

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

Report 3 – Analysis of County-Reported Public Mental Health Workforce Needs

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Planning and Development

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Executive Summary

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

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

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

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

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

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

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

This report, *Report 3 – Analysis of County-Reported Public Mental Health Workforce Needs*, provides a picture of the public mental health workforce needs as identified by the state’s county mental health departments. This report identifies county strategies used to fill those needs, and county feedback on statewide WET programs and more specifically contains: 1) summary of surveys identifying county-reported mental health workforce needs, and 2) an analysis of county annual updates WET sections.

County-Reported Needs

Understanding county mental health departments’ reported workforce, education, and training needs is critical to assessing the state’s overall workforce needs and to developing the WET Five-Year Plan, this report outlines county mental health departments’ reported workforce needs from three sources: 1) the county-reported needs assessment conducted in July 2013; 2) a county follow-up survey conducted in October 2013; and 3) an analysis of the county annual updates. Each of the three sources provides a distinct perspective on county-reported workforce needs.

The County-Reported Needs Assessment, conducted by OSHPD in July 2013, surveyed county mental health departments about their current workforce needs. The survey asked questions in regards to the counties’ highest workforce needs, workforce shortages, hard-to-fill and hard-to-retain positions, diversity needs, and declining workforce needs. The Needs Assessment also solicited feedback on each of the statewide WET programs. These Needs Assessments were completed by 41 counties and provided details regarding their counties’ major workforce needs and perspectives on the statewide WET programs.

The OSHPD WET Needs County Follow-Up Survey was administered in October 2013 to solicit further information about county workforce needs. While the original needs assessment asked counties to list their highest need positions, the OSHPD WET Needs County Follow-Up Survey asked counties how they currently cope and compensate for vacancies. Completed by 24 counties, the OSHPD WET Needs County Follow-Up Survey data serves as a window into how counties strategize around current workforce shortages.

Welfare and Institutions Code (WIC) 5847(a) requires that County mental health programs prepare an Annual Updates, providing updates on individual county MHSA programs and expenditures. For counties that allocated WET funds and planned WET programs, the MHSA Annual Updates provided a picture of current county-driven activities to enhance their mental health workforce.

Together, these three sources provide the most comprehensive sources to date on California's county-reported mental health workforce needs. Their corresponding reports identify key workforce needs, current strategies to cope with those needs, feedback on WET programs, and county-driven programs to develop their mental health workforces.

In an effort to understand how geography and regional trends may be related to workforce needs, findings were analyzed by MHSA region and county size. Regional and county size trends can help to identify targeted workforce needs and strategies.

Key Findings

Across MHSA regions and county sizes, a clear picture of the state's highest workforce needs emerged. Some of these findings include:

- ***Psychiatrists were identified as the highest workforce shortage, and hard-to-fill, hard-to-retain occupation.*** This pattern was consistent within each MHSA region and across all county sizes. Additionally, Psychiatrists with child/adolescent specialties ranked as the second highest workforce need across the state. Other noted workforce needs across the state included Licensed Clinical Social Workers, Marriage and Family Therapists, and Psychologists.
- ***The Superior region, small counties, and medium counties reported bilingual capabilities as a workforce diversity need more frequently than other regions or other county sizes.*** While this region and small and medium counties have the state's smallest concentrations of minority populations, these areas reported important needs to serve their diverse population.
- ***Counties reassigned duties to existing staff in similar/same positions to compensate for current workforce shortages.*** This strategy puts increased demands on existing staff, and could potentially lead to burnout and lower retention.
- ***Large counties had the highest utilization rates of current WET programs, including the Stipends, Mental Health Loan Assumption Program, and Residency programs.*** Small and medium-sized counties had lower WET program utilization rates. This may be due in part to the dependency on access to schools and students for some of the WET programs.

- **Reported workforce needs do not intuitively align with counties' participation in statewide WET programs.** (Note: This may also indicate that there were no WET program awardees in those counties which reported low WET program participation.) Although Psychiatrists were most frequently reported as the state's highest workforce need, only 20% of counties reported use of the Psychiatric Residency program. This pattern also applied to Psychiatric Mental Health Nurse Practitioners, which were also reported as high workforce needs but whose participation in WET programs is low. This may indicate that counties lack the resources to implement or take advantage of these programs, and that more immediate assistance may be needed to help meet workforce needs.

Frequently Used Acronyms and Abbreviations

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

Table 1: Frequently Used Acronyms and Abbreviations

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

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



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

Section 1: Summary of County-Reported Public Mental Health Workforce Needs Assessment Survey

In June 2013, OSHPD asked the California counties' MHSA program staff to complete a survey that provides an assessment of their public mental health workforce needs. This section of the report provides a summary of the workforce needs as identified in all of the County-Reported Public Mental/Behavioral Health Workforce Assessments Survey. The assessment contained several data points including: workforce shortages by occupational category, workforce demands that have been met and/or declined, hard-to-fill and hard-to-retain positions, diversity needs, language needs, and current opportunities for consumer and/or family members in the workforce. The County-Reported Public Mental/Behavioral Health Workforce Needs Assessments also provided county-level participation data in the five statewide WET programs: 1) Stipend programs, 2) the Mental Health Loan Assumption Program, 3) the Song-Brown Physician Assistant Residency Program, 4) the Psychiatric Residency Program, 5) Regional Partnerships, and 6) the Client and Family Member Statewide Technical Assistance Center (Working Well Together). RDA analyzed each set of data (1) at the state level as a whole; (2) by MHSA Region; and in addition, (3) by county size cohort based on the 2012 Census Bureau population sizes and MHSA designated size thresholds.² See Appendix 2 for a complete list of counties by region and by county size.

Limitations

A primary limitation of this data source is that only 41 of the 59 California counties and municipalities (representing 89% of California's population) submitted the Workforce Needs Assessment. Secondly, among those that did submit the Assessment, reporting styles differed in thoroughness and consistency. As such, RDA undertook a number of measures to synthesize county responses while retaining as much of the diversity in responses as possible. Third, counties reported their workforce needs in the Assessment, but did not provide descriptions of their current workforce.

Methodology

County-Reported Public Mental/Behavioral Health Workforce Needs Assessment responses were transcribed from individual reports into a single spreadsheet, capturing virtually all of the

² http://www.mhsoac.ca.gov/Evaluations/docs/Eval_PriorityIndicators_SmallCountiesList.pdf
<http://quickfacts.census.gov/qfd/index.html>

responses. The methods for analyzing the data are discussed in this section and briefly re-introduced in the relevant sections where the data is used.

OSHPD Occupational Categories

Several of the questions in the Needs Assessment asked county respondents to utilize a list of OSHPD designated occupational categories (see Appendix 3 for the complete list). However, counties frequently diverged from the list. For example, when asked to provide a list of the county's top seven workforce shortages in order of highest need, counties often listed multiple positions in one rank. In this example, if a county wrote next to Highest Need 1, "Child Psychiatrist, Geriatric Psychiatrist, and Licensed Clinical Social Worker," all three of these positions were classified as a first highest need, and thus the total response count exceeds 41 (the number of Needs Assessments returned to OSHPD).

