenges. Challenges include: an aging workforce; lack of mental health career awareness; stigma associated with mental health and careers; increasing training program costs; and barriers to training and employment in public mental health and underserved areas. Supply challenges will increase pressure on the capacity of providers to meet access, quality and cost goals. Public, safety net and rural mental health providers may face greater workforce and capacity challenges. A large portion of the three million additional insured through Medi-Cal may seek services from them; including the most severely mentally disabled.

Mental Health Services Act Workforce Education and Training

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposes a one percent tax on personal income in excess of \$1 million to support the public mental health system (PMHS) via prevention, early intervention and services. Historically underfunded, California's PMHS suffers from a critical shortage of qualified mental health personnel to meet the needs of the diverse population they serve, in addition to mal-distribution, lack of diversity, and under-representation of practitioners with consumer and family member lived experience. To address the workforce issues, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. A total of \$444.5 million was made available for the WET component with the Department of Mental Health (DMH). In 2008, DMH developed the Five-Year Workforce Education and Training Development Plan (Five-Year Plan). The Plan provided a framework for the advancement of mental health workforce education and training programs at the County, Regional, and State levels.

In July 2012, following the reorganization of DMH, the MHSA WET programs were transferred to the Office of Statewide Health Planning and Development (OSHPD). OSHPD assumed responsibility for the administration of WET programs developed under the 2008-2013 Plan and

the development of a new Five-Year Plan that will be in effect from April 2014 through April 2019.

Career Pathways Sub-Committee

A key component of the 2014-2019 WET planning process was development of career pathway recommendations for select public mental health occupations. OSHPD partnered with the California Workforce Investment Board (CWIB) to reconvene the Career Pathways Sub-Committee (the Committee). In 2011 and 2102, the Committee developed recommendations for 12 key health professions. The 2013 Committee's charge was to develop career pathways and recommendations that will strengthen the supply, distribution and diversity of the public mental health workforce in 7 selected professions. The Committee included key public and private stakeholders representing multiple mental health professions employers, government agencies, K-12, higher education and advocates. A team of consultants from University of California, Berkeley School of Public Health facilitated the process.

The career pathways and recommendations developed by the Committee are summarized in the following report. OSHPD and the WET Advisory Committee will review and incorporate recommendations in into the 2014 – 2019 WET Plan. The Health Workforce Development Council of the California Workforce Investment Board will also review and integrate the pathways and relevant recommendations into its overall health workforce priorities and action plans. The Committee approved pathways and recommendations for the following professions:

- Substance Use Disorder Counselor (SUDC) (Appendix B)
- Clinical Psychologist (Appendix C)
- Licensed Professional Clinical Counselors (Appendix D)
- Marriage and Family Therapist (MFT) (Appendix E)
- Peer Support Specialists (Appendix F)
- Psychiatric Mental Health Nurse Practitioner/Clinical Nurse Specialist (Appendix G)
- Psychiatrists (Appendix H)

Cross Pathway Recommendations:

The Committee also identified important common themes and “cross pathway” recommendations. Cross-pathway recommendations apply to and would benefit multiple mental health professions. They are also designed to enable a larger, more qualified and diverse pool of candidates for all mental health professions. These recommendations are summarized on pages 10-11 of the report.

Infrastructure Recommendations:

Effective implementation of profession-specific pathways and cross-pathway recommendations to meet California's emerging mental health workforce needs will require sufficient and sustainable infrastructure, partnerships and investment. To address this need, the Committee developed ten infrastructure recommendations which are summarized on pages 12-13 of the report.

INTRODUCTION

California is already experiencing statewide and regional shortages and mal-distribution in many critical mental health professions. In particular, California's historically underfunded, Public Mental Health System (PMHS) suffers from a critical shortage of qualified mental health personnel to meet the needs of the diverse population they serve, in addition to mal-distribution, lack of diversity, and under-representation of practitioners with consumer and family member lived experience. Healthcare reform implementation and other key trends, such as population growth and aging, will exacerbate these challenges. In 2014, up to 5.9 million additional Californians will have access to health and mental health coverage through implementation of the Affordable Care Act of 2010 (ACA) (Lavarreda and Cabezas, 2011). The ACA also provides increased coverage for mental health, behavioral health and substance use disorder services. Workforce shortages could undermine the ability of these newly insured with coverage for health and mental health to access services and obtain quality care.

The expected increase in mental health workforce demand may occur simultaneously with major mental health workforce supply challenges. Anticipated supply challenges include: an aging health workforce; lack of mental health career awareness; stigma associated with mental health and careers; increasing training program costs and barriers to training and employment in public mental health and underserved areas. Supply challenges will increase pressure on the capacity of providers to meet access, quality and cost goals. Safety net and rural providers in particular may face greater workforce challenges if a large portion of the three million additional insured through Medi-Cal, seek services from them. Many public mental health and other safety net providers are already experiencing shortages in key professions and could have a hard time competing with private providers for a shrinking workforce pool. Emerging delivery models and expanded use of health information technology and tele-health may offer opportunities to mitigate workforce challenges. However, they are in the early stages of adoption and have not yet yielded significant breakthroughs in how to most effectively and efficiently utilize and train future health professionals.

Given significant implications of impending supply and demand challenges, coordinated planning and action is needed now to ensure that California's mental health workforce is prepared to meet the goals of healthcare reform and other emerging priority health needs.

BACKGROUND

In November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposes a one percent tax on personal income in excess of \$1 million to support the public mental health system (PMHS) via prevention, early intervention and services. To address the workforce issues, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. A total of \$444.5 million was made available for the WET component with the Department of Mental Health (DMH).

Pursuant to Welfare and Institutions Code (WIC) Section 5820 through 5822, in 2008, DMH, in concert with stakeholders, developed the Five-Year Workforce Education and Training

Development Plan (Five-Year Plan). The 2008-2013 WET Five-Year Plan provided a framework for the advancement and development of mental health workforce education and training programs at the County, Regional, and State levels. Specifically, the Five-Year Plan provided the vision, values, mission, measureable goals, objectives, and actions, funding principles, and performance indicators for the use of MHSA WET funds. The Five-Year Plan included a ten-year budget projection for the administration of the \$444.5 million made available for the WET component of MHSA. The ten-year budget set aside \$210 million to be distributed to counties for local WET program implementation, and \$234.5 million to be set aside for the administration of WET programs at the State and regional levels. The Five-Year Plan developed by DMH was approved by the California Mental Health Planning Council in 2008 and covered the period from April 2008 to April 2013

(http://www.oshpd.ca.gov/HPEF/Text_pdf_files/WET/MHSA_FiveYearPlan_5-06-08.pdf).

In July 2012, following the reorganization of DMH, the MHSA WET programs were transferred to the Office of Statewide Health Planning and Development (OSHPD). OSHPD assumed responsibility for the administration of the WET programs developed under the 2008-2013 WET Five-Year Plan and the development of a new WET Plan for April 2014 through April 2019. Per WIC Section 5820(e), the Five-Year Plan requires final approval from the California Mental Health Planning Council and submission to the California State Legislature by April 2014.

To ensure the development of a comprehensive plan, OSHPD employed a robust stakeholder engagement process that involved diverse stakeholder groups. OSHPD established the WET Five-Year Plan Advisory Sub-Committee which was comprised of diverse stakeholder groups that advised OSHPD throughout the WET Five-Year Plan development process. OSHPD also engaged diverse stakeholders throughout the state utilizing a variety of strategies including community forums, focus groups, key-informant interviews, webinars, and online surveys. Additionally, OSHPD reconvened the Career Pathways Sub-Committee which developed career pathways and recommendations for select public mental health occupations. All of the aforementioned activities were used to further inform OSHPD in the development of the WET Five-Year Plan.

A core component of the Career Pathways Sub-Committee's work is the development of career pathways for priority mental health professions. Career pathway development is critical to addressing impending workforce supply challenges. The 14 member Committee includes key public and private stakeholders representing multiple mental health professions, mental health employers, government agencies, K-12, higher education and advocates. The Committee conducted Phase III of its work July through August 2013. A team of consultants from University of California, Berkeley School of Public Health served as consultants and facilitators to the Committee process.

The Committee's charge was to develop statewide career pathways, recommendations, and action plans that will strengthen the supply, distribution and diversity of California's Public Mental Health Workforce. The career pathways and its recommendations developed by the Sub-Committee will inform the Office of Statewide Health Planning and Development (OSHPD) in its development of the Mental Health Workforce Education and Training (WET) Five-Year Plan, 2014 – 2019. OSHPD and the WET Advisory Committee will review and incorporate

recommendations in into the 2014 – 2019 WET Plan. The Health Workforce Development Council of the California Workforce Investment Board will also review and integrate the pathways and relevant recommendations into its overall health workforce priorities and action plans.

For purposes of the Committee’s charge and process, “career pathways” were defined as a coordinated set of components which, when aligned correctly, provide a “pathway” to achieve a sufficient supply, distribution and diversity of qualified candidates for a specific health profession. The Committee adopted a common framework for pathway development (see Appendix A). The Committee used the framework to develop career pathways for seven professions. The professions were selected using prioritization criteria established by the Committee. Given the short timeframe for completion of the Committee’s work, availability of considerable career pathway information was a key factor in the selection of initial priority professions.

Career Pathway Sub-Committee Membership

Members who assumed responsibility for this charge and served on the Committee are listed in the table below. Committee Members were invited to participate from a diverse array of health professions and health organizations across the state of California, in an effort to represent a depth and breadth of expertise, perspectives and interests.

Table 1. Career Pathway Sub-Committee

MEMBER NAME	ORGANIZATION
Marianne Baptista, MFT, CPRP	California Association of Social Rehabilitation Agencies
Steve Barrow	Advocates for Health, Economics, and Development
Cindy Beck	California Department of Education
David A. Cherin, PhD	Cal State Fullerton, Social Work, California Social Work Education Center Curriculum Committee
Sherry Daley	California Association of Alcoholism and Drug Abuse Counselors
Angel Galvez	Tulare County Department of Mental Health
Rowena Gillo, LCSW	Pacific Clinics
Cynthia Harrison, RN,MS	Mission College Health Workforce Initiative Bay Area Regional Center
Erynne Jones, MPH	California Primary Care Association
Kimberly Mayer, MSSW	California Institute for Mental Health

Table 1. Career Pathway Sub-Committee

MEMBER NAME	ORGANIZATION
Brandy Oeser	UCLA Integrated Substance Abuse Programs
Alejandra Postlethwaite, MD	UC San Diego Department of Psychiatry, Rady Children’s Hospital
Melodie Schaefer, PsyD	California Psychology Internship Council
Adrienne Shilton	California Institute for Mental Health

Process and Methodology

The Committee developed a robust methodology to guide its work. The University of California, Berkeley team comprised of Jeff Oxendine, Maeve Sullivan, and Evlyn Andrade facilitated the process and supported the Committee. Work was completed July-September 2013.

PROCESS

The Committee leveraged existing workforce expertise by engaging leaders from priority professions to develop career pathways and recommendations. Pathway development leaders were selected by OSHPD after a public application process. The UCB team then worked closely with selected leaders for each profession to facilitate the development of the career pathway.

The career pathway development process included the following steps:

1. Consultants and leaders of each prepared the selected pathways using the approved pathway framework.
2. The Committee reviewed the pathways developed by the leaders and consultants. For each pathway, the Committed vetted the pathway components, supply and demand information, key barriers and recommendations and additional pathway components. Key questions, edits and suggested changes were discussed.
3. The consultants and leaders subsequently worked to incorporate the Committee’s edits and prepare an updated version of the pathways.
4. The Committee then reviewed the updated pathways, confirmed the edits, made additional changes, and decided on final recommendations for OSHPD. Decisions were made by consensus after robust discussion.
5. Consultants presented a consolidated list of cross-pathway recommendations that had been raised by the Committee throughout steps one through four, for review and discussion.
6. Consultants presented a consolidated list of infrastructure recommendations that had emerged throughout steps two through five, for review and discussion.
7. The Committee then reviewed the cross-pathway recommendations and infrastructure recommendations, confirmed the edits, made additional changes, and

decided on final recommendations for OSHPD. Decisions were made by consensus after robust discussion.

See Appendix A for Career Pathway Definition and Framework

Framework for Pathway Development

The Comprehensive Health Career Pathway Framework was used to develop career pathways for each selected profession. The goal was to define the relevant components, identify barriers and opportunities for increasing the supply and develop recommendations for enhancing pathway and capacity.

The Committee worked with leaders and the consultants to adapt the pathway model to the specific professions. The components developed for each pathway is summarized below. These components were developed by experts and the consultants and presented to the Committee for each pathway, time and data permitting. The Committee then reviewed and modified the pathways, barriers and recommendations and recommended moving them forward to the Council for final review and approval.

Additional Elements Developed for Pathways

In addition to using the pathway framework to develop career pathways, the elements in the table below were also developed for each selected profession as the basis for developing recommendations and fulfilling the Committee’s charge:

Table 3. Additional Pathway Elements

ADDITIONAL ELEMENTS DEVELOPED FOR EACH PATHWAY
<ul style="list-style-type: none">• Background information, including an understanding of the current state of supply and demand for the given profession, as well as projections based on ACA implementation and other relevant factors, to provide an estimate of and justification for the current and future need.
<ul style="list-style-type: none">• Barriers related to the pathway components that are currently most responsible for and critical to ensuring sufficient numbers of qualified, diverse individuals pursuing and ultimately entering and advancing in the given profession.
<ul style="list-style-type: none">• Recommendations to address each priority barrier, allowing for consideration of the pathway itself as well as “big picture” issues around items such as recruitment, retention, attrition, transfer, articulation and curricular disconnects, and the identification of policies needed to facilitate the progress of students between education segments in California. Three levels of recommendations were: pathway-specific, cross-pathways, and infrastructure recommendations.

Development of Recommendations

While the primary focus of this initiative was to identify pathway-specific recommendations, the work would have been incomplete without also identifying and addressing several themes that arose across pathways. Similarly, many recommendations can only be implemented successfully and with maximum impact when accompanied by infrastructure-level changes. Therefore, in addition to pathway specific recommendations, the Committee also developed cross-pathway and infrastructure recommendations. Each of the three types of recommendations is described in the table below.

Table 4. Types of Recommendations developed by the Committee

RECOMMENDATION TYPE	DESCRIPTION
Pathway-Specific	<ul style="list-style-type: none"> Recommendations that apply only or primarily to the career pathway under consideration.
Cross-Pathway	<ul style="list-style-type: none"> Recommendations that apply across multiple career pathways and increase the overall candidate pool.
Infrastructure	<ul style="list-style-type: none"> Recommendations related to sufficient staffing, organization, data and resources to develop and implement effective and ongoing workforce planning, programs, policies, and systems within and across professions.

The three types of recommendations are complementary and together further strengthen each set of recommendations.

A summary of the pathways and the experts engaged to develop the pathway is included in the table below. The pathway, barriers and recommendations for each profession is included in the appendix listed in the table.