A second frequent issue was that while the OSHPD list of occupational categories was extensive, counties often used variations of the occupational categories that were slightly ambiguous. For example, OSHPD provided two nurse designations: (1) Clinical Nurse Specialist, and (2) Psychiatric Mental Health Nurse Practitioner. Counties frequently cited "Registered Nurse," or "Mental Health Nurse," or simply "Nurse." After consulting experts in mental health professions and reviewing previous approaches to these designations, RDA chose to group all "Nurse Practitioner" listings under the Psychiatric Mental Health Nurse Practitioner category; and all other nurse designations (without the specific practitioner capacity) as a new category "Nurse, Other."

Another common aspect of the data was that counties frequently included diversity classifications in responses to occupational categories. For example, in listing a workforce shortage, "Bilingual Psychiatrist" or "Spanish-speaking Psychiatrist" was a common response. RDA created categories for Bilingual and Spanish to track how frequently counties cited these as specific needs.

In some instances, county-reported responses did not appear to answer the listed question, suggesting a misinterpretation. For example, one county listed the same set of five positions for the highest need positions and declining demand positions. In cases such as these, RDA excluded the answers for the analysis of these questions. Few of these cases were encountered during this step, and thus did not have a significant impact on the results of this analysis.

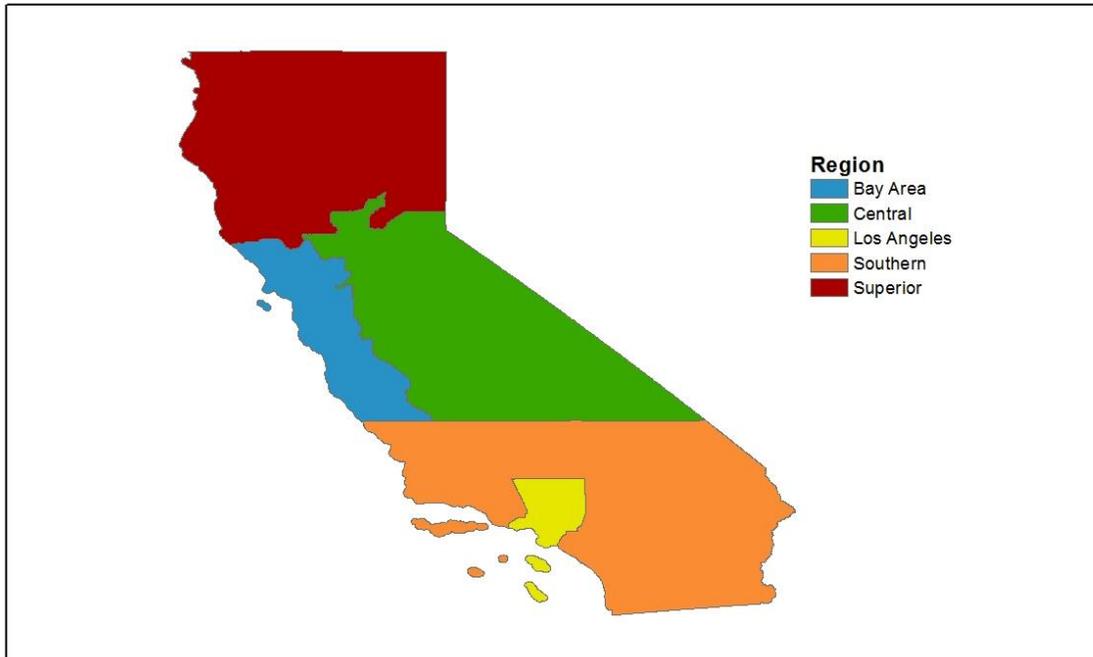
MHSA Regions & County Sizes

This report will present the data through three different analytical cross-sections: (1) across all counties in California as an aggregate; (2) by MHSA region; and (3) in cohorts based on county size. A full breakdown of counties' distribution within region and designated county sizes can be found in Table 32 in the appendix.

MHSA Regions

The MHSA program divides California's counties into five regions: Bay Area, Central, Los Angeles, Southern, and Superior. The MHSA Los Angeles region includes only Los Angeles County and therefore the type of figures used to illustrate the data for Los Angeles Region in this report is different than the other regions which all contain more than one county. Figure 1 shows the geographic distribution and boundaries of the five MHSA regions.

Figure 1: California MHSA Regions



County Sizes

This report will also present an analysis of cohorts based on county size; these cohorts are determined by 2010 total population for each county: large counties are those with greater than 800,000 persons; medium counties have between 200,000-800,000 residents; and small counties are those with less than 200,000 persons. In 2010, one-half of California's counties had populations under 200,000 persons.

Figure 2: California County Sizes Distribution (n=59)

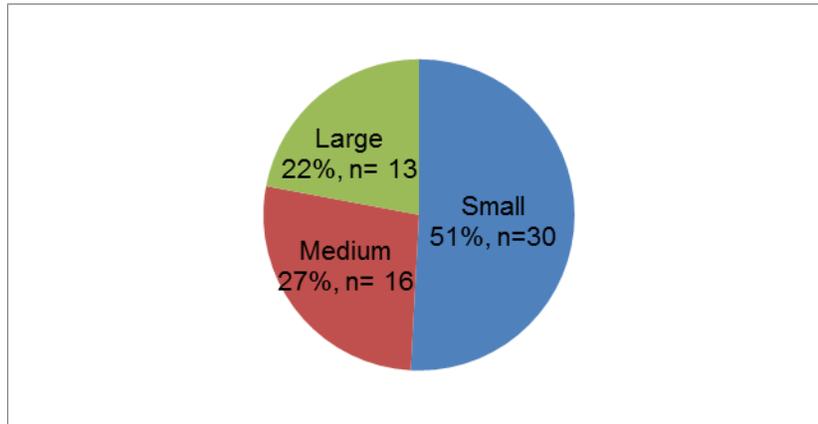


Table 2: MHSA Regions by County Size

MHSA Region	Small	n*	Medium	n*	Large	n*
Bay Area	23%	3	46%	6	31%	4
Central	58%	11	32%	6	11%	2
Los Angeles	--	--	--	--	100%	1
Southern	10%	1	30%	3	60%	6
Superior	94%	15	6%	1	--	--
Total	51%	30	27%	16	22%	13

* n equals the number of counties in each region.

Table 2 shows the distribution of county sizes across each MHSA Region. Both MHSA Central and Superior Regions are predominantly comprised of small counties. Both MHSA Bay Area and Southern Regions have more equal quantities of each-sized counties. The MHSA Los Angeles Region is made up of one very large county with a population of 9.96 million.³ The last row in the table notes the distribution of county sizes across the state – one-half of California’s counties are small, and the remaining are split between medium and large counties.

Workforce Needs

Workforce Shortages

The following data on workforce shortages are derived from the County-Reported Needs Assessment section on Existing and Future Mental/Behavioral Health Workforce Shortages. Counties were prompted to list the top seven mental/behavioral workforce shortages in their county, ranked in the order of highest need. The highest need position was analyzed separately, while the needs ranked two through seven were grouped under the category “Other Needs.” Counties were asked to draw from the list of occupational categories provided by OSHPD, but

³ <http://quickfacts.census.gov/qfd/states/06/0644000.html>

as discussed in the Methodology section above, RDA also added categories such as Bilingual, Nurse, Other, and Spanish, in order to account for common additional responses.

Overall Trends

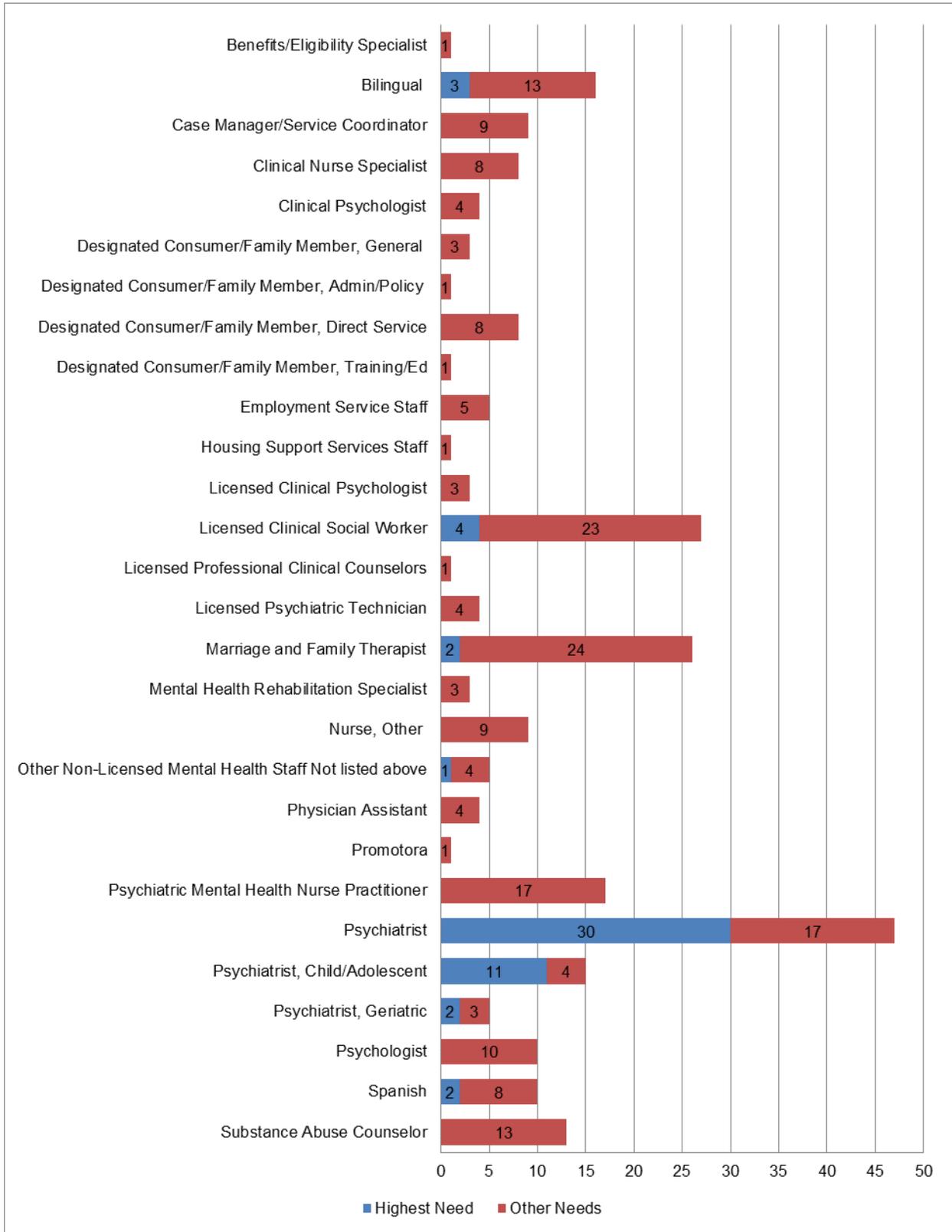
Figure 3 depicts the total count of the times any county reported a position as a workforce shortage, and specifies whether the position was reported as a “Highest Need” or “Other Need.” Overall, Psychiatrists, Licensed Clinical Social Workers (LCSWs), and Marriage and Family Therapists (MFTs) were the most commonly reported workforce shortage. Psychiatrists far outpaced any other reported statewide need, with counties reporting a need for Psychiatrists (without specifying an age group), child/adolescent Psychiatrists, and Geriatric Psychiatrists a total of 67 times out of 295 responses. Psychiatrists were also most frequently ranked as the highest need position, cited a total of 47 times out of the 67 responses across these three categories.

A “second tier” of shortages was represented by LCSWs and MFTs, each cited over 25 times, with several counties indicating these as their highest need. Psychologists, Clinical Psychologists, and Licensed Clinical Psychologists were also cited a total of 17 times. Psychiatric Mental Health Nurse Practitioners and Substance Abuse Counselors were each cited at least 10 times, though not as highest need positions.

Needs for bilingual (language not specified) and Spanish-speaking mental health workers were also each reported at least 10 times, with several counties indicating this as their highest need. Designated Consumer and/or Family Member positions were cited as shortages a total of 13 times, with the most frequently-reported position type as direct services.

The least-cited positions included Benefits/Eligibility Specialists, Housing Support Services Staff, Licensed Professional Clinical Counselors (LPCC), and Promotoras. It should be noted that LPCC are a fairly new profession that many counties have not begun using yet and thus they have not been identified as a high need.