PATHWAY	LEAD INDIVIDUAL(S)
<ul style="list-style-type: none"> Substance Use Disorder Counselor (Appendix B) 	<ul style="list-style-type: none"> Sherry Daley and Brandy Oeser
<ul style="list-style-type: none"> Clinical Psychologist (Appendix C) 	<ul style="list-style-type: none"> Melodie Schaefer
<ul style="list-style-type: none"> Licensed Professional Clinical Counselors (Appendix D) 	<ul style="list-style-type: none"> Rowena Gillo and Adrienne Shilton
<ul style="list-style-type: none"> Marriage and Family Therapist (MFT) (Appendix E) 	<ul style="list-style-type: none"> Marianne Baptista
<ul style="list-style-type: none"> Peer Support Specialists (Appendix F) 	<ul style="list-style-type: none"> Sharon Kuehn and Angel Galvez
<ul style="list-style-type: none"> Psychiatric Mental Health Nurse Practitioner/Clinical Nurse Specialist (Appendix G) 	<ul style="list-style-type: none"> Cynthia Harrison and Rowena Gillo

PATHWAY	LEAD INDIVIDUAL(S)
<ul style="list-style-type: none"> Psychiatrists (Appendix H) 	<ul style="list-style-type: none"> Alejandra Postlethwaite

In many cases, the expert groups reached out to much wider networks of contacts to ensure diverse representation in the development of the pathway and recommendations.

Cross-Pathway Recommendations

The Committee identified important common themes and “cross pathway” recommendations. Cross-pathway recommendations apply to and benefit multiple mental health professions. These recommendations are also designed to enable a larger, more qualified and diverse pool of candidates for all mental health professions. The Committee did not prioritize or propose sequencing or time frames for cross-pathway recommendations but encouraged the WET Committee to do so as part of its strategic plan development. The recommendations are summarized below:

Career Awareness:

1. Increase awareness of career options, how to pursue and support resources starting with K-12 throughout all educational and employment levels.
2. Target recruitment campaigns and programs to all target groups with emphasis on rural, underserved and underrepresented groups in mental health careers to:
 - a. enhance equal access to affordable, quality services.
 - b. have the workforce reflect the rich diversity of California
3. Outreach and recruitment campaigns need to address the stigma associated with receiving services and pursuing mental health careers.
4. Infuse mental health career curriculum and support services into existing health career pathway programs and events.
5. Engage consumers and the public including parents and families in understanding value of mental health and career options
6. Develop a matrix that describes the characteristics of each mental health profession in a side by side comparison

Career Assessment and Support:

1. Increase career assessment, skill building and career pathway management support for individuals throughout all stages of their pathway
2. Develop new models and programs for mentorship and career counseling for people pursuing mental health careers.

Training Programs:

1. Develop solutions to address the high and growing cost of education for all professions
2. Integrate inter-professional education and team work into all training programs and provide experience working with professionals from all MH roles and backgrounds.

3. Establish mechanisms for integrating emerging competencies as health reform, technology and other changes into curriculum and training.
4. Develop new training programs in underserved areas and/or increase access to training via distance learning combined with local field work.
5. Strengthen integration of cultural and linguistic sensitivity and responsiveness into all training programs and in hiring practices

Internships and Clinical Training:

1. Increase funding and opportunities for internships and clinical training in public mental health settings and underserved rural and urban areas.
2. Improve access to internship and clinical training, supervision and services through increased use of broadband and tele-health.

Financing and Support Systems:

1. Improve/increase incentives for students to choose and to practice mental health careers and service in public mental health with a priority emphasis on underserved areas (e.g., scholarship & loan repayment)
2. Increase awareness of programs that offer financial support and how to utilize; particularly key target groups
3. Examine and improve reimbursement from Medi-Cal, Medicare, and private payors to ensure access to mental health in public and private settings

Hiring, Scope of Practice and New Delivery Models:

1. Implement solutions to reduce the significant backlog in licensure applications processing at California Board of Behavioral Health Sciences.
2. Educate leadership of public and private mental health systems about:
 - a. the range of professions/credentials capable of meeting the requirements for positions;
 - b. promising practice models for appropriate use;
 - c. strategies for securing adequate reimbursement;
3. Educate all professionals on emerging models of services related to ACA and other trends.
4. Examine functions, roles and scope of practice for the careers within new delivery models. Strengthen evidence and best practices for most cost effective use.

Workforce Development

1. Align and integrate MH workforce with overall workforce efforts in CA and regionally.
2. Develop roundtable/forum to discuss and coordinate issues, interests and integration across professions.

The Committee did not have sufficient time to prioritize the cross pathway recommendations. The WET Advisory Committee or entities implementing the WET plan should refine and prioritize them.

Infrastructure Recommendations

In addition to the cross-pathway recommendations listed above, ten overarching infrastructure-level recommendations for California were identified with broad impact on many or all of the health career pathways under consideration. These are summarized below:

1. Finalize comprehensive California strategic plan for mental health workforce and diversity. Develop aligned regional plans.
2. Implement sufficient statewide public and private infrastructure to implement and be accountable for statewide plan implementation.
3. Identify lead organizations for implementation of recommendations in each profession and funds for necessary infrastructure.
4. Establish public and private funding streams to sufficiently invest in priority workforce programs and infrastructure.
5. Establish solid organizing workforce intermediaries in priority regions with sufficient funding and capacity.
6. Develop forecasts of future demand by profession (statewide and regionally). Have mechanism for reporting and adjustment.
7. Support implementation of and reporting on mental health careers in OSHPD clearinghouse. Ensure that all priority professions are included and that reporting is required.
8. Develop and maintain regional maps of training programs and supply and demand
9. Develop and fund an entity capable of conducting targeted outreach regarding the full range of MH careers in California.
10. Implement web and social media strategy to promote mental health careers in California.

Conclusion and Next Steps

The Career Pathways Committee fulfilled its initial charge within the available timeframe by accomplishing its intended objectives for its efforts in Phases III (July through August 2013). This included development of seven career pathways for priority mental health professions in California, as well as identification of cross-pathway and infrastructure-level recommendations to support all mental health professions. This report, which contains a summary of the findings and recommendations, will inform the Office of Statewide Health Planning and Development (OSHPD) in its development of the Mental Health Workforce Education and Training (WET) Five-Year Plan, 2014 – 2019. These career pathways and their recommendations will also be integrated with the California Health Workforce Development Council (HWDC) overall workforce plan. The career pathways and recommendations may also inform other efforts to prepare California to meet its emerging health workforce needs.

Based on the Committee's work, the UC Berkeley team identified several next steps OSHPD can consider to maximize and leverage the Committee's efforts and capitalize on the momentum generated from these intensive efforts. Potential next steps include:

- Determine a quantifiable goal for workforce shortages to be addressed within each career pathway under consideration.

- Project the impact of each of the recommendations (pathway-specific, cross-pathway, and infrastructure) toward achieving the desired workforce in each career pathway, including cost of implementation, time to impact, and the amount of the workforce supply or capacity needs that would be addressed.
- Develop prioritization criteria to apply to recommendations. Consider cost, impact, timing, sequencing and other factors.
- Prioritize recommendations, including pathway-specific, cross-pathway, and infrastructure recommendations using the criteria. Emphasize recommendations with maximum impact to achieve the critical goals of the Council. Establish near-term, mid-range and long-term recommendations.
- Develop implementation proposals to submit for funding for high-priority recommendations.
- Develop additional statewide and/or regional pathways for priority regions and professions using the pathway model. Identify target regions to start with based on need, opportunity, champions and contribution to statewide and regional needs.

The Office of Statewide Health Planning and Development (OSHPD) is accountable for the development of the MHSA WET Five-Year Plan and is currently in the process of developing the next five year plan for the period of April 2014 to April 2019. The WET Five-Year Plan provides a framework for the advancement and development of mental health workforce programs at the state and local level. Specifically the WET Five-Year Plan provides the vision, values, mission, measureable goals and objectives, proposed actions and strategies, funding principles, and performance indicators for mental health workforce. The WET Five-Year Plan includes elements that were informed by WIC Section 5822 and a robust stakeholder engagement process that involved diverse stakeholder groups throughout California, and provides a framework on strategies that state government, local government, community partners, education institutions, and other stakeholders can enact to further efforts to adequately sustain and increase a qualified, diverse, and robust public mental health system workforce in California. It also incorporates recommendations on the development of career pathways for select public mental health occupational classifications. This WET Five-Year Plan intends to continue and expand upon the strategies and program accomplishments of the previous WET Five-Year Plan April 2008-April 2013.

Appendices

Appendix A. Career Pathway Definition and Framework

DEFINITION

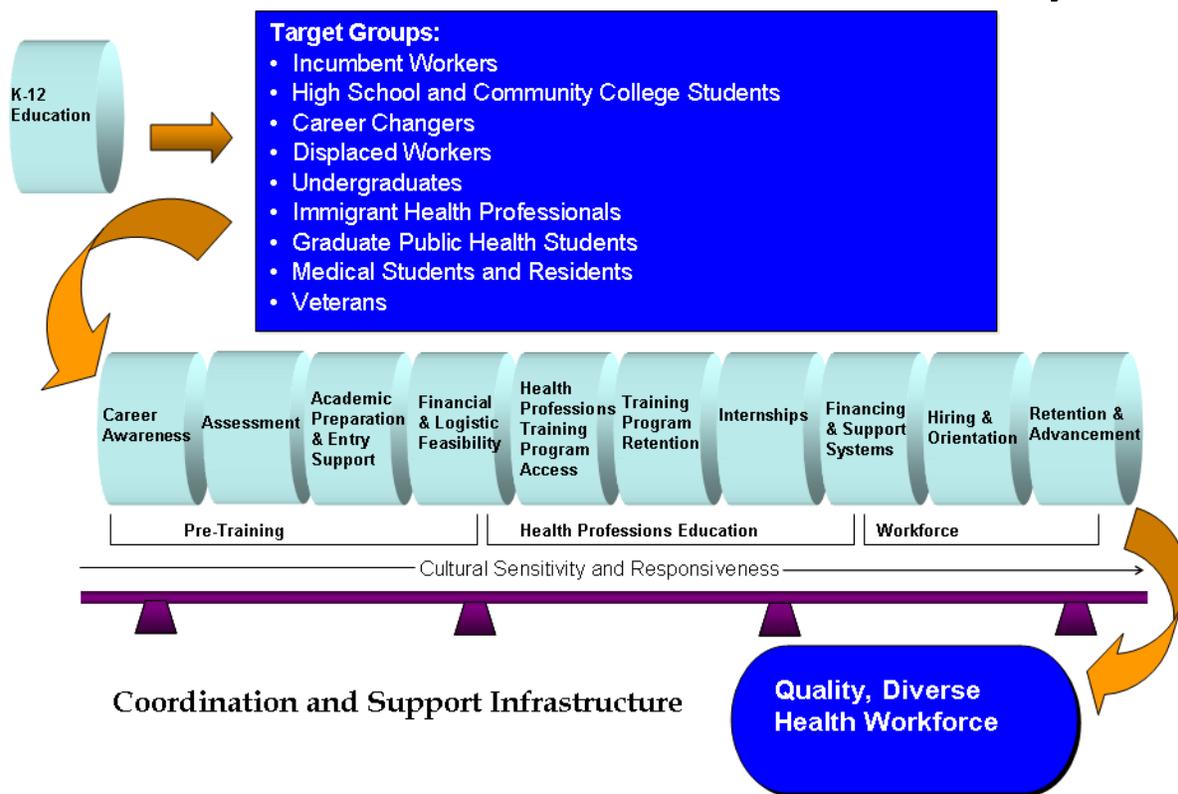
For purposes of this project, **“career pathways” are defined as a coordinated set of components which, aligned correctly, provide a “pathway” for California to achieve a sufficient supply, distribution and diversity of qualified candidates for a specific health profession.** The Committee chose to use this “systems level” approach to career pathway development to focus recommendations on the system components that need to be in place, coordinated and at capacity achieve and continue to enable a sufficient overall pool of candidates. For example, to have a sufficient supply of qualified nurses to meet anticipated employer staffing demands related to PPACA implementation, requires alignment of key “system” components such as sufficient training program access, clinical internship placements, and incentives for graduates to work in outpatient primary care settings. The Committee’s career pathway development approach involved identifying these components for priority professions and development of recommendations to address barriers to sufficient workforce capacity. The Coordinated Health Workforce Pathway, in the Illustration, provides a visual depiction of the components used by the Committee in its career pathway definition.

The “systems level” pathway approach used by the Committee is different from “individual” level career pathway development that is commonly used by some education and career development stakeholders. Individual pathways commonly define the steps, curriculum, positions and requirements for an individual to enter and progress within pathway for a specific profession. The Committee acknowledged that the systems and individual level pathway approaches are complimentary and important to increasing health workforce capacity and opportunities for residents. As such, while the priority focus was on systems level pathway development, when possible, the Committee also summarized individual level pathway information for selected professions. The Committee recommended that future pathway development efforts in California include both approaches.

FRAMEWORK

As previously described, the Committee approved use of a common framework for development of career pathways and recommendations. Use of the common framework provided a clear, consistent and comprehensive method of pathway development across professions. The Committee approved use of the *Coordinated Health Career Pathway Model* (see Illustration) developed by Jeff Oxendine as its common pathway development framework. The model was then adapted by the consultants and experts to fit the specific workforce system components and key barriers facing each profession.

Coordinated Health Workforce Pathway



Jeff Oxendine©

PATHWAY COMPONENT DESCRIPTIONS

The blue box lists the key target groups that can be encouraged and supported to pursue health careers. For pathway development, it is important to recognize that each target group has different needs and entry points into the pathway for a profession. This should be taken into account when developing outreach and support strategies. However, recommendations for ensuring a sufficient overall candidate pool for a given profession should include strategies to recruit and support candidates from all target groups throughout the pathway.

Note: The components of the framework are intentionally not connected. This is because progression from one component to the next presents an opportunity for a barrier to arise in the system. These barriers could then result in sub-optimal “bottle necks” for sufficient supply in the profession and points where candidates may be more likely to drop fall out of the pathway. The coordinating infrastructure component of the model is intended to be sure there are dedicated, expert people and resources to ensure that each component is at sufficient scale and capacity and that candidates are supported through the entire pathway.