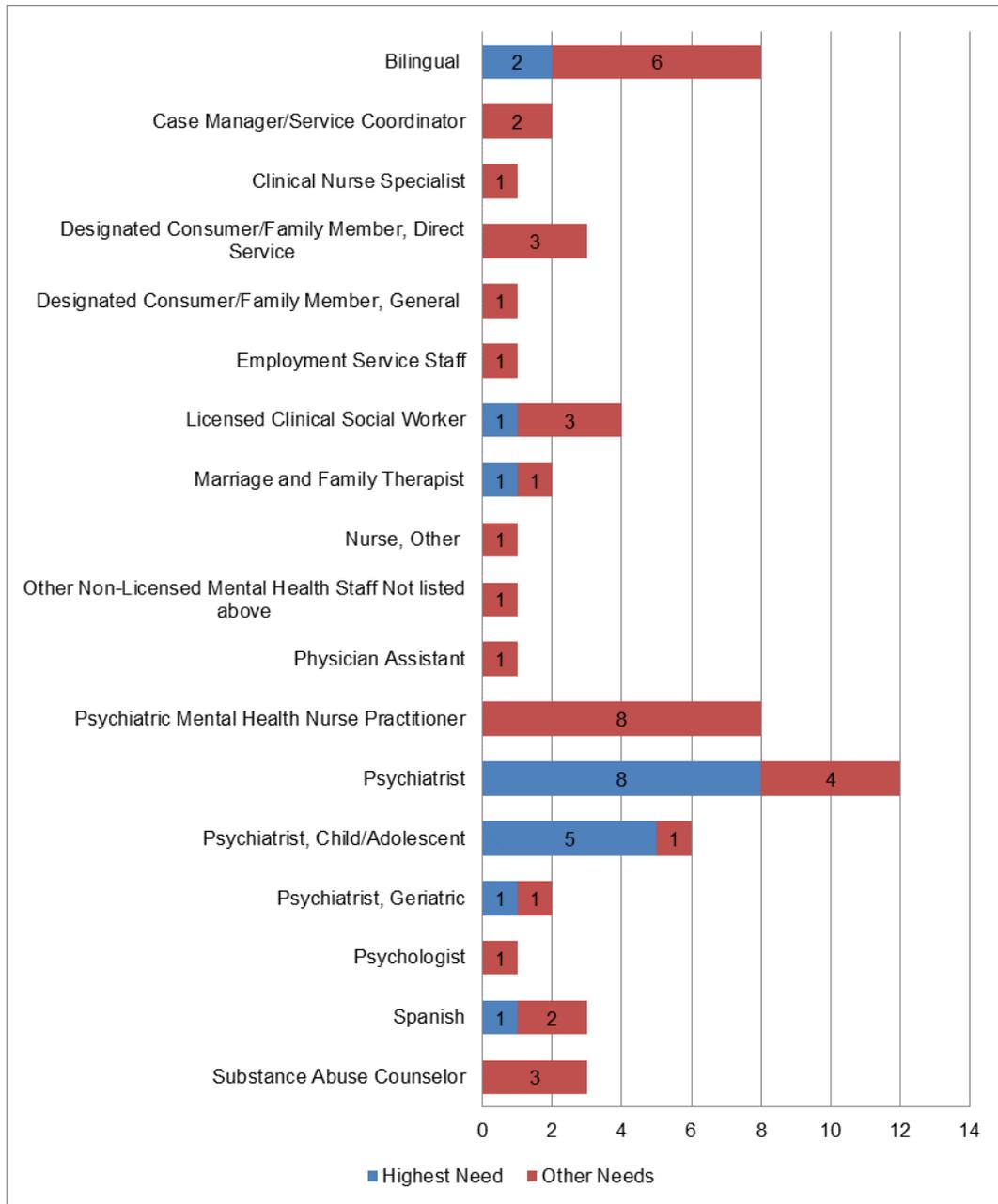
Figure 3: Statewide Trends in Workforce Shortages (n=41 counties)



Shortage Trends by Region

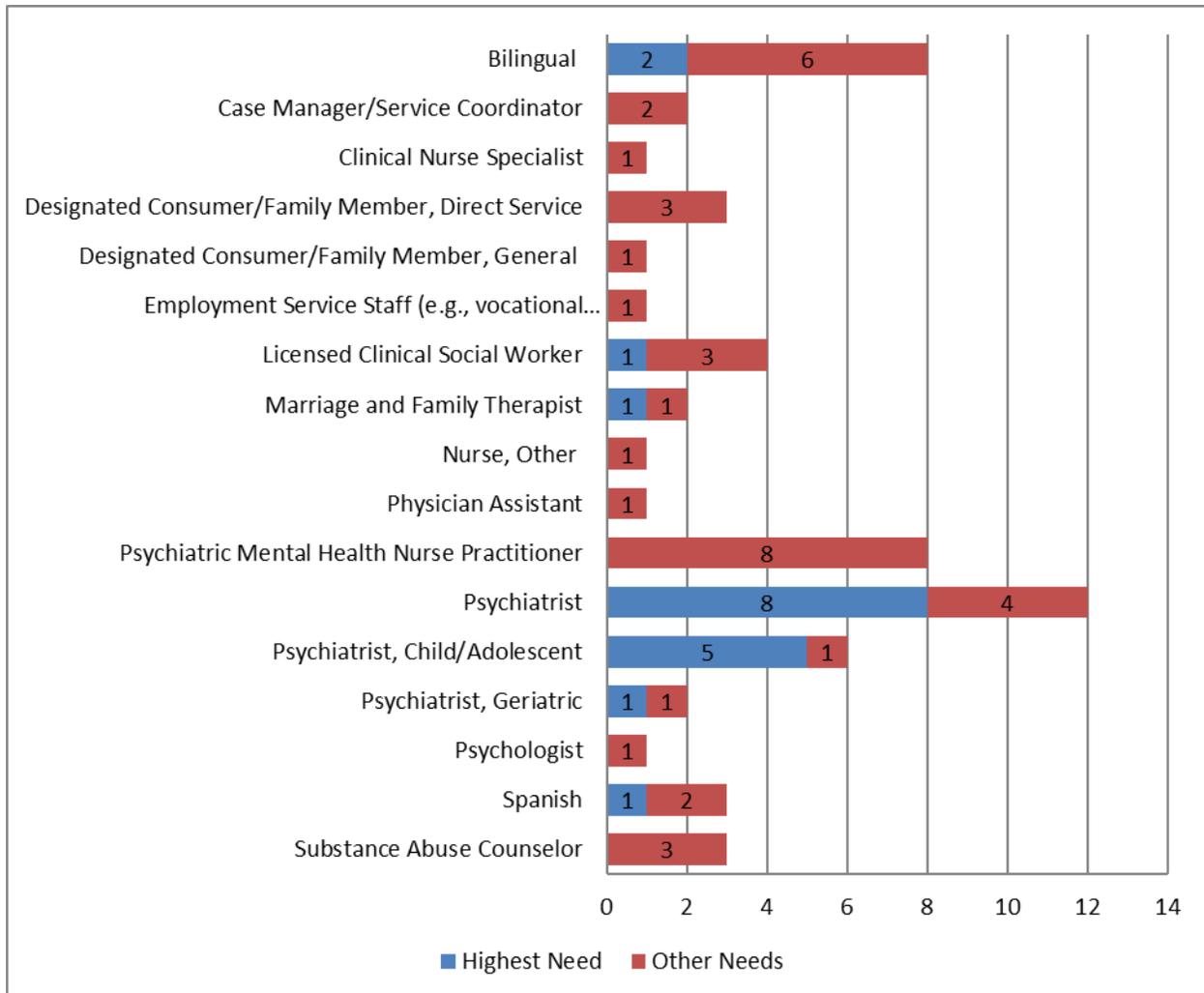
In the following section, workforce shortages are analyzed by region. While Psychiatrists were consistently the highest frequency and highest need position across regions, there were nuances at the “second tier” of demands, and among the lower-ranked positions. Diversity needs for bilingual and Spanish-speaking staff and needs for Designated Consumer and/or Family Member position also differed by region.

Figure 4: Bay Area Region Workforce Shortages (n=9)



In Figure 4, workforce shortages reported by Bay Area region counties are depicted by highest and other needs. Similar to the statewide trend, Bay Area counties identified Psychiatrists and Child/Adolescent Psychiatrists as their highest need workforce shortages. Also reflective of statewide trends, LCSWs and MFTs fell within a second tier of commonly-reported shortages. Bilingual and Spanish-speaking also made up a large proportion of reported needs in this region.

Figure 5: MHSA Central Region Workforce Shortages (n=16)



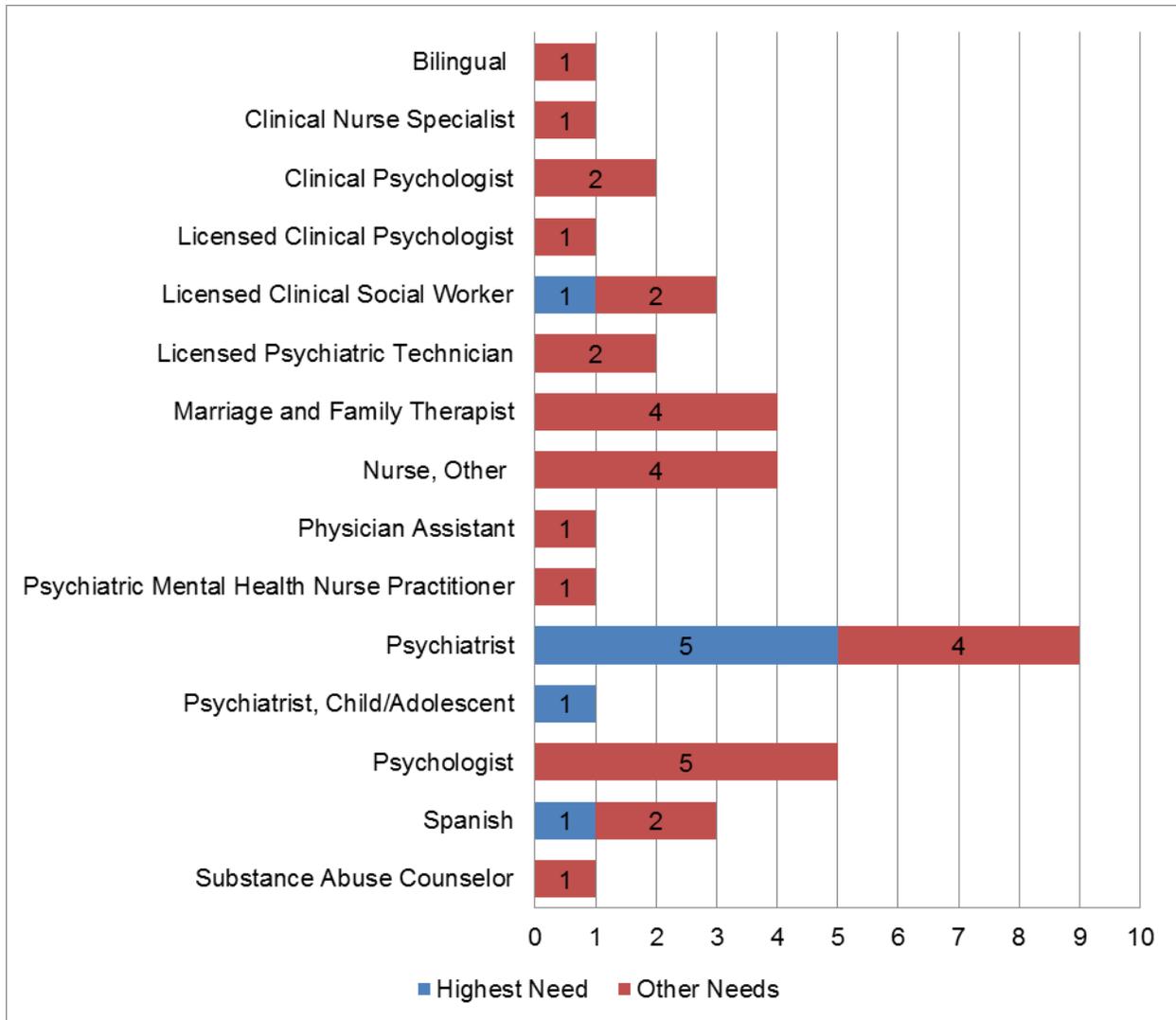
In the MHSA Central region, again Psychiatrists and Child/Adolescent Psychiatrists constituted the highest need and most frequently cited workforce shortages, followed by LCSWs, MFTs, Psychiatric Mental Health Nurse Practitioners, and Psychologists (including Clinical and Licensed Clinical Psychologists). Designated Consumer and/or Family Member positions in the Direct Service and General categories were also reported with some frequency, as were Substance Abuse Counselors, Clinical Nurse Specialists, bilingual and Spanish-speaking staff, and Case Managers/Service Coordinators.

Table 3: MHSA Los Angeles Region Workforce Shortages (n=1)

Los Angeles Region Workforce Shortages (in order of rank)
1. Psychiatrist, Child Psychiatrist, Geriatric Psychiatrist, Addiction Psychiatrist, Psychiatric Mental Health Nurse Practitioner
2. Clinical Supervisors
3. Licensed Clinical Social Worker/Marriage and Family Therapist/Community Mental Health Psychologist
4. Other MH Therapist (Licensed Vocational Nurse, Marriage and Family Therapist, LPCC)
5. Advocates and Stigma Reduction Staff (Peers, Parent and Family Members)
6. Integrated Care/Housing/Employment Specialists
7. Substance Abuse Counselor

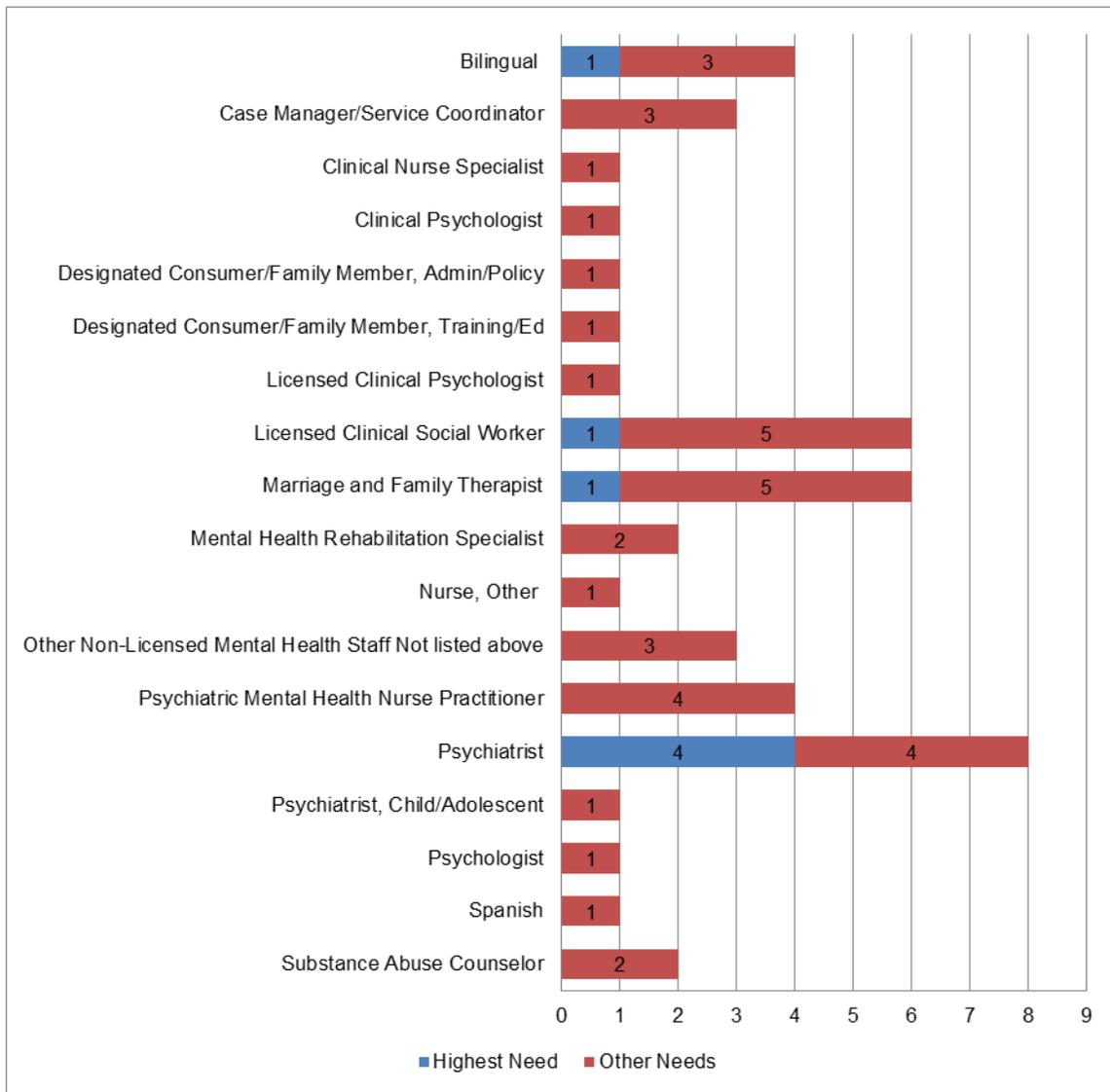
Los Angeles region reported seven total workforce shortages; reporting the greatest shortages in positions that furnish medication including Psychiatrists (both general and specialty) and Nurse Practitioner.