Table A-1. Definition and Description of Pathway Components

PATHWAY COMPONENTS
<ul style="list-style-type: none"> <p>K-12 Education: The role and importance of quality of educational and career preparation that candidates receive at the K-12 level. Effective K-12 preparation is an important foundation for candidates from all target groups. Candidates need basic knowledge and skills to be ready for and capable of obtaining the training or college education needed as a first step toward health profession entry. Candidates without sufficient K-12 preparation require costly and time consuming remediation by colleges, universities, health professions education schools and health employers. Insufficient K-12 preparation can limit the numbers of qualified, diverse candidates overall and for specific health professions and in specific regions within the state.</p>
<ul style="list-style-type: none"> <p>Career Awareness: Target groups’ awareness of specific health career options and how to pursue them. To produce a sufficient supply of candidates for a specific profession, target groups must be aware of that option, understand what is involved and consider it attractive and potentially viable enough to begin exploring or pursuing. There is often limited awareness, among key target groups, of highest priority need health professions. This can be particularly true for candidates from low income or underrepresented populations. Career awareness is necessary but not sufficient for candidates to pursue health careers. Other pathway components must also be in place and coordinated.</p>
<ul style="list-style-type: none"> <p>Assessment of Fit and Readiness: Is a combination of three components (1) candidates ability to determine if a career they are aware of is a fit with their interests, goals and talents (2) an assessment of the candidates aptitude and preparation for a health career (3) a determination of how candidates can strengthen their readiness to pursue education, training or work in a given profession. Once candidates are aware of and interested in a health career, it is important that they are then able to assess it and be assessed in the three ways described above. This can be accomplished through shadowing, pre-professional training, internships, career counseling, academic advising volunteering and mentoring. Career pathway development requires ensuring that these components are accessible and utilized so that a sufficient pool of candidates can make well informed decisions and advance further along the pathway.</p>
<ul style="list-style-type: none"> <p>Academic Preparation and Entry Support: Candidates' ability to (1) obtain the academic preparation they need to access the training program or job that they want to pursue and (2) obtain support to understand how to adequately prepare, apply and gain entry. Candidates need to know how to obtain required academic preparation and then be able to access it for their desired health career. They also need to know how to get from where they are to entry into their chosen field and need solid academic and career advice about the educational options that best fit their circumstances. In particular, candidates need good advice and support to successfully navigate application processes which are often complex and confusing, particularly for people with little exposure to higher education. Once</p>

Table A-1. Definition and Description of Pathway Components

PATHWAY COMPONENTS
<p>candidates’ qualifications and fit are assessed, they need opportunities to strengthen their preparation and presentation. There are many programs that offer this kind of training and support for entry level workers and post baccalaureate programs offer this for aspiring physicians and dentists. Some candidates apply but encounter challenges or don’t get accepted to their program and need additional support to adjust their options, strengthen their preparation and stay in the process.</p>
<ul style="list-style-type: none"> <p>Financial and Logistical Feasibility: Candidates’ ability to (1) secure financial arrangements that enable them to participate in a training program and (2) logistically be able to participate in the training program given their circumstances and how and where it is offered. Health career education and training programs need to be financially and logistically viable for candidates from all backgrounds. Many well qualified candidates are not able to obtain the training they need due to these barriers, particularly with rising educational costs. This is often particularly true for candidates in rural or urban underserved areas or candidates who need to continue working. Designing training programs and financial support options that make health training programs more accessible and affordable will result in more sufficient numbers of candidates and greater participation and advancement from all groups. Expansion of on-line educational courses and degree programs with financial resources available to make them affordable is an example of enhancing financial and logistic feasibility to increase candidate access and training program capacity.</p>
<ul style="list-style-type: none"> <p>Training Program Access: Sufficient training program access to admit and graduate sufficient numbers of qualified, diverse candidates to meet the demand for workers in a specific profession and geographic area. Without sufficient training program access, qualified, motivated candidates cannot pursue their chosen career and California cannot produce a sufficient supply of professionals to meet the demand. A number of factors influence training program access including: faculty Full Time Equivalent positions (FTE) and salaries, cost of providing the training, State funding, internship training slots and training facilities. It is important to “right size” programs to meet the statewide and regional demand or rely on recruitment from other states or countries.</p>
<ul style="list-style-type: none"> <p>Training Program Retention: The ability to retain and graduate admitted students in a health training program. Training programs in some health professions experience high attrition rates. This can undermine the work of getting sufficient numbers and diversity of candidates into training programs. Retention challenges can also results in (1) significant education costs that don’t produce graduates that enter the field at a time when resources are limited (2) insufficient numbers of graduates (3) slots that other qualified candidates are not able to use and (4) problems and expense for people who were not able to complete the program. In some impacted professions, candidates used limited slots that could have gone to qualified candidates who could complete the program. Many factors can influence retention.</p>

Table A-1. Definition and Description of Pathway Components

PATHWAY COMPONENTS
With concerted efforts, retention can be enhanced for most professions.
<ul style="list-style-type: none"> Internships and Clinical Training: Structured, formal internship, residency and clinical training experiences in health organizations that enable students to (1) apply theory in practice; (2) develop hands-on skills on the job; (3) satisfy training requirements; (4) obtain needed experience; and, (5) get a job. Sufficient internship capacity for priority professions, settings and geographic areas are critical to meeting workforce supply needs and providing opportunity for participants. Internships are an important part of health professions training. For many professions, internships are required part of the curriculum and their availability influences training program capacity. They are also an important opportunity for exposure and career decision refinement, including the type of organization and role candidates want to work in. Internships are also a primary source of practical skill building and mentorship. The location and settings for training may influence where candidates may ultimately practice. In many fields internships are the bridge to employment opportunities.
<ul style="list-style-type: none"> Financing and Support Systems: A combination of factors that (1) make it financially attractive for candidates to pursue a health career; (2) enables training program participants to enter and then successfully practice in a given profession or setting; and (3) enable professionals working in a profession and/or geographic region to viably meet their financial goals and thrive. Key factors in attracting and retaining sufficient candidates into priority professions, settings and geographic areas are compensation, financial incentives, and support systems to help them succeed in their practice. Factors such as reimbursement, recruitment incentives and other financial incentives also have a significant influence. Once professionals enter practice in a given organization or community, they need support to be successful given the demands of practice and administration. The practice environment and its impact on professional and personal work-life and satisfaction are key factor in professional selection and retention. Systems need to be put in place to influence sufficient numbers and diversity of members to pursue and succeed in priority professions, safety net institutions and underserved areas.
<ul style="list-style-type: none"> Hiring and orientation: Effective recruitment, hiring and orientation support to enable sufficient numbers of training program graduates and existing health professionals to work and initially succeed in target organizations and settings. Even if sufficient numbers of professionals are trained, organizations still need to recruit, orient and develop them in a manner that secures their practice in priority settings, organizations and geographic areas. Some organizations, such as government agencies or types of professions may have hiring processes, practices and time frames that undermine their ability to hire or compete for candidates even if the need is great. Adjusting these barriers may enhance recruitment and elimination of vacancies. In some professions or organizations where shortages exist, insufficient orientation and ongoing support can result in a loss of recent hires after costly and

Table A-1. Definition and Description of Pathway Components

PATHWAY COMPONENTS
<p>pro-longed recruitment. This continues the cycle of shortages. Streamlining recruitment, hiring and orientation practices is important to increasing workforce capacity.</p>
<ul style="list-style-type: none"> <p>Retention and advancement: Ensuring that candidates within an organization, geographic area or professions have sufficient opportunities to stay with the organization and have upward mobility. In many cases, significant effort and resources are invested in recruitment of candidates but not in planning for and ensuring retention and advancement. Retention and advancement are particular challenges for rural or urban underserved areas, government or small non-profit agencies and some academic settings.</p>
<ul style="list-style-type: none"> <p>Coordinating infrastructure: Availability of sufficient staffing, organization, data and resources to (1) develop, implement and coordinate pathway components; (2) provide ongoing workforce planning and development and tracking; (3) establish relationships and monitor changing circumstances to make adjustments to policies and programs as needed; and, (4) organize continuity of support for candidates as they progress through the pathway. Sufficient coordinating infrastructure is required to put all of the components of the pathway in place at sufficient scale, linkage and quality within geographic areas or professions. An organizing intermediary, coalition, lead organization or individuals are required to mobilize and build relationships with stakeholders responsible for each element and enhance collaboration and investment to ensure the system level pathway is in place and barriers to sufficient supply and diversity are addressed. Coordinating infrastructure is also critical to provide “case management” and other support services for candidates as they progress through the different components and stages of their career pursuit. The components in the model are not connected because going from each stage is an opportunity for people to fall out of the pathway. Sufficient system level and individual level supports must be in place to ensure adequate supply in priority professions and geographic areas.</p>
<ul style="list-style-type: none"> <p>Cultural responsiveness and sensitivity: The degree to which attitudes, behaviors, conditions and systems among organizations and individuals that interact with candidates throughout the pathway are culturally response and sensitive to the candidates’ background. Throughout the pathway, from pre-training though advancement, it is important to ensure that services are promoted and provided to candidates and patients in a culturally responsive and sensitive manner. This includes race, ethnicity, age, sexual orientation, culture, language, gender, income status and other factors that influence learning, choices, success and provision of service to clients. Health professions education institutions, higher education, K-12, employers, advisors and others from all backgrounds need to practice cultural responsiveness and sensitivity to meet the needs of an increasingly diverse population.</p>

Appendix B. Substance Use Disorder Counselor (SUDC)

Background Information

CURRENT SITUATION AND FUTURE NEED

Addressing Substance Use Disorder Counselor (SUDC) shortages is critical due to the incidence and prevalence of substance use disorders in California and the associated significant on individual, family and population health. Substance Use Disorders have a major impact on overall health quality, costs and outcomes. Substance Use Disorder (SUD) is ranked in the top five for clinically preventable burdens and causes of death and morbidity. Reducing the burden of substance use can have a significant return on investment in health care spending. The level of health care services used by addicts before receiving treatment is more than double that of non-addicts.

There are severe shortages of SUDCs statewide and in many geographic locations. While, there are an estimated 3.5 million persons with diagnosable substance use disorders in California, there are less than 20,000 alcoholism and drug abuse counselors currently certified by private credentialing bodies in California (The Department of Alcohol and Drug Programs). California employs fewer SUD counselors per population than the national average (CA 2.01/p100,000 - US 2.2/p100,000).

Additionally, the majority of the SUD workforce is white, female, and in their 40's or 50's, while 57% of those receiving SUD treatment are non-white, 60% are male, and 60% are under 35. It is critical that SUDC workforce expansion efforts focus on recruitment of men, racial/ethnic minorities (particularly black and Hispanic), and younger adults as it is important that clients receive treatment from individuals who are similar in racial/ethnic background, gender, and age. There are also severe shortages of counselors available for the treatment of children, youth and the elderly.

The Affordable Care Act (ACA) has made substance abuse treatment a priority and significantly expanded coverage for treatment. However, current workforce shortages and a lack of concerted effort to increase supply, distribution and diversity of SUDC's create concern that the need will not be met. The SUD benefit was not generally available under insurance plans before ACA implementation, and as a result, focus groups failed to recognize its absence.

SUD counseling is a single diagnosis specialty. In California, there current initiatives aimed at improving the number of counselors and their competency level are addressed by five, small non-profit professional associations. Education, training and testing requirements vary tremendously within these certifying bodies. The SUD workforce is undefined, lacks clear parameters and cuts across multiple licensed, certified, and unclassified professions. Multiple certifying bodies with different requirements and standards make it difficult to ensure a quality SUD workforce.

California's SUD workforce is not as large as it should be. According to the 2012 OSHPD/WIB report, California had just 2.01 SUD counselors per 100,000 total population; approximately 8.6% lower than the national average (Career Pathway Sub-Committee Updated Report). Furthermore, the State's 2012 Mental Health and Substance Use Needs Assessment reported

that there are “very few” board certified addiction psychiatrists practicing in California, and there is a dearth of SUD providers of any sort serving the State’s rural populations (California Mental Health and Substance Use System Needs Assessment). Consequently, California’s SUD workforce needs to grow and develop greater disciplinary and geographic diversity in order to better meet the SUD service needs of the State’s population.

Contributing to workforce shortages and quality variation is a 50% turnover rate in SUD frontline staff and directors yearly. (*Lillian T. Eby, Hannah Burk, Charleen P. Maher. “How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover.” Journal of Substance Abuse Treatment 2010;39:264-271.*)

The lack of clear educational and career pathways for workers hampers recruitment and contributes to turnover, as many skilled workers leave the sector in the search of upward career mobility. In addition, low salaries dramatically impact the longevity in the field as 67% of SUDC earn less than \$35,000 annually and 20% of those in the field do not receive health benefits. (*Pacific Southwest Addiction Technology Transfer Center, CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey.*)

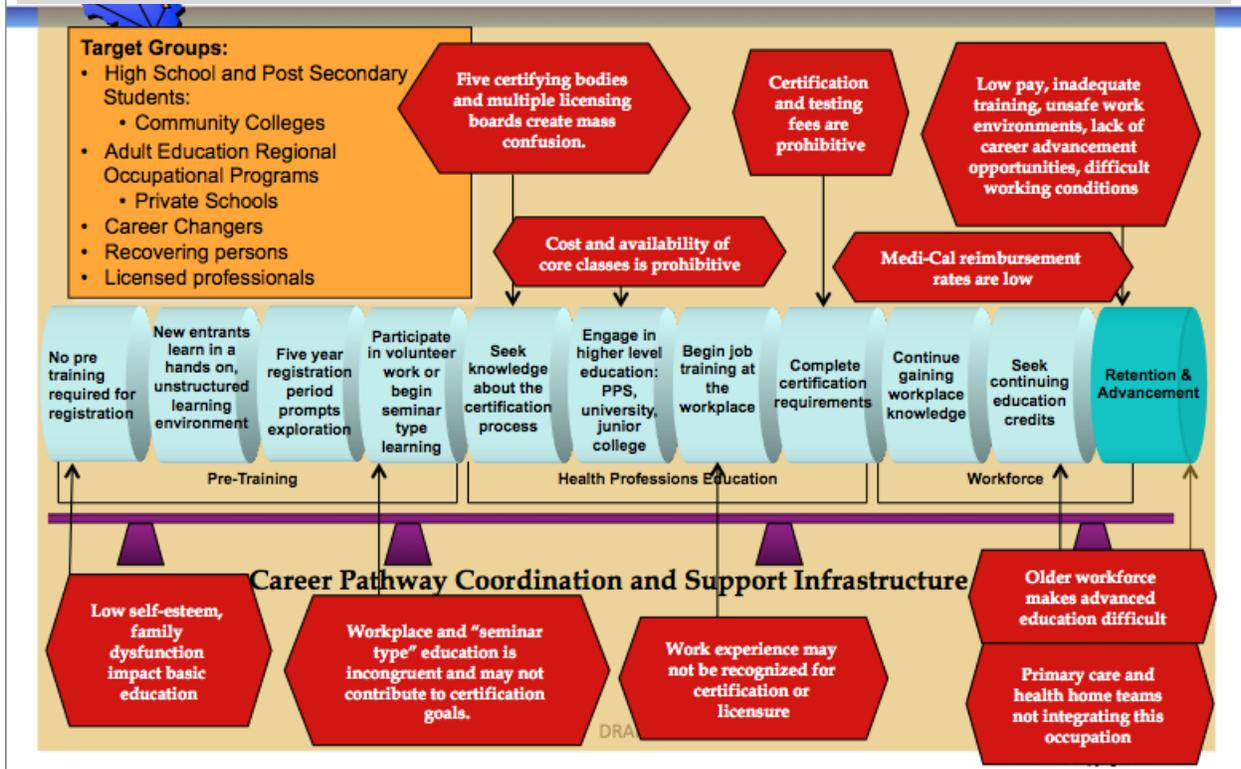
The ACA will expand Medicaid coverage to between 149,000- 195,000 previously uninsured Californians, who need SUD treatment. These shifts will require the SUD treatment workforce in California to grow by between 2,100-2,828 FTEs by 2019. (*Technical Assistance Collaborative & Human Services Research Institute, California Mental Health and Substance Use System Needs Assessment.*)

Pathway and Components

VISUAL DEPICTION

The pathway below represents the final system pathway developed for Substance Use Disorder Counselors in California. The barriers and recommendations developed are detailed in the following section.

Substance Use Disorder Counselor (SUDC) Workforce Pathway



BARRIERS AND RECOMMENDATIONS

The barriers identified in the pathway model are addressed below, accompanied by recommendation(s) to address these barriers.