Figure 6: Southern Region Workforce Shortages (n=8)



In the MHSA Southern region, workforce shortages reflected statewide trends with some variation. Psychiatrists were still cited with the greatest frequency, while Psychologists (including Clinical and Licensed Clinical Psychologists) and MFTs were cited at higher frequencies than LCSWs. Similar to other regions, the Southern region identified a need for bilingual and specifically Spanish-speaking staff.

Figure 7: Superior Region Workforce Shortages (n=7)



MHSA Superior region workforce shortages were relatively consistent with the statewide “tiers” of need established above: Psychiatrists were both the highest need and most frequently cited shortages, followed by LCSWs, MFTs, and Psychiatric Mental Health Nurse Practitioners. Child/Adolescent Psychiatrists, however, were not reported as a highest need shortage. Bilingual and Spanish-speaking needs made up a large proportion of needs in this region.

Conclusions: Workforce Shortages by MHSA Region

Across regions, many of the cited workforce shortages were consistent. Psychiatrists (without a specified age group) were always the greatest overall need and the most frequently cited highest need. Child/Adolescent Psychiatrists generally represented the other “highest need” classifications.

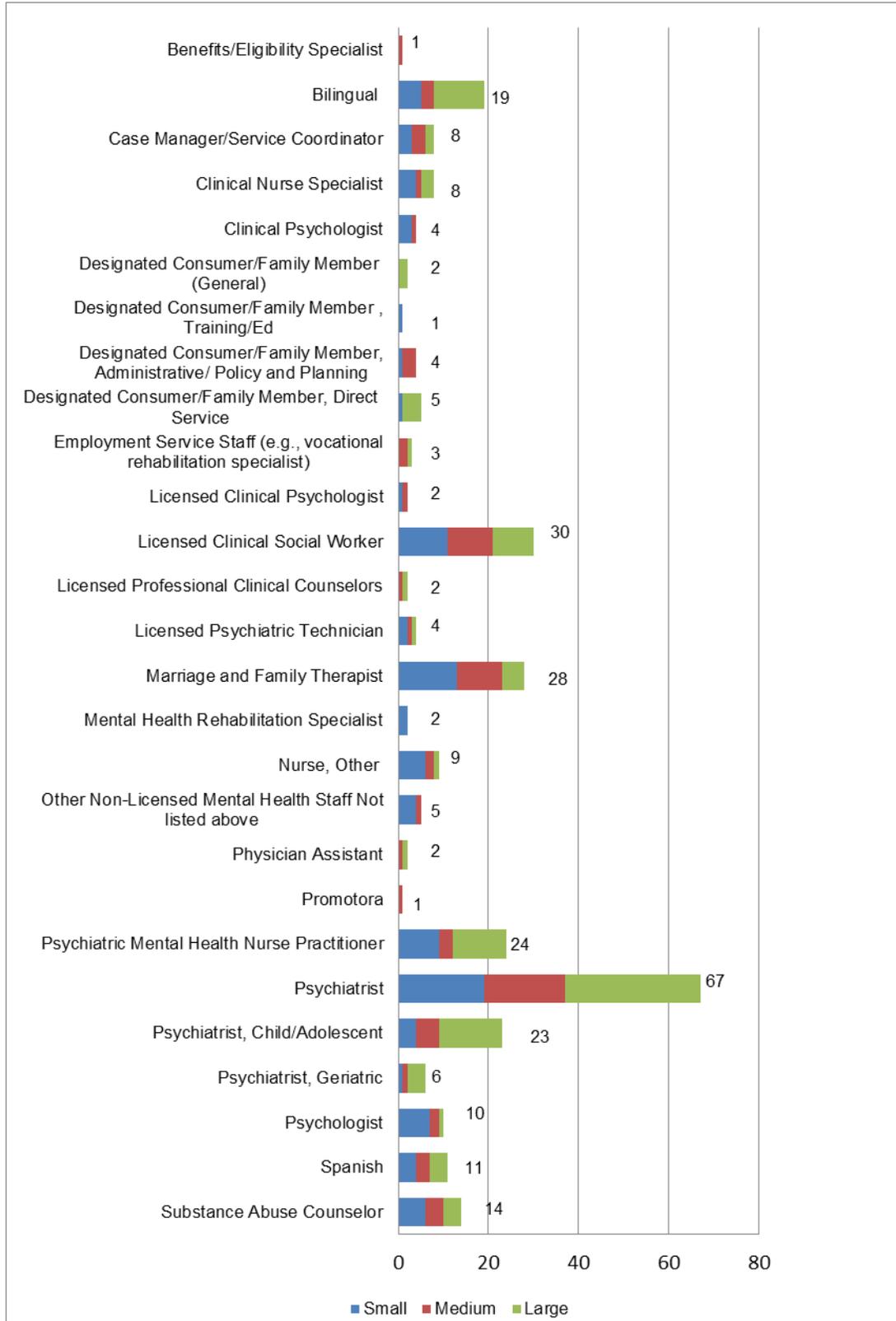
Apart from Psychiatrists, LCSWs, MFTs, Substance Abuse Counselors, and Psychiatric Mental Health Nurse Practitioners were among the more frequently cited workforce shortages.