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> No requirement for persons to obtain skill or education before becoming registered 	<ul style="list-style-type: none"> Change counselor certification regulations to require an orientation course and defined requirements including ethics training. Require continuing education on a yearly basis to reach certification within five years. Work with Department of Education Career Pathways Initiative to develop SUD career awareness
<ul style="list-style-type: none"> Workplace and “seminar type” education is incongruent, poorly organized and may not contribute to certification or licensure goals. 	<ul style="list-style-type: none"> Create a central clearinghouse for approved education that relates to certification and licensure Direct financing for SUD education at the junior college and private postsecondary levels.
<ul style="list-style-type: none"> Five certification bodies with complex requirements make 	<ul style="list-style-type: none"> Unify certifying bodies into one state-sanctioned, credentialing body. Create licensure path that

BARRIER	RECOMMENDATION
<p>career planning difficult. Low cost alternatives that are incapable of creating competent counselors attract many students because they are “easy” and inexpensive. Education at this level is not accepted for licensure.</p>	<p>incorporates education, training and testing efforts of certification.</p> <ul style="list-style-type: none"> • State of California recognize a uniform, career ladder (requires legislation or regulatory change). • Create a platform for consumers, employers and individuals for recognizing professional competency in SUD counseling.
<ul style="list-style-type: none"> • The majority of the SUD treatment workforce is White, female, and in their 40s or 50s. 63% of Californians receiving SUD treatment are male, and 57% of them are non-White (34% are Hispanic, 16% are Black). Almost 60% of individuals who need SUD services are under the age of 35. It is important for clients to receive treatment from individuals who are of a similar age, gender, and racial/ethnic background. 	<ul style="list-style-type: none"> • There should be focused workforce recruitment and expansion efforts on adding more men, racial/ethnic minorities (particularly Hispanics and Blacks), and young individuals to California’s SUD workforce. Partner with organizations such as the Alliance for Boys and Men of Color in CA to develop and implement a statewide strategy.
<ul style="list-style-type: none"> • Reimbursement remains low in both private and public payer systems. 	<ul style="list-style-type: none"> • Conduct a high level task force to bring Covered California, Dept. of Health Care Services and health plans together with SUD specialty providers to discuss reimbursement levels, contracting barriers (background checks, etc.) and integration issues (charting, etc.) • Create a mechanism and indicators for evaluating care given to Drug Medi-Cal patients vs. California Covered patients. Address any inequities (including reimbursement for providers) • Advocate for the drug treatment Medi-Cal reimbursement to be increased to the same level as sufficient private reimbursements.
<ul style="list-style-type: none"> • Most entry-level SUD professionals are older than the average student beginning a career. They generally are self-supporting and work fulltime, making advanced education difficult. 	<ul style="list-style-type: none"> • Develop education and outreach programs to advise potential SUD Counselors regarding the availability of student loans to assist with education and living expenses. • Create loan forgiveness for SUD Counselors who commit to five years in the field, particularly in underserved communities.
<ul style="list-style-type: none"> • Although less expensive than licensing, certification fees and examination costs can reach over \$500. Scholarships and financial aid are not available for these costs. 	<ul style="list-style-type: none"> • Create loan programs and scholarships to cover certification and testing fees. • Prepare colleges and universities for licensure level curriculum using other state’s programs as models.

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> • There is no coordination between licensure boards and certifying entities regarding approved work experience. Hours of experience are often not credited toward higher professional levels. No license is available in SUD counseling. 	<ul style="list-style-type: none"> • Prepare colleges and post-secondary institutions for future licensing. • Create a pilot project to develop model curriculum and adopt uniform standards for workplace supervision that allow interns from multiple disciplines to receive credit toward licensure for SUD experience. • Develop a one-time “grandparent” opportunity for SUD specialties under existing licenses.
<ul style="list-style-type: none"> • Low salaries and benefits dramatically impact longevity in the field. Levels are not commensurate with the high levels of stress associated with SUD services or the skills required to deliver them well (a direct care SUD worker in a 24-hour residential treatment facility earns less than an assistant manager at a Burger King) • SUD workers receive particularly low salaries because of low reimbursement rates for SUD services by third-party payors 	<ul style="list-style-type: none"> • Collect cost- benefit data to demonstrate the value of SUD Counselors • Develop education campaign aimed at employers and insurers which would convey the comparative value of the SUD counselor, particularly given the increased benefit mandated under the ACA. • Include required coursework in working with dually diagnosed individuals other than substance abuse • Address the absence of licensure on the career ladder.
<ul style="list-style-type: none"> • Workplace conditions and low pay discourage longevity. • High patient/counselor ratios; conflicting demands from constituents (ie– program philosophy v. criminal justice demands, co-occurring treatment regimens vs. rehabilitative approaches; high levels of documentation from multiple agencies; safety issues at the workplace are all common reasons for leaving the field. 	<ul style="list-style-type: none"> • Implement systematic recruitment and retention strategies at the state and local levels. • Develop model approaches to reduce “burn out” in the profession.
<ul style="list-style-type: none"> • Because there is no license for SUDCs, private practice settings where addiction can be treated in its earlier, less severe stages are not as available as they are in states with licensure for SUD counselors. 	<ul style="list-style-type: none"> • California should invest in “growing” its private provider base. • Pilot demonstration projects to assess early intervention and treatment are warranted to demonstrate the economic value of integrated, early treatment • Develop educational cross-over to move people to a Master’s degree
<ul style="list-style-type: none"> • Because the SUD benefit has not been included to the degree that it will under the ACA, medical teams 	<ul style="list-style-type: none"> • Launch an initiative to ensure that key members of the health workforce develop basic competencies in recognizing and referring SUD

BARRIER	RECOMMENDATION
at all levels need basic education in screening and referral.	patients. • Create a pilot project for primary care professionals for orientation and continuing training on SUD referral.

SOURCES CONSULTED

- University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report*
- Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment Final Report*. Report prepared for California Department of Health Care Services. Boston: The Authors, 2012
- *California Mental Health and Substance Use System Needs Assessment*.
- Lillian T. Eby, Hannah Burk, Charleen P. Maher. "How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover." *Journal of Substance Abuse Treatment* 2010;39:264-271.
- *Pacific Southwest Addiction Technology Transfer Center, CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*.

Appendix C. Clinical Psychologist

Background Information

CURRENT SITUATION AND FUTURE NEED

Currently there are approximately 19,485 licensed clinical psychologists in California (2013 CPA data.) Nationally, the American Psychological Association projects a 20% growth of demand for psychologists. (American Psychological Assn., n.d., 2011). There is a need to increase the number psychologists practicing in rural areas (Am. Psychological Assn., 2007) and also in behavioral health (Runyan, 2001).

Doctoral level educational programs within the state of California have the capacity to provide well-trained psychologists to meet the increased demand for psychologists, including target geographic and specialty areas. Currently, there are 36 degree programs (Psy.D., Ph.D.).The recommendations summarized in this section will ensure that the training capacity is leveraged to meet the growing demand for mental and behavioral health capacity.

The California Psychology Internship Council (CAPIC) is a statewide consortium of doctoral programs, and internship agencies and postdoctoral programs dedicated to ensuring excellence in training for psychologists and in mental health services. CAPIC is playing a lead role in strengthening the supply, distribution and diversity of psychologists in California; particularly in public settings and rural areas. CAPIC is a statewide consortium comprised of 36 Psychology Doctoral Degree Program members, 144 Psychology Internship Programs, and 20 Postdoctoral Training Programs. One of CAPIC's primary functions is serving as a central statewide coordinator or pre-doctoral internships.

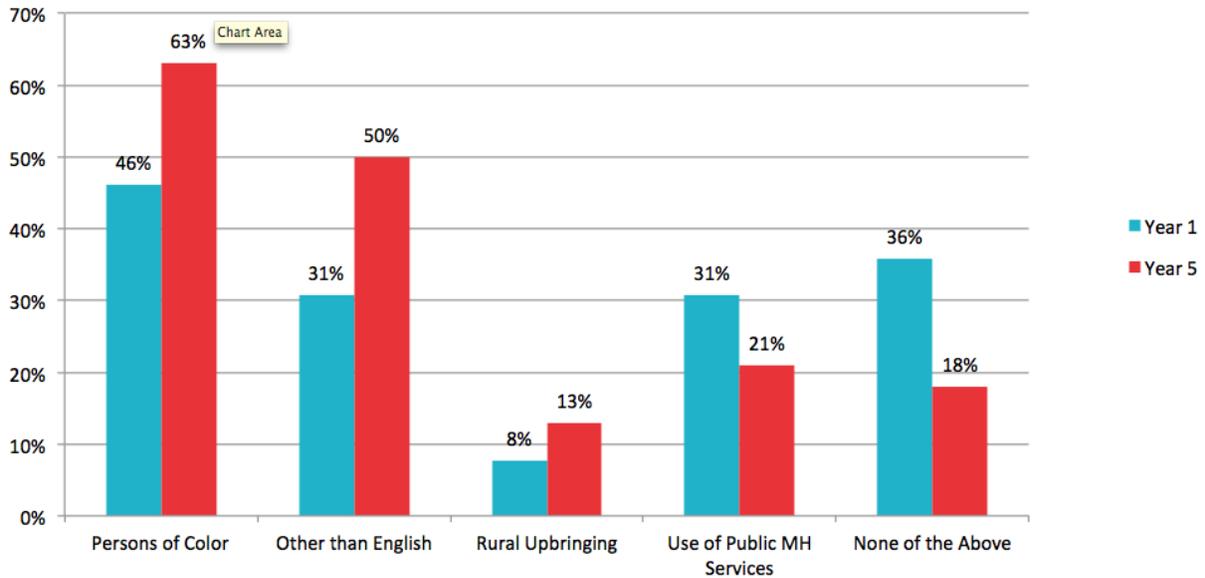
Internships are a required part of doctoral level training and licensure and are essential to meeting service and workforce needs; particularly in public mental health settings. In 2012, CAPIC placed 466 doctoral programs interns in California. The majority of interns were placed at agencies funded all or in-part by state/county mental health. Approximately 500,000 hours of on-site support and 250,000 of direct services are provided by these interns annually to consumers of Mental Health Services state-wide.

CAPIC also administers internships for Mental Health Services Act funded students. CAPIC has awarded stipends over the past five years to 181 clinical psychology students committed to working in the California public mental health system. In 2013-14 CAPIC will award an additional 35 FTE stipends to another cadre of psychology doctoral students committed to working in the California public mental health system. Stipend recipients have been successful throughout 2008 to present (funded years of program to date), in obtaining post-doctoral positions in the state mental health system, showing a need for psychologist positions throughout the state.

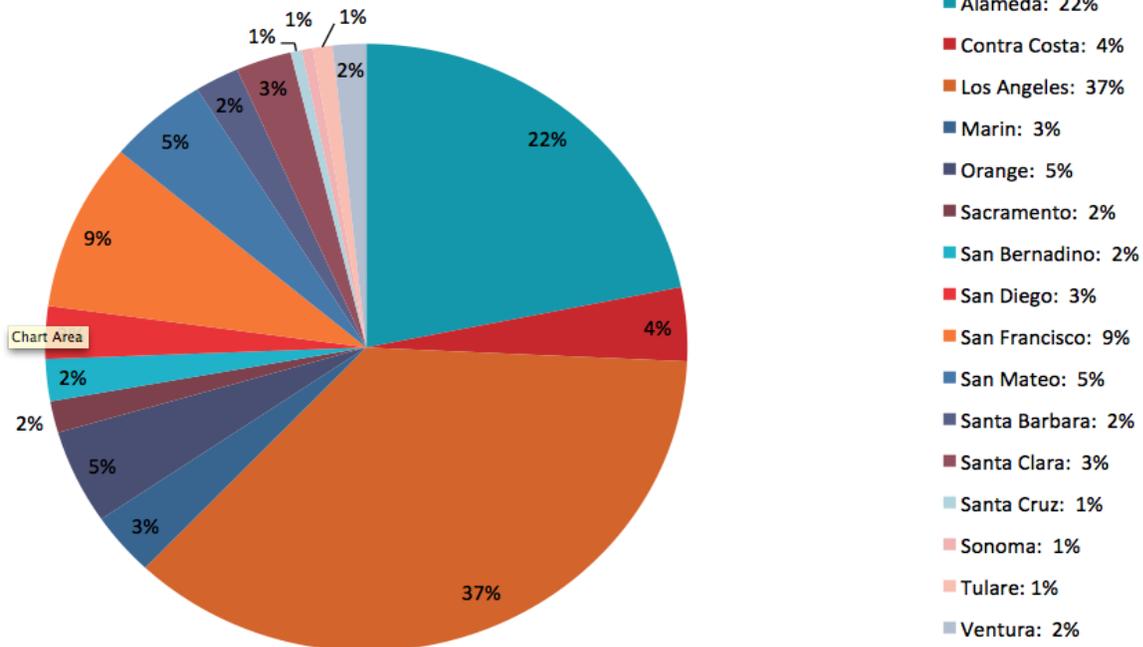
CAPIC/MHSA stipend recipients represent the diversity of California's population and in particular the underserved & underrepresented mental health client populations. The number of interns from underrepresented racial and ethnic groups increased from 46% in Year 1 (2008-2009) to 63% Year 5 (2012-2013). Interns that spoke languages other than English rose to 50%. Intern stipend recipients from rural communities rose from 8% to 13% but the small percentage

indicates the need for increased rural student recruitment. Overall diversity (e.g. ethnicity, language competency, and rural upbringing) of CAPIC/MHSA stipend recipients significantly increased since this program began indicated in following chart. One exception- stipend recipients' use of public mental health services, which dropped from its high of 51% last year (Year 4, not shown) 21% in Year 5 (shown). Geographic distribution of psychology intern's stipend recipients is shown in the 2nd chart.

**Diversity of Stipend Recipients
Comparison of Year 1 (2008-09) to Year 5 (2012-13)**



**CAPIC/MHSA Stipend Recipient Predoc Service by County
Years 1 - 5 (2008 - 2013) Combined**

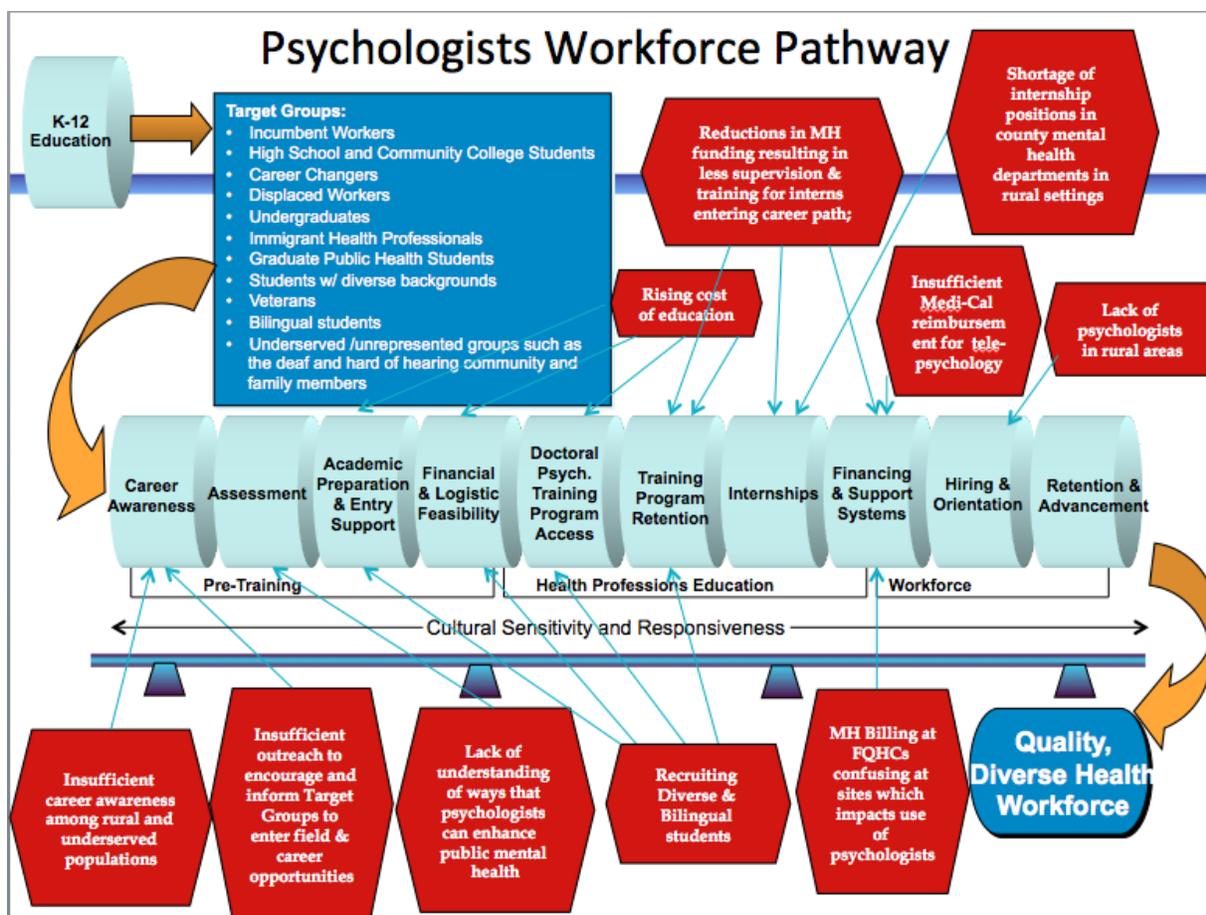


While through internships progress has been made at increasing the diversity and supply of psychologists, due to funding cuts, the number of internships has been reduced during a time when the demand for psychologists is increasing. Increasing the number of internships is one important solution to meeting California’s mental health workforce needs. This and other key barriers to recruitment and retention of the needed supply of psychologists are depicted in the pathway diagram below.