Diversity shortages (Bilingual or Spanish needs) were cited in the MHSA Bay Area and Superior regions, much more so than in the MHSA Central or Southern regions. Designated Consumer and/or Family Member positions were only cited in some regions. When cited, direct service or general needs were more common than the other types of designated consumer and/or family member types of positions.

Workforce Shortage Trends by Size

Workforce shortages by county size are depicted in Figure 8. Small counties are represented by blue, medium counties by red, and large counties by green. For ease of comprehension, demands by highest need or other needs have been collapsed in this chart into overall counts, and no distinction is made by need rank.

Figure 8: Overall Workforce Shortages by County Size (n=41)



Needs for Psychiatrists were reported by small, medium, and large counties at fairly even frequency, with a somewhat higher number of large counties reporting this need. MFTs and LCSWs were also relatively evenly split across county sizes, although a higher number of small counties and a lower number of large counties reported a need for MFTs. Needs were also relatively evenly split by county size for Substance Abuse Counselors, Spanish-speaking staff, and Case Managers/Service Coordinators.

A greater number of large counties reported needs for bilingual staff, Child/Adolescent Psychiatrists and Psychiatric Mental Health Nurse Practitioners. More small counties listed needs for Psychologists, including Clinical and Licensed Clinical Psychologists. Among the less frequently cited workforce shortages, reported needs also varied by county size for the designated consumer and/or family member positions.

Figure 9: Small Counties Workforce Shortages (n=18)

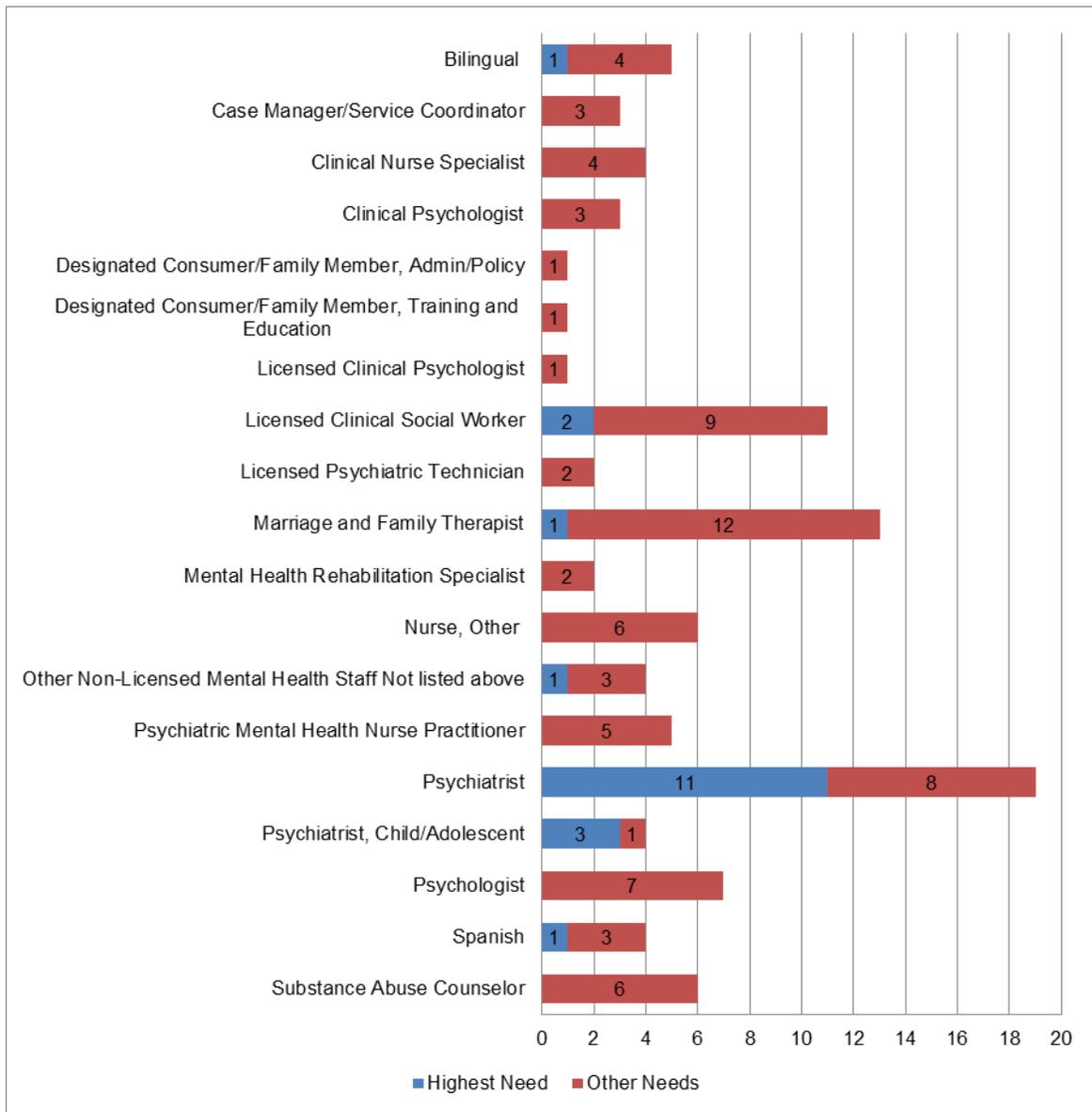
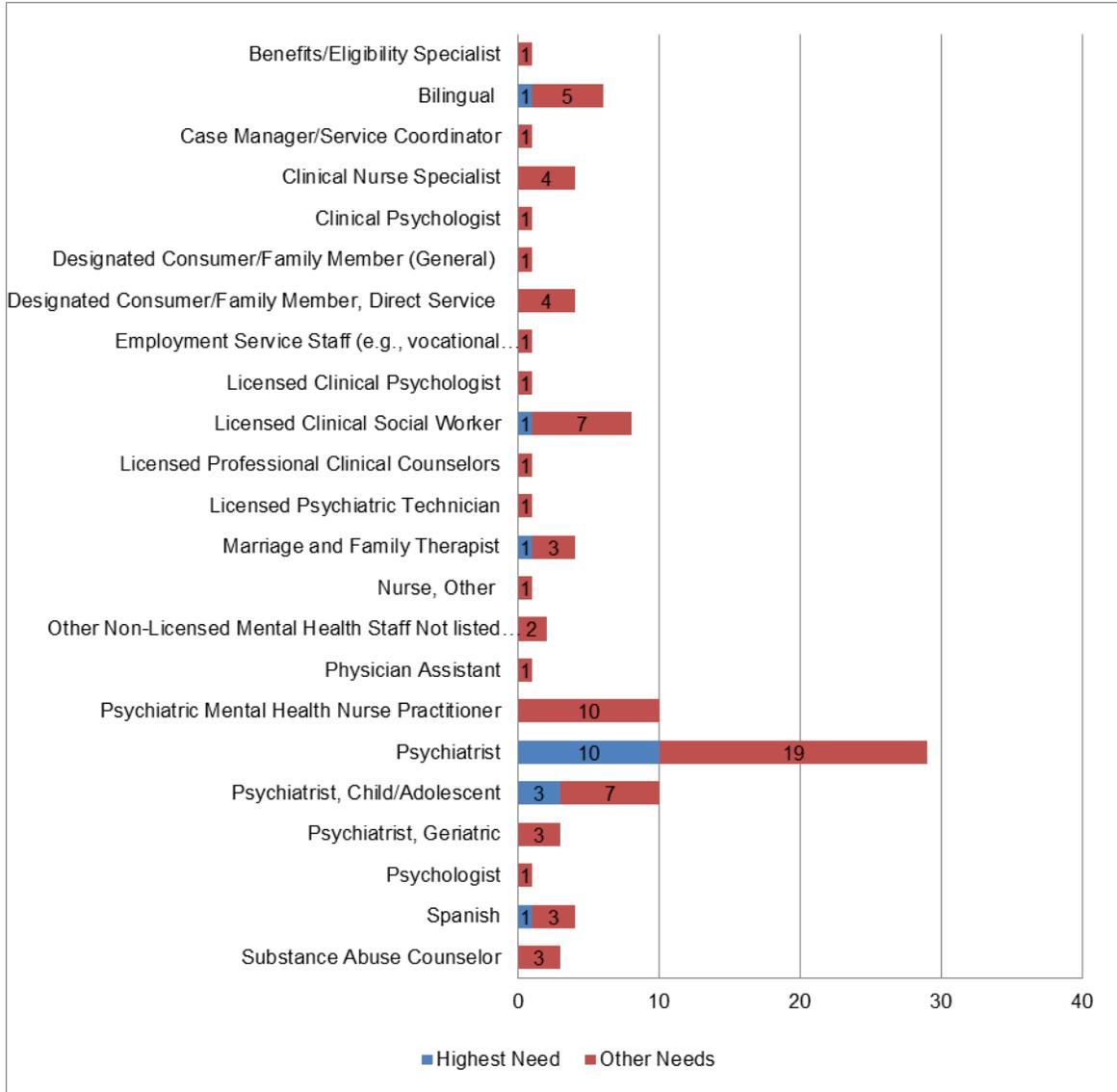