Pathway and Components

VISUAL DEPICTION

The pathway below represents the final system level pathway developed for Psychologists in California. The barriers and recommendations developed are detailed in the following section.



BARRIERS AND RECOMMENDATIONS

Table C-1. Clinical Psychologists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> Level and growth in the cost of Education 	<ul style="list-style-type: none"> Increase the number of MHSA stipend internships in the public health mental system to 90 per year. Expand to additional

Table C-1. Clinical Psychologists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
	<p>counties; prioritize high need counties.</p> <ul style="list-style-type: none"> • Increase support of MHSA Stipend Program to \$25,000 • Encourage discussion of reducing time to graduation to reduce student loan costs. • Develop funding for loan repayment for people working in underserved areas
<ul style="list-style-type: none"> • Lack of bilingual & diverse doctoral candidates in psych. 	<ul style="list-style-type: none"> • Greater community outreach to grade/H.S., veterans, consumers, community colleges, immigrant Health Professionals
<ul style="list-style-type: none"> • Reduction of psychologists in county mental health and in rural areas; shortage of internships in county mental health & in rural areas. 	<ul style="list-style-type: none"> • Develop incentive/loan forgiveness programs for rural work locations (ex: Prison system; Native Amer.) • Recruit from rural communities • Explore tele-psychology opportunities to provide needed care
<ul style="list-style-type: none"> • Other disciplines not aware of varied skills of profession 	<ul style="list-style-type: none"> • Develop opportunities for cross-discipline conferences, round-tables, care coordination meetings; community education
<ul style="list-style-type: none"> • Lack of psychologists in rural areas 	<ul style="list-style-type: none"> • Develop Tele-psychology opportunities to provide needed care • Address living/support needs to recruit/retain psychologists in rural areas (support center for every discipline)
<ul style="list-style-type: none"> • Colleges not prepared to provide necessary info to students on interface of MH & Integrated healthcare plan 	<ul style="list-style-type: none"> • Develop relevant trainings for psychologists & how to integrate training into doctoral training programs
<ul style="list-style-type: none"> • Reimbursement for psychological services under ACA is not yet clarified • MH Billing at FQHCs confusing for sites; impacts use of psychologists • Insufficient Medi-Cal reimbursement for tele-psychology in FQHC's 	<ul style="list-style-type: none"> • Work with managed care plans at the state and county health services level to ensure sufficient coverage and reimbursement • Develop FAQ documents and pertinent information on billing procedures for FQHCs and all other health settings • Advocate to Medi-Cal workgroup for sufficient reimbursement for tele-psychology services
<ul style="list-style-type: none"> • Reduced MH funds resulting in: less psychologists & increased workloads; reductions training to interns; reduction in internships state-wide 	<ul style="list-style-type: none"> • Advocate for MHSA funds dedicated to support mental health services and the hiring of psychologists state-wide; ensure availability of psychologists to support internship training programs via supervision & training

SOURCES CONSULTED

- California Psychological Association
- Division II (Education & Training) Board of the California Psychological Association
- California Psychology Internship Council
- American Psychological Association
- Personal Communication w/ LA City Department of Mental Health Psychologists

Appendix D. Licensed Professional Clinical Counselors

Background Information

CURRENT SITUATION AND FUTURE NEED

Licensed Professional Clinical Counselors (LPCC) are clinicians that are trained and have a scope of competency to work with individuals, families, and groups, from children to older adults. LPCCs prevent, diagnose, and treat mental, emotional, and behavioral disorders and problems. They combine traditional psychotherapy with a practical, problem-solving approach that creates a dynamic and efficient path for change and problem resolution (American Mental Health Counselors Association <http://www.amhca.org/about/facts.aspx>). In many states LPCCs are also named Licensed Professional Counselors (LPCs), Licensed Clinical Professional Counselors (LCPCs), Licensed Mental Health Counselors (LMHCs) and Licensed Professional Counselor of Mental Health (PCMH). Because this profession is new to California (approved for licensure in 2009) there are currently only 300 LPC/LPCCs in the state, while there are 126,378 LPC/LPCCs nationwide.

LPCCs are masters and doctoral-degreed mental health service providers who provide similar mental health services as Licensed Clinical Social Workers (LCSWs) and Licensed Marriage and Family Therapists (LMFTs).

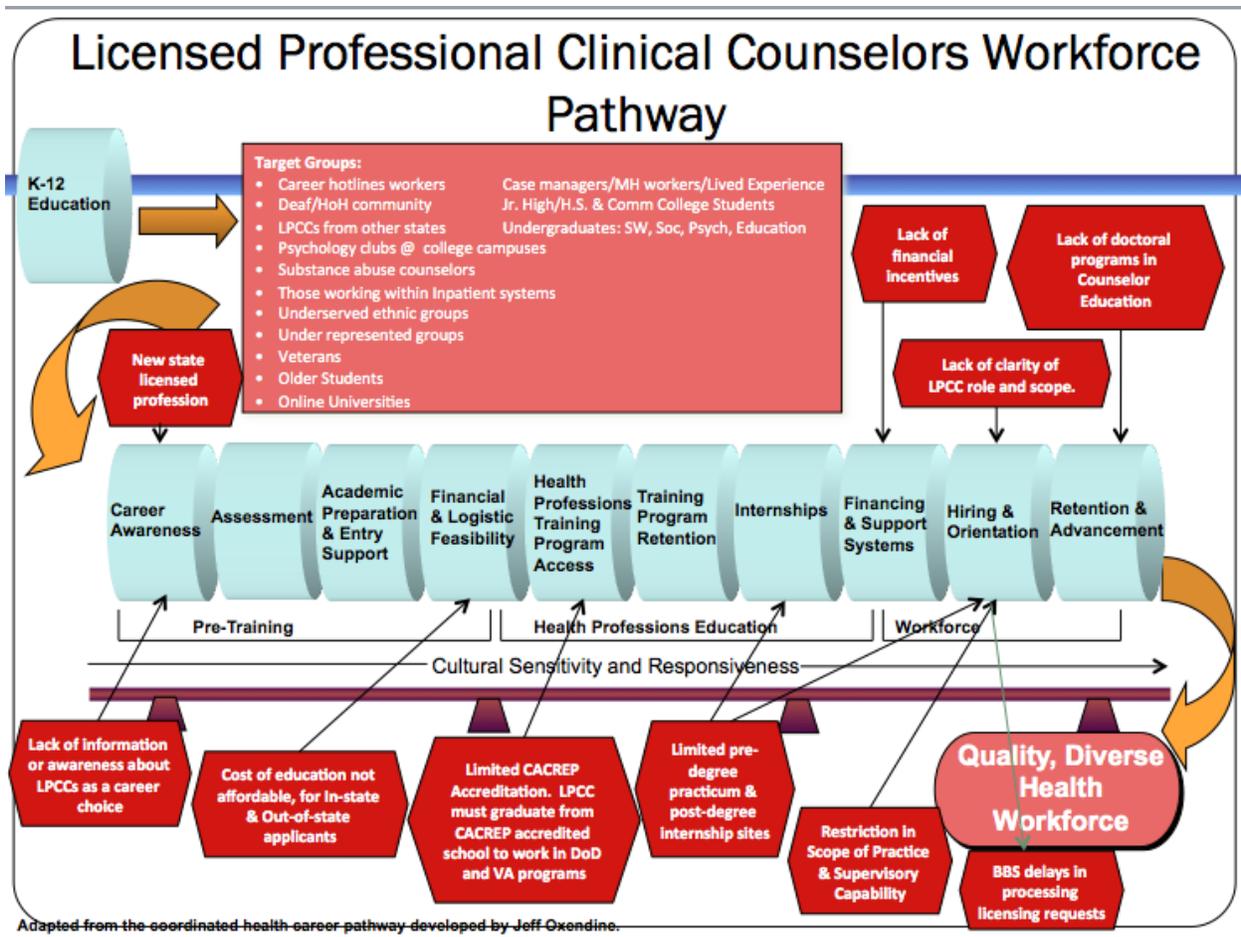
While LPCCs are new to California, in the other 49 states they make up a large percentage of the workforce employed in mental health centers, agencies, and organizations (American Counseling Association <http://www.counseling.org/PublicPolicy/WhoAreLPCs.pdf>). LPCCs practice independently in a variety of settings including hospitals, community-based mental health organizations, colleges and universities.

According to a 2012 Health Benefits Exchange Briefing an estimated 200,000-300,000 uninsured individuals will obtain coverage for behavioral health services beginning in 2014 as a result of the ACA. This will require 3,866-5,205 additional behavioral health clinicians by 2019. The committee chose this pathway because LPCCs bring essential functions to the public mental health workforce and can help meet this need. Being that LPCC is a new state licensed profession, collaboration between key groups on a statewide level and a campaign to educate workforce providers and payors about the LPCC profession is critical increase the number of LPCCs in California. The pathway and key barriers to recruitment of LPCC's are depicted below.

Pathway and Components

VISUAL DEPICTION

The pathway below represents the final system pathway developed for Licensed Professional Clinical Counselor in California. The barriers and recommendations developed are detailed in the following section.



BARRIERS AND RECOMMENDATIONS

The barriers identified in the pathway model are addressed below, accompanied by recommendation(s) to address these barriers.

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> • LPCC is a new state licensed profession, therefore not familiar to CA's public health care system and diverse community-based MH/Behavioral Health providers. Lack of clarity and understanding in LPCCs professional role, scope of practice, scope of competency, and supervisory capability. 	<ul style="list-style-type: none"> • Collaboration between key groups on statewide level and campaign to educate workforce providers and payors about LPCC • Collaboration between key groups that have the ability to educate, communicate, and disseminate information about LPCCs on a statewide level (e.g., BBS, CMHDA, CCCMHA, CiMH, OSHPD, CALPCC) • Campaign to educate workforce providers and payors about LPCC • Use of multi-media approach to educate and communicate to the public and diverse communities about LPCCs professional role, scopes of practice and competency, and

BARRIER	RECOMMENDATION
	supervisory capability
<ul style="list-style-type: none"> Restriction in Scope of Practice & Supervisory Capability 	<ul style="list-style-type: none"> Remove restrictions in Scope of Practice & Supervisory Capability CA to model after 49 states that do not have Scope and Supervisory Capability restrictions Collaboration among the licensed disciplines
<ul style="list-style-type: none"> Limited Pre-degree practicum & Post-degree internship sites for PCC Interns 	<ul style="list-style-type: none"> Collaboration between academic institutions, DMH (county mental health) and CBOs to create increased community-based practicum/internship sites, and educate staff about benefits of PCC interns Funding for paid internships
<ul style="list-style-type: none"> Cost of Education not affordable 	<ul style="list-style-type: none"> Develop financial incentive programs for LPCC graduates Create employment commitment incentives for LPCC graduates to work in public behavioral health similar to other MHSA WET stipend programs (MSW, MFT)
<ul style="list-style-type: none"> CAPREP accreditation requires full-time instructors to have doctoral degrees in Counselor Education and California has no doctoral programs in Counselor Education. 	<ul style="list-style-type: none"> Collaborate with the UC, CSU and private universities, to develop doctoral programs to prepare counselor educators
<ul style="list-style-type: none"> Limited CACREP Program Accreditation May impact number of LPCCs who can work at DoD and VA programs, unless LPCC graduated from a CACREP-accredited counseling program. (Adds to statewide workforce shortage of qualified MH professionals, particularly in working with Vets, those on active duty, and their families.)* 	<ul style="list-style-type: none"> Encourage more university counseling programs to become CACREP-accredited Provide financial incentives to students who attend CACREP-accredited counselor training programs.
<ul style="list-style-type: none"> Online (often private) universities who offer counseling training programs that are CACREP-accredited are more expensive than traditional state universities. Increased tuition is added hardship on the potential.* <p>*NOTE: There are no alternative accreditation bodies for LPCC programs specific to California, only nationally via CACREP. For definition of the terms “Accredited” or “Approved” see California Business & Professions Code Section 4999.12</p>	<ul style="list-style-type: none"> Develop scholarships, stipends and loan forgiveness/repayment targeted to LPCCs

SOURCES CONSULTED

- The pathway and recommendations were approved by:
- American Counseling Association
<http://www.counseling.org/PublicPolicy/WhoAreLPCs.pdf>
- American Mental Health Counselors Association <http://www.amhca.org/about/facts.aspx>
- Board of Behavioral Sciences http://www.bbs.ca.gov/pdf/publications/pcci_faq.pdf
- Business and Professions Code, Chapter 16, Licensed Professional Clinical Counselors
<http://www.leginfo.ca.gov>
- California Association for Licensed Professional Clinical Counselors (CALPCC)
www.calpcc.org
- California State University of Fullerton / College of Health & Human Development
<http://hhd.fullerton.edu/counsel/degree.htm#MFT%20Licensure%20Preparation>
- Career Builder <http://www.careerbuilder.com>
- Council for Accreditation of Counseling and Related Educational Programs (CACREP)
<http://www.cacrep.org>
- Counselor License Resources <http://www.counselor-license.com/states/california-counselor-license.html>
- Dyeson, T.B., *Social Work Licensure: History and Definition*, Home Health Care Management & Practice / August 2004 / Volume 16, Number 5, 408-411
<http://www.sagepub.com/jimenezstudy/articles/Dyeson.pdf>
- Esptein, J., *The Living History of the MFT License*, The Therapist / January-February 2013 <https://www.camft.org>
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- Indeed Job Search Engine <http://www.indeed.com/jobs?q=Licsw+Lpcc&start=30>
- The National Certified Counselor / Volume 25, Number 3 / Fall 2009
<http://www.nbcc.org/Assets/Newsletter/Issues/fall09.pdf>
- University of Redlands / Masters of Arts in Clinical Mental Health Counseling
<http://www.redlands.edu/academics/school-of-education/11789.aspx>
- University of San Diego / Masters of Arts in Counseling
<http://www.sandiego.edu/soles/academics/ma-counseling-clinical-mental-health/>

Appendix E. Marriage and Family Therapist (MFT)

Background Information

CURRENT SITUATION AND FUTURE NEED

A marriage and family therapy performs services with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and pre-marriage counseling. The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships.

In California, there are 79 graduate programs that lead to a degree in Marriage Family Therapy or Counseling with an MFT emphasis. Programs are 60 semester units or 90 quarter units in length and include field experience. A minimum of 104 weeks of supervision and 3,000 hours of experience in specific areas of practice is required. The average length of time from starting a graduate program to licensure is 6-7 years.

In California, as of June 2013 there were 33,309 licensed Marriage and Family Therapists (MFTs) and 15,974 registered interns (BBS). The Department of Labor Statistics projects the future need for MFTS to be an increase of 41% by 2020 (U.S. News and World Report <http://money.usnews.com/money/careers>).

The “typical” MFT is a white, middle-age, English-only speaking female who works in private practice in LA County or the Greater Bay Area. Thus, there is a need for greater gender and ethnic diversity and language capability in the workforce as well as greater geographic distribution of practitioners to areas with greatest need.

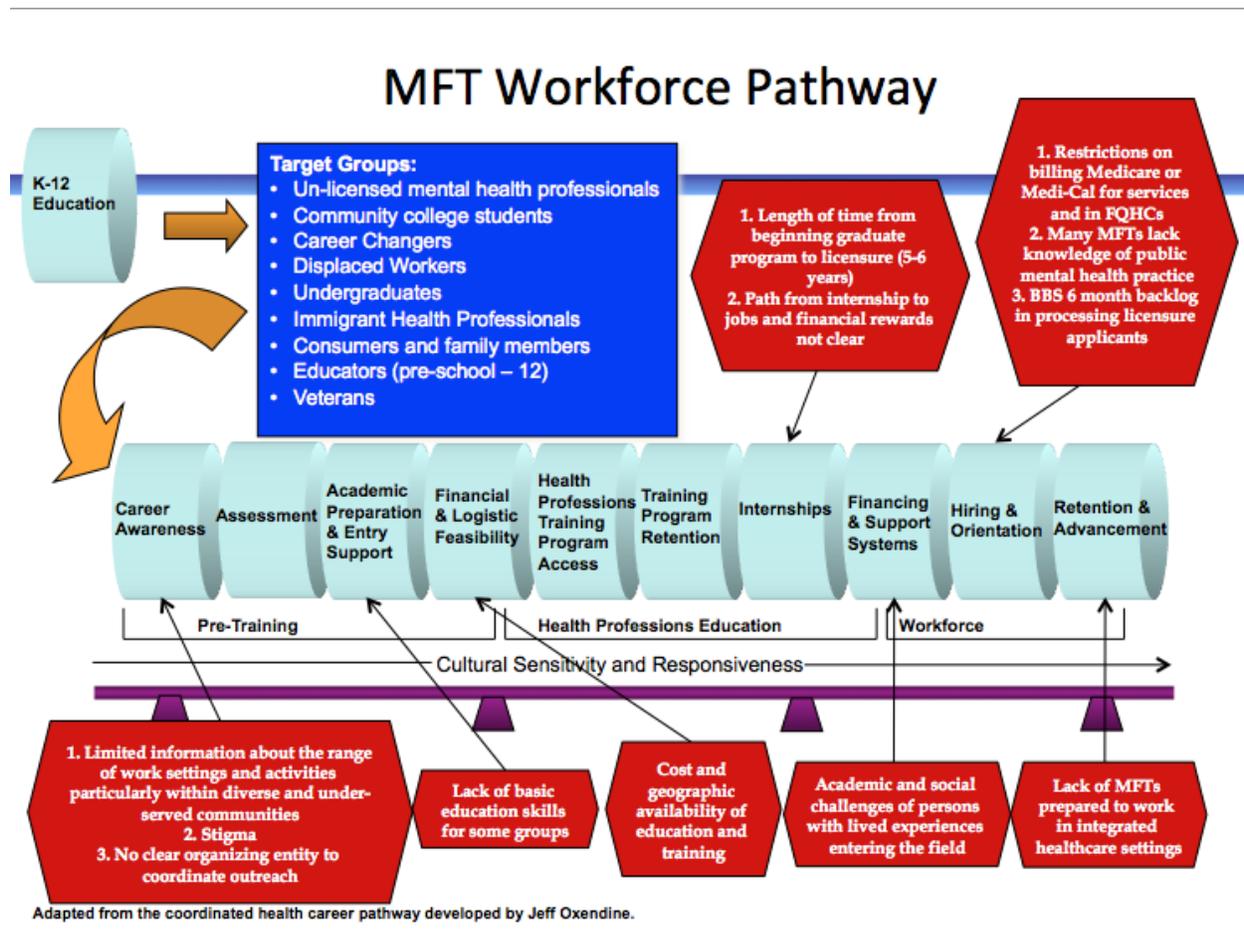
It is important to note that the geographic distribution of licensed mental health professionals does not correspond to the areas with greatest need. The Bay Area has the greatest concentration of MFTs (123 per 100,000 population) followed by the Central Coast, Northern and Sierra Regions, Orange County and Los Angeles County. The San Joaquin Valley and the Inland Empire have the lowest concentration. The regions with the highest percentage of adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) are San Joaquin Valley and the Northern and Sierra Region, the lowest is the Greater Bay Area (CA Healthcare Foundation Report).

The CAMFT 2012 survey showed that 63% of pre-licensed MFTs reported their primary work setting as non/profit or government entities while only 17% of Licensed MFTs reported these settings as primary. While community based organizations (CBOs) often hire and provide supervision for pre-licensed MFTs, they report that once licensed, MFT’s leave for settings with higher pay and better benefits. With the implementation of the ACA, MFTs will likely provide clinical oversight, assessment, treatment planning and therapeutic interventions, particularly with families. Workforce shortages will require licensed professionals to “work at the top of their license” with services such as rehabilitation and case management provided by non-licensed staff.

Pathway and Components

VISUAL DEPICTION

The pathway below represents the system pathway developed for MFT's in California. The barriers and recommendations developed are detailed in the following section.



BARRIERS AND RECOMMENDATIONS

The barriers identified in the pathway model are addressed below, accompanied by recommendation(s) to address these barriers.

Table E-1. Marriage and Family Therapist Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> • Lack of basic education skills, particularly reading, writing and math for some groups needed to succeed in a graduate program 	<ul style="list-style-type: none"> • Greater target efforts in community colleges and CSUs where there is more diversity among students and remedial courses are available • Assessment process in place to identify where help with skills is needed
<ul style="list-style-type: none"> • Limited information about the range of work settings 	<ul style="list-style-type: none"> • Limited information about the range of work settings and activities for MFTs may contribute to lack of diversity

Table E-1. Marriage and Family Therapist Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<p>and activities for MFTs may contribute to lack of diversity and no clearly designated entity to oversee outreach and marketing on a state-wide basis</p>	<ul style="list-style-type: none"> • No clearly designated entity to oversee outreach and marketing on a state-wide basis
<ul style="list-style-type: none"> • Cost and geographic availability of graduate programs, internship opportunities and supervision 	<ul style="list-style-type: none"> • Continue/expand loan forgiveness and stipend programs • Encourage universities to develop creative payment plans • Develop distance learning and/or hybrid programs such as Chico, UCLA, and Humboldt • Utilize new CA tele-health broadband system to expand distance learning • Utilize web-based technology for supervision • Develop “roving supervisor” program – target programs in underserved areas
<ul style="list-style-type: none"> • Length of time from beginning graduate program to licensure, the backlog in approving licensure applicants by BBS and the path from internship to jobs and financial rewards not clear 	<ul style="list-style-type: none"> • Create pool of funds for public mental health organizations to provide paid internships • Create incentives for organizations to provide paid internships • BBS review procedure for counting hours • BBS develop a plan to reduce the backlog in processing applications from 6 months to 8 weeks • Encourage use of funds for appropriate staffing
<ul style="list-style-type: none"> • Many current MFTs do not have the knowledge or skills required to work in public mental health settings • Bias against hiring MFTs in some community organizations and county mental health programs 	<ul style="list-style-type: none"> • Provide ongoing (CEU) training opportunities on principles and practices of recovery-oriented practice • Promote revised curriculum which includes recovery-oriented practice • Provide opportunities for communication between employers and professional organizations (CAMFT, AAMFT-CA)
<ul style="list-style-type: none"> • Academic and social challenges for persons with lived experience entering the field 	<ul style="list-style-type: none"> • Develop regional mentoring programs of MFTIs and MFTs with lived experience to provide support and guidance to current students (ex: Working Well Together)
<ul style="list-style-type: none"> • Restrictions on billing Medicare for services and in Federally Qualified and in some other Health Centers 	<ul style="list-style-type: none"> • Broaden the communication on status of advocacy efforts by CAMFT and AAMFT to organizations focused on workforce issues • Explore Planned Parenthood model where MFTs provide services in health clinics
<ul style="list-style-type: none"> • Lack of MFTs (and other mental health professionals) prepared to work in integrated healthcare 	<ul style="list-style-type: none"> • Develop post-licensure certificate program or CEU courses (see Center for Integrated Primary Care, University of Massachusetts Medical School) • Include working in integrated settings in MFT curriculum

Table E-1. Marriage and Family Therapist Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
settings	
<ul style="list-style-type: none"> • Need for mental health services exceeds availability of licensed mental health professionals 	<ul style="list-style-type: none"> • Utilize team models - such as Full Service Partnerships (FSPs) which utilize a multidisciplinary staff, including both peer and unlicensed staff, to provide a range of services. • Expand provision of MFT services through tele-health

SOURCES CONSULTED

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- Board of Behavioral Sciences (BBS)
 - California Association of Marriage and Family Therapists (CAMFT)
 - American Association of Marriage and Family Therapists – California Chapter (AAMFT-CA)
 - MFT Educators Consortium
 - Office of Statewide Health Planning and Development (OSHPD)
 - UCSF Center for the Health Professions
 - California Healthcare Foundation
 - Department of Labor
 - The California Public Mental Health Needs Assessment, 2009
 - Regional Partnership (Central Region)
 - U.S. News and World Report

Appendix F. Peer Support Specialists

Background Information

CURRENT SITUATION AND FUTURE NEED

In California, it is estimated that there are currently 6,000 Peer Support Specialists (PSS). PSS can provide the following services:

- Individualized support to coach wellness, resiliency and recovery
- Facilitate Wellness Recovery Action Plan (WRAP) & other Health Management groups, ex. Diabetes
- Model coping skills and self-help strategies
- Assist in development of Individualized Educational Plan (IEP) & related school-based services
- Educate, advocate & mentor families & parents in navigating systems & community services
- Liaison to services for wellness needs, community resources, groups & natural supports

These services can take place in a variety of settings including:

- Crisis Respite Houses & Crisis Residential
- Hospitals & Outpatient Programs
- Housing & Employment Programs
- Primary Care Wellness Coaching
- Wellness Centers
- Homeless Forensic Programs (AB109)
- Full Service Partnerships/Integrated Service Teams
- Peer-Run Programs

Peer Support Specialists are being used increasingly by public mental health agencies in numerous California Counties. Counties such as Alameda and Riverside have increased the role and use of PSS and found significant benefits related to patient care quality, continuity and cost. They have also been able to obtain reimbursement for services from some key payers. Based on this experience and the successful use of PSS in other states, increasing the supply of PSS can make a significant cost effective contribution to meeting mental health workforce needs in California.

PSS typically reflect the cultural, ethnic, linguistic, sexual orientation, & socio-economic diversity of the population they serve. Given the anticipated mental health workforce shortages as a result of the ACA implementation, PSS can help fill this gap while increasing diversity. The DHCS Behavioral Health Services Needs Assessment from February of 2012 projects that 33,312 Peer Support Specialists are needed to build an optimal, cost-effective recovery and resiliency workforce. Currently, there is no scope of practice, training standards, supervision standards, or state certification for PSS. With the ACA implementation it is critical to implement State PSS Certification to help reduce the mental health workforce shortage. As of September 2012, thirty-six states have established peer specialist training and most of those have state certification programs. The following link provides a detailed report on the training and certification process in those states:

<http://blogs.utexas.edu/mental-health-institute/files/2012/10/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview.pdf> (This erroneously lists CA as a state with certification and lists Recovery Innovations as the training entity which is only true in a handful of counties, not for the entire state).

Working Well Together (WWT) is an organization working toward development of a statewide certification program for PSS in California. WWT recommends the program include rigorous and standard training and testing requirements. Recommendations include:

- 80 hours of training by accredited programs with testing
- Additional 25 hours of training for specialty emphasis in whole health, forensics, co-occurring, foster care, etc.
- Continuing Education requirements for re-certification
- Lived experience with mental health challenges or family
- 6 months of full time peer specialist internship, work or volunteer

The average time from starting a training program to State Certification could be under 1 year. Sample core competencies for State Certification would include the following:

1. Wellness, Recovery, & Resiliency
2. Interpersonal Communication & Collaborative Documentation Practices
3. Professional Role Competencies (Law, Ethics, Boundaries)
4. Integrated & Whole Health Services
5. Trauma Informed & Substance Use Service Competencies
6. Diversity & Cultural Responsiveness
7. Systems Competencies & Navigation
8. Effecting Change: Education & Advocacy
9. Professional Development & Self Care
10. Wellness Coaching, Natural Supports, & Local Resources

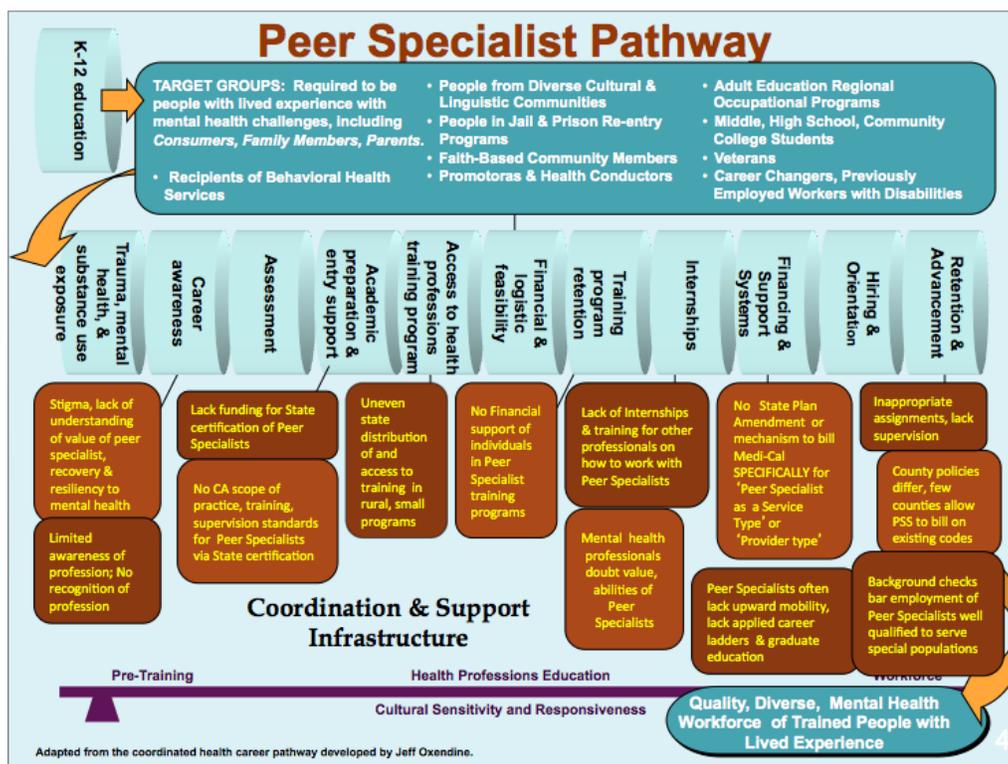
Another problem faced by PSS is that under existing Medi-Cal codes, few counties in California currently allow PSS to bill, thus it is imperative that PSS are able to bill Medi-cal throughout California. The following map shows the 31 states that where Medicaid pays for Peer Specialist.



Pathway and Components

VISUAL DEPICTION

The pathway below represents the final system pathway developed for the Peer Support Specialist in California. The barriers and recommendations developed are detailed in the following section.



BARRIERS AND RECOMMENDATIONS

Table F-1. Peer Support Specialist Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
Lack of: <ul style="list-style-type: none"> • Peer Specialist Scope of Practice • Training Standards • Supervision Standards • State Certification of Peer Specialists through Certifying Body 	<ul style="list-style-type: none"> • Adopt Working Well Together Stakeholder Final Recommendations to implement State Peer Specialists Certification • Include Consumer, TAY, Adult, Older Adult, Family member, and Parent Provider • Establish State Certifying Body
<ul style="list-style-type: none"> • Lack funding for California State Certification of Peer Specialists 	<ul style="list-style-type: none"> • Use MSHA WET dollars to fund & establish CA Peer Specialist Certification & initial funding of Certifying Body • Explore ongoing sources to fund certification expense • One source may be Certification fees paid by local agency/county
<ul style="list-style-type: none"> • No financial support for individuals in Peer Specialist training programs 	<ul style="list-style-type: none"> • Develop Peer Specialist Stipend program using MSHA WET funds to support completion of training & internships for Certification

Table F-1. Peer Support Specialist Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> Lack CA State Plan Amendment or mechanism to bill Medi-Cal for Peer Support Services as a 'Service type' or Peer Specialist as a 'Provider type' 	<ul style="list-style-type: none"> Explore ongoing sources to fund certification expense Amend State Plan to create a new Medi-Cal (Medicaid) billing 'service' & 'provider' type, specifically for Peer Support Follow-up on Federal recommendation to the state agency Develop/promote other billing mechanisms for Medicare & other payors Initiate a dialog with Exchange plan and affiliated health plans
<ul style="list-style-type: none"> Lack of recognition of Peer Support Services as a unique service 	<ul style="list-style-type: none"> Develop policy statement on peer support as distinct from other disciplines to maintain the integrity of peer specialist services (R12) Work with existing licensed professionals to ensure that the services of PSS are integrated with the behavioral health team
<ul style="list-style-type: none"> Under existing Medi-Cal codes, few CA Counties currently allow Peer Specialists to bill (under Rehab. Option, Targeted Case Management) Lack of knowledge about recovery & resiliency based documentation practices 	<ul style="list-style-type: none"> Provide CMHDA and counties training on PS job classifications, documentation practices, to allow peer specialists to bill based on promising practices in counties already securing federal reimbursement for existing codes Train staff to use collaborative documentation & CMS-approved recovery/resiliency-oriented language in documentation
<ul style="list-style-type: none"> Limited awareness of profession Lack of recognition of Peer & Family Specialist Profession 	<ul style="list-style-type: none"> Develop State Certification to legitimize profession Establish a Peer Specialist Consortium or Professional Association Fund a plan for extensive & expansive training on the values, philosophy & efficacy of peer support to MH system (R10)
<ul style="list-style-type: none"> Stigma & Discrimination 	<ul style="list-style-type: none"> Fund a plan for extensive training on the values, philosophy & efficacy of peer support to MH system (R10) Partner with CalMHSA to leverage statewide anti-stigma campaign to impact Behavioral Health professionals & service providers Employ multiple Peer Specialists in diverse programs and teams
<ul style="list-style-type: none"> Retention Barriers Work assignments outside of Peer Specialist role Lack of supervision or effective supervision 	<ul style="list-style-type: none"> Creation of a Certifying Body to collaborate with PSS/ Providers and other behavioral health professions to finalize Scope of Practice & Supervision Standards
<ul style="list-style-type: none"> Mental Health professionals doubt the value & abilities of Peer Specialists 	<ul style="list-style-type: none"> Develop a plan for welcoming environments that embrace the use of multi-disciplinary teams incorporating PSS fully (R11) Leverage statewide anti-stigma campaign to impact Behavioral Health service providers

Table F-1. Peer Support Specialist Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
	<ul style="list-style-type: none"> • Encourage MH graduate programs to cover the value, role, & integration of Peer Specialists • More exposure to Peer Specialists in psychiatric residency
<ul style="list-style-type: none"> • Lack of internships & lack of training for other professionals on how to work with Peer Support Specialists 	<ul style="list-style-type: none"> • Train other professionals on the distinctly unique role & value of Peer Specialists including cost benefit • Develop Internships in CBOs, clinics, health organizations • Incentivize internships for PSS & agencies by developing a State-funded stipend program as part of the PSS Certification process
<ul style="list-style-type: none"> • Uneven & lack of access to training programs in rural, small counties 	<ul style="list-style-type: none"> • Fund & implement statewide certification for Peer Specialists • Identify Certifying Body • Establish statewide Curriculum Standards • Implement Training Programs including exploring the use of distributed education • Ensure linguistic & cultural Access
<ul style="list-style-type: none"> • Employment background checks bar employment of Peer Specialists well qualified to serve special populations 	<ul style="list-style-type: none"> • Educate HR on alternative methods of screening for qualified peer specialists • Look at promising models from other states • Work with committees & state agencies to address civil services barriers to the employment of PSS (R15)
<ul style="list-style-type: none"> • Lack of opportunities for Peer Specialists to advance to higher paying positions 	<ul style="list-style-type: none"> • Establish certification & new reimbursement for Peer Specialist Services • Develop career ladder opportunities for peer specialists to advance into management & leadership & to cross pathways to licensed professions • Value lived experience in all behavioral health professions • Highlight/promote counties successful with ladders

SOURCES CONSULTED

- Working Well Together
- Department of Health Care Services (DHCS) Final 1115 Waiver Behavioral Health Services Needs Assessment (February, 2012) California Mental Health Prevalence Estimates:
<http://www.dhcs.ca.gov/provgovpart/Documents/California%20Prevalence%20Estimates%20-%20Introduction.pdf>
- Repper, J. & Carter, T. (2011). A Review of the Literature on Peer Support in Mental Health Services. *Journal of Mental Health*, 20(4): 392–411
- Certification of Consumer, Youth, Family & Parent Providers: A Review of the Research (March, 2012)
- WWT Certification of Consumer, Youth, Family & Parent Peer Providers: A Summary of Regional Stakeholder Meeting Findings (June, 2012)
- Draft “Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers” (June, 2013)

- Vestal, C. (2013, September 11). 'Peers' May Ease Mental Health Worker Shortage Under Obamacare. *USA Today*.
<http://www.usatoday.com/story/news/nation/2013/09/11/stateline-mental-health/2798535/>
- *Peer Specialist Training and Certification Programs A National Overview*; Kaufman, L., Brooks, W., Steinley-Bumgarner, M., Stevens-Manser, S. 2012. Peer Specialist Training and Certification Programs: A National Overview. University of Texas at Austin Center for Social Work Research.
- *The Pillars of Peer Support Services Summit IV: Establishing Standards for Excellence, The Carter Center, Atlanta, GA, September 24-25, 2012*; Daniels, A. S., Tunner, T. P., Bergeson, S., Ashenden, P., Fricks, L., Powell, I., (2013), Pillars of Peer Support Summit IV: Establishing Standards of Excellence, www.pillarsofpeersupport.org ; January 2013.
<http://www.pillarsofpeersupport.org/POPS2012.pdf>

Appendix G. Psychiatric Mental Health Nurse Practitioner – Clinical Nurse Specialist

Background Information

CURRENT SITUATION AND FUTURE NEED

Advanced practice registered nurses (APRNs) are nurses who have received education beyond their initial registered nurse (RN) education to work in a specialized role in the delivery of health care services, preparing him/her for one of the four recognized APRN roles.

APRNs are prepared in master's-degree programs that often carry a credit load equivalent to doctoral degrees in the other health professions. An APRN has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care and has clinical experience of sufficient depth and breadth to reflect the intended license.

In the United States there are four types of APRNs:

- Certified Nurse Midwives (CNM)
- Certified Registered Nurse Anesthetists (CRNA)
- Clinical Nurse Specialists (CNS): bring specialized knowledge about the patient population, the environment, and disease management
- Clinical Nurse Leader (CNL)

The CNL is an advanced clinician with education at the master's degree level, but not prepared as an advanced practice registered nurse as the APRN is currently defined. The CNL is a Generalist that oversees the lateral integration of care for a distinct group of patients and may actively provide direct patient care in complex situations (California Board of Registered Nursing <http://www.rn.ca.gov/pdfs/forms/survey2010cns.pdf>, American Association of Colleges of Nursing <http://www.aacn.nche.edu/cnl/frequently-asked-questions>).

California has experienced a prolonged shortage of psychiatrists (California Health Care Foundation, CA Health Care Almanac Regional Markets <http://www.chcf.org/almanac/regional-markets>). Nearly 30 percent of physicians are over 60 years old - a higher percentage than any other state (CIMH, Jarvis and Freeman Briefing Paper 4: Workforce Issues Today and in the Future Workforce Implications of Increased Demand for Mental Health and Substance Use Service, June 2012). There is an increased demand for integrated services that are multi-culturally responsive. Specifically, there is a need for more culturally responsive and competent provider practices to engage underserved populations. Finally, healthcare nursing professionals are not adequately prepared to work in community-based mental health/behavioral health settings. The addition of APRNs and CNLs would positively impact all of these shortage areas.

The shortage of Registered Nurses (RNs) experienced in California is well documented. According to the "United States Registered Nurse Workforce Report Card and Shortage Forecast" published in the January 2012 issue of the American Journal of Medical Quality, a shortage of registered nurses is projected to spread across the country between 2009 and 2030. In this state-by-state analysis, the authors forecast the RN shortage to be most intense in

the South and the West. (American Association of Colleges of Nursing, Nursing Shortage Facts Sheet <http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage>)

While experts interviewed indicated that it was “difficult” to estimate specific numbers of APRN’s needed for successful implementation of the Patient Protection and Affordable Care Act (PPACA) the changing demands of this nation's complex healthcare environment require the highest level of scientific knowledge and practice expertise to assure quality patient outcomes (California Institute for Mental Health, Jarvis <http://www.cimh.org/LinkClick.aspx?fileticket=qYRw198CQAo%3D&tabid=36>).

According to the National Association of Community Health Centers report *Building a Primary Workforce for the 21st Century*:

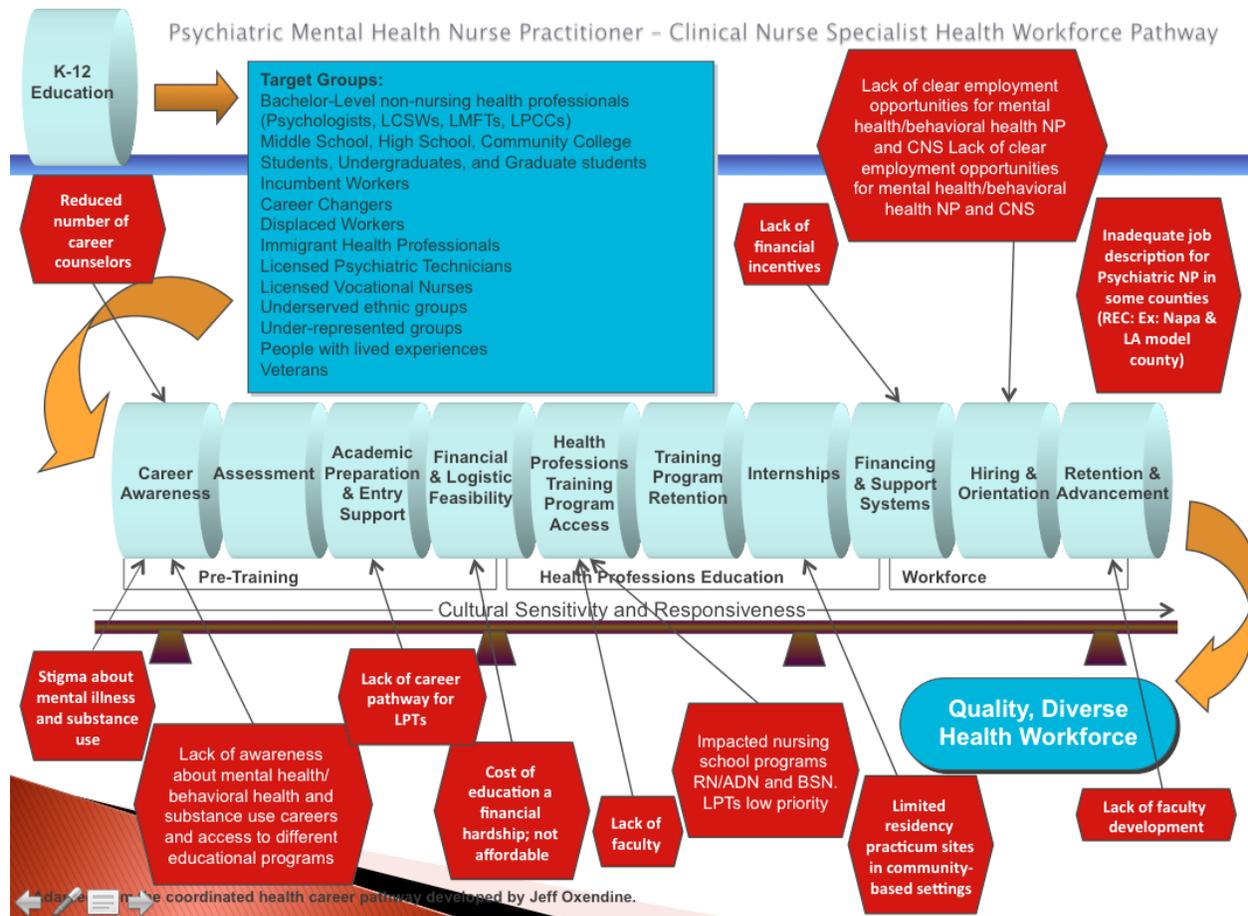
- Health centers are increasingly challenged to meet their primary care workforce need. Health centers currently need 1,843 primary care providers, inclusive of physicians, nurse practitioners, physician assistants, and certified nurse midwives. On top of this need, they are 1,384 nurses short;
- To reach 30 million patients by 2015, health centers need at least an additional 15,585 primary care providers, just over one third of whom are non-physician primary health care providers. Health centers also will need another 11,553 to 14,397 nurses;
- To reach 69 million patients, health centers will need at least 51,299 more primary care Providers over the current number, as well as an additional 37,981 to 44,522 nurses.

An increased number of APRNs will significantly help to fill these large shortages and increased demand for nurses in health and mental health. Increasing the role and supply of the Psychiatric Mental Health Nurse and Clinical Nurse Specialist are key to meeting mental health needs and advancing integration of primary care and mental health. The following pathway and recommendations will increase the supply, distribution and diversity of Psychiatric Mental Health Nurses in California.

Pathway and Components

VISUAL DEPICTION

The pathway below represents the final system pathway developed for Psychiatric Mental Health Nurse Practitioner – Clinical Nurse Specialists in California. The barriers and recommendations developed are detailed in the following section.



BARRIERS AND RECOMMENDATIONS

The barriers identified in the pathway model are addressed below, accompanied by recommendation(s) to address these barriers.

Table G-1. Psychiatric Mental Health Nurse Practitioner – Clinical Nurse Specialists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> NPs not able to practice independently to the full extent of their education and training 	<ul style="list-style-type: none"> Allow APRNs to practice independently to the full extent of their training and education. Enact SB 291. Develop formal collaborative consulting relationship between NPs and Psychiatrists, with clear and established set of protocols that allows the NPs to practice independently to the full extent of their education and training
<ul style="list-style-type: none"> Limited nursing school clinical practicum sites and internships available within community-based MH/BH settings 	<ul style="list-style-type: none"> Increase internship sites for nursing students and develop transition-to-practice residency for APRNs/DNPs within community based sites and underrepresented multicultural specific for APRNs and DNPs EX: Pacific Clinics Nursing Bridge model

Table G-1. Psychiatric Mental Health Nurse Practitioner – Clinical Nurse Specialists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> Lack of career pathway from psychiatric technician (PT) to registered nurse (RN) arena 	<ul style="list-style-type: none"> Develop higher education/career pipeline from PT to RN/ADN-BSN EX: Pacific Clinics Nursing Bridge Model Enhance collaboration between BRN and BVNPT , and nursing schools to develop standardized PT to ADN curriculum
<ul style="list-style-type: none"> Cost of education not affordable to potential nursing students, and a financial hardship to nurses who have previous education loans 	<ul style="list-style-type: none"> Develop financial incentive programs for nursing students, such as scholarships, stipends, and loan forgiveness/repayment programs
<ul style="list-style-type: none"> Lack of awareness of faculty development for mental health/behavioral health Lack of nursing faculty to precept/supervise students in community-based MH/BH settings Lack of APRNs working within the community-based MH/BH arenas to lend experience as nursing faculty 	<ul style="list-style-type: none"> Collaboration between Health Workforce Centers , DMH, CBOs and other organizations to develop, market, and offer faculty development opportunities Create post-certification residency with stipends to extern at a community-based MH/BH settings working with underserved communities Provide faculty leadership development/training to APRNs within community-based MH/Behavioral Health sectors Develop financial incentive programs such as loan forgiveness and stipends combined with commitment to employment in MH/BH settings
<ul style="list-style-type: none"> Limited number of psychiatrists' to provide supervision to NPs which limits client/consumer service access and efficiency within the community 	<ul style="list-style-type: none"> Enact SB 491 in its original intent: allow NPs to practice independently to the full extent of their education and training Modify supervisory relationship to formal collaborative consulting relationship between NPs and Psychiatrists, which will allow for more independence in practice for NPs with little reliance on Psychiatrists – will enhance service access to consumers/clients Develop and provide a supervisory/preceptor training program for psychiatrists Recruit psychiatrists

SOURCES CONSULTED

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Appendix H. Psychiatrists

Background Information

CURRENT SITUATION AND FUTURE NEED

Presently, there are 6,682 Psychiatrists in California. According to the Bureau of Labor Statistics (BLS), 4,540 psychiatrists were employed as of May 2012. 68% of psychiatrists in California are white, 15% are Asian/Pacific Islanders, and less than 5% are Hispanic. The overall trend in the U.S. shows a greater portion of psychiatrists approaching retirement age and a smaller proportion of psychiatrists in the younger age groups.

In 2002, 21% of California psychiatrists practiced in public settings. 36% of payment for psychiatry services was through public insurance programs and less than 4% of care was uncompensated.

California is experiencing regional challenges related to the supply of psychiatrists. Alpine, Amador, Calaveras, Colusa and Placer Counties do not have a psychiatrist. In contrast, Los Angeles has the most psychiatrists, 1,772. In 2001 there were 700 Child Psychiatrists in California, (7.6/100,000 youth). The stated need in 2006 was 14.38/100,000. Presently, the need for direct psychiatric care, excluding children and adolescents in California, is estimated to be 16.6 Psychiatrists per 100,000 people. However, there are only 10 licensed psychiatrists per 100,000 people in California.

The educational requirements for a Psychiatrist are very significant. A candidate must attend 4 years of undergraduate school, followed by 4 years of Medical School, 4 years of Psychiatry Residency (3 years if becoming a Child Psychiatrist, which totals 5 years.)

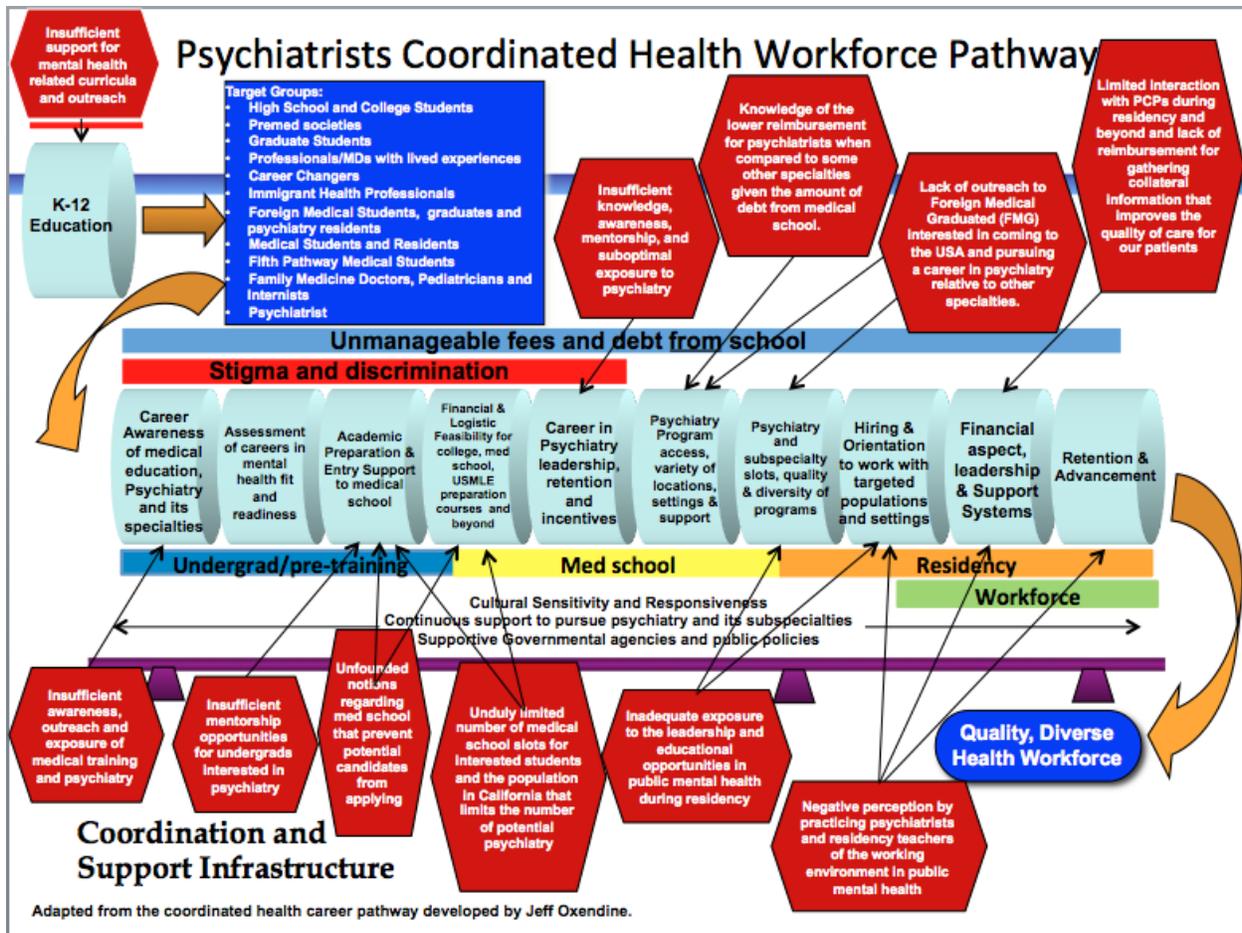
Presently, the existing education and training capacity in California shows that there are 132 slots for psychiatric residency and that 129 of those slots were filled.

The expansion of mental health coverage under the ACA implementation will increase the demand for psychiatric services. The pathway and recommendations in the next sections can lead to an increase in the supply, distribution and diversity of psychiatrists to meet the growing need.

Pathway and Components

VISUAL DEPICTION

The pathway below represents the final system pathway developed for Psychiatrists in California. The barriers and recommendations developed are detailed in the following section.



BARRIERS AND RECOMMENDATIONS

The barriers identified in the pathway model are addressed below, accompanied by recommendation(s) to address these barriers.

Table H-1. Psychiatrists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> Stigma and Discrimination in K-12 	<ul style="list-style-type: none"> Fund develop and distribute anti-stigma and discrimination educational programs at schools for students, teachers and families and targeted at children and adolescents
<ul style="list-style-type: none"> Insufficient support for mental health related curricula and outreach in K-12 schools and other settings: Insufficient mental health services and outreach in schools to students and families Insufficient knowledge by school counselors about the career pathways to medicine and other mental health disciplines. 	<ul style="list-style-type: none"> Enhance early intervention for children and adolescents at risk for mental health issues by improving service delivery at schools Require Behavioral Sciences as a course in high school. Train vocational school counselors in career pathways in medicine and increase student’s access to career counselors Psychiatric presence in science focused career fairs.

Table H-1. Psychiatrists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> • Behavioral Sciences options are limited in school curriculums • Insufficient bilingual or English immersion programs that expose English learners to science enriched curriculums • Insufficient knowledge of resources available to attend college among students and their families • Mental health clinics do not have a psychiatrists on campus 	<ul style="list-style-type: none"> • Science and mental health focused career fairs for minority students with bilingual professionals as participants
<ul style="list-style-type: none"> • Insufficient support for mental health related curricula and outreach in K-12 schools and other settings 	<ul style="list-style-type: none"> • Enhance shadowing opportunities, internships and mentorships for high school students interested in psychiatry (If student from underserved community, ideally the mentor should be from the same area.) • Enhance bilingual science courses, K-12 • Enhance family and children Peer Model programs. • Enhance anti bullying programs by including psychiatry • Enhance dual diagnosis programs at schools • Infuse curriculum and opportunities for exposure to students in health academies • Use tele-communication to enhance awareness and outreach at schools • Have psychiatrist's treat kids in their natural environment(s)
<ul style="list-style-type: none"> • Stigma and Discrimination in colleges/undergrad 	<ul style="list-style-type: none"> • Anti-stigma and discrimination educational programs at colleges for students, teachers and families • Anti-stigma and discrimination marketing campaigns targeted at college students • Use youth peers and/or celebrities with lived experience to provide marketing for psychiatry
<ul style="list-style-type: none"> • Insufficient awareness, outreach and exposure of medical training and psychiatry in colleges: • Absence of Behavioral Science requirements for the UC and CSU systems • Insufficient awareness of careers in psychiatry • Insufficient outreach to minority students and to community colleges in underserved 	<ul style="list-style-type: none"> • Add a Behavioral Science requirement for the UC and CSU systems for med school entrance • Increase awareness of job opportunities and need for psychiatrists in California, especially the need for psychiatrists who are bilingual and bicultural • Enhanced rewards for work in public mental health settings

Table H-1. Psychiatrists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
<p>areas</p> <ul style="list-style-type: none"> • Insufficient outreach of careers in psychiatry to psychology majors or others interested in the mental health field • Insufficient outreach of careers in psychiatry to students with lived experiences attending student health clinics • Insufficient knowledge of the academic preparation needed to get into medical school 	<ul style="list-style-type: none"> • More psychiatric presence at college career fairs • Improve dissemination of medical school requirements and avenues of admission.
<ul style="list-style-type: none"> • Stigma and discrimination regarding psychiatry training in medical school 	<ul style="list-style-type: none"> • Enhance integration and increase participation of psychiatry in early medical student education
<ul style="list-style-type: none"> • Insufficient mentorship opportunities for undergrads interested in psychiatry 	<ul style="list-style-type: none"> • Identify people with lived experiences who are interested in psychiatry and provide peer support and career mentorship • Offer support for psychiatry specific internships and mentorship opportunities in underserved and/or public mental health settings • Increase support for mental health research and service focused summer externships and internships that will support college tuition
<ul style="list-style-type: none"> • Unfounded notions regarding med school: The notion that medical school is inaccessible to most students including underrepresented minority college students. 	<ul style="list-style-type: none"> • Enhance education regarding medical school admission, requirements, attainability and medical student lifestyle to college student with an emphasis to minority students and community colleges in underserved areas
<ul style="list-style-type: none"> • Unduly limited number of medical school slots for interested students and the population in California 	<ul style="list-style-type: none"> • Increase medical school slots in CA by increasing the number of slots in current medical schools or opening new medical schools in underserved areas • Add satellite medical schools in underserved areas that could offer onsite or distance learning • Support ethnic specific internships/clerkships/rotations in underserved areas • Offer loan forgiveness to medical students willing to enter psychiatry and work in an underserved area
<ul style="list-style-type: none"> • Increasingly unmanageable fees and debt assumption for college and medical school 	<ul style="list-style-type: none"> • Decrease the direct costs of medical school through increased student support

Table H-1. Psychiatrists Pathway Barriers and Recommendations

BARRIER	RECOMMENDATION
	<p>and teaching efficiency</p> <ul style="list-style-type: none"> • Increase dedicated teaching activities in psychiatry to faculty receiving indirect state funds • Emphasize activities in psychiatry that are clinical service and teaching oriented that allocate state funding appropriately • Shortened or fast track route to medical school and service requirement if going into mental health service • Enhance state funding to increase and improve teaching psychiatry for medical school
<ul style="list-style-type: none"> • Insufficient knowledge, awareness, mentorship, and suboptimal exposure to psychiatry during medical school: <ul style="list-style-type: none"> • Inadequate awareness of psychiatry as a profession especially in the field of public mental health. • Insufficient availability of mentorship from psychiatric and minority leaders during medical school. • Variability of quality of medical student rotations. • Perception by some of a relative lack of scientific and evidence based psychiatric practices. 	<ul style="list-style-type: none"> • Enhance mentorship opportunities with psychiatry and minority leaders • Enhance the quality of medical student rotations by offering rotations with enhanced supervision and career mentorship guidance by senior psychiatric department members • Increase promotion of medical student interest groups such as PsychSIGN, AMSA, and AMA student groups • Improve psychiatry education during medical school to reflect scientific and evidence based practices currently in use. • Enhance integration of a mind-body curriculum with focus on psychosomatic illnesses and consultation liaison medicine early on during med school.

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