Figure 9 depicts the counts of reported workforce shortages of small counties, delineated by highest need and other needs. The overall demand for Psychiatrists is consistent with the statewide trend, but small counties reported MFTs and LCSWs at higher frequencies than the statewide averages.

Nurses and Substance Abuse Counselors are in mid-level demand. Psychiatric Mental Health Nurse Practitioners were cited as a workforce shortage five times, Clinical Nurse Specialists four times, and other nurses (including any mention of a Registered Nurse, Nurse, or Licensed Vocational Nurse) were cited six times. Combined, Nurses were mentioned for a total of 15 times, which place them just a few counts behind general Psychiatrists.

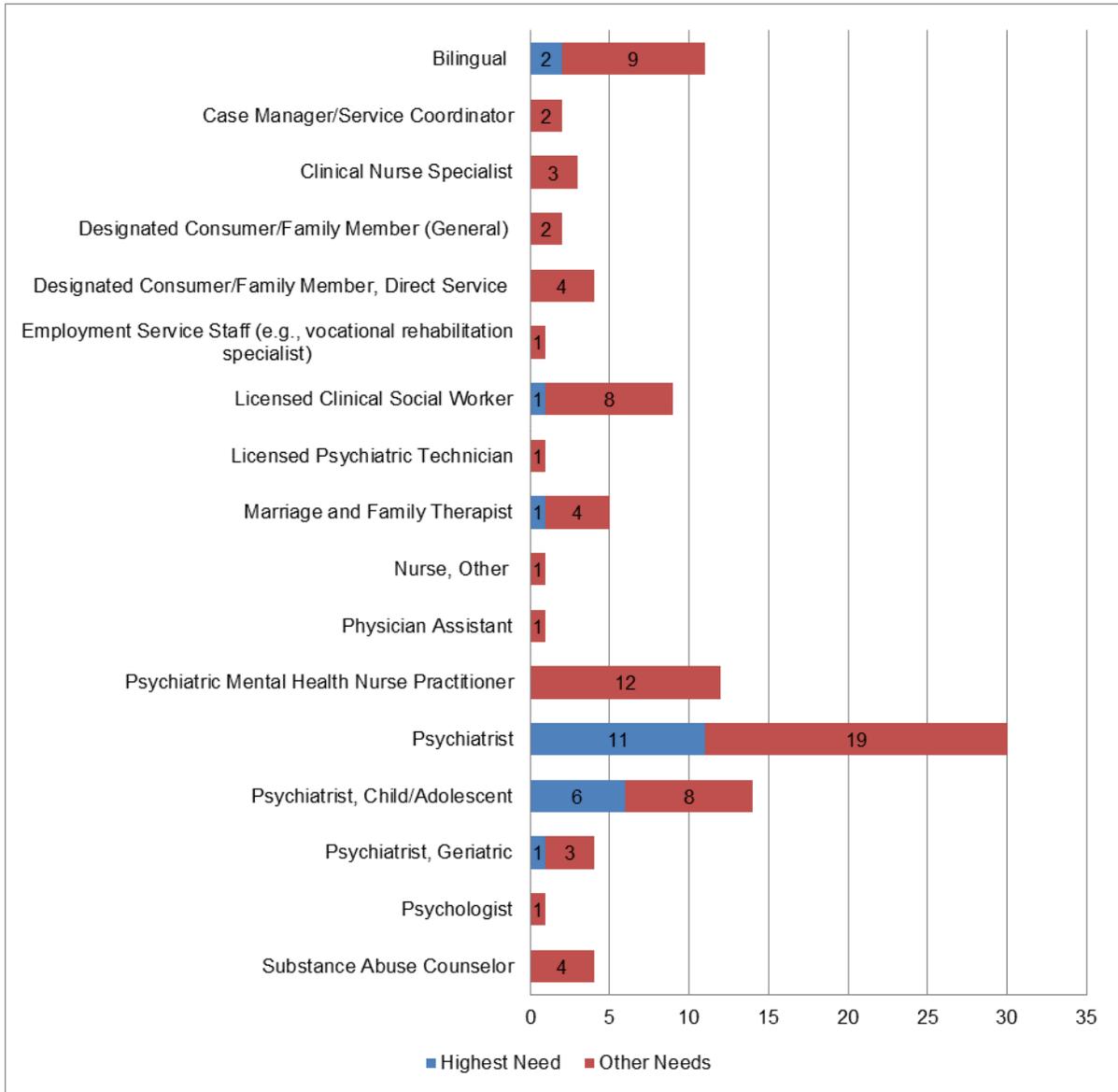
Bilingual and Spanish workforce shortages were also high for small counties, representing a combined 11 counts.

Figure 10: Medium Counties Workforce Shortages (n=11)



Medium counties cited Psychiatrists at a greater frequency than the statewide average. Shortage reports for LCSWs, MFTs, and Nurses were lower than the statewide trend. Needs reports for Bilingual or Spanish shortages were also considerably lower than both the statewide trend and for small counties.

Figure 11: Large Counties Workforce Shortages (n=12)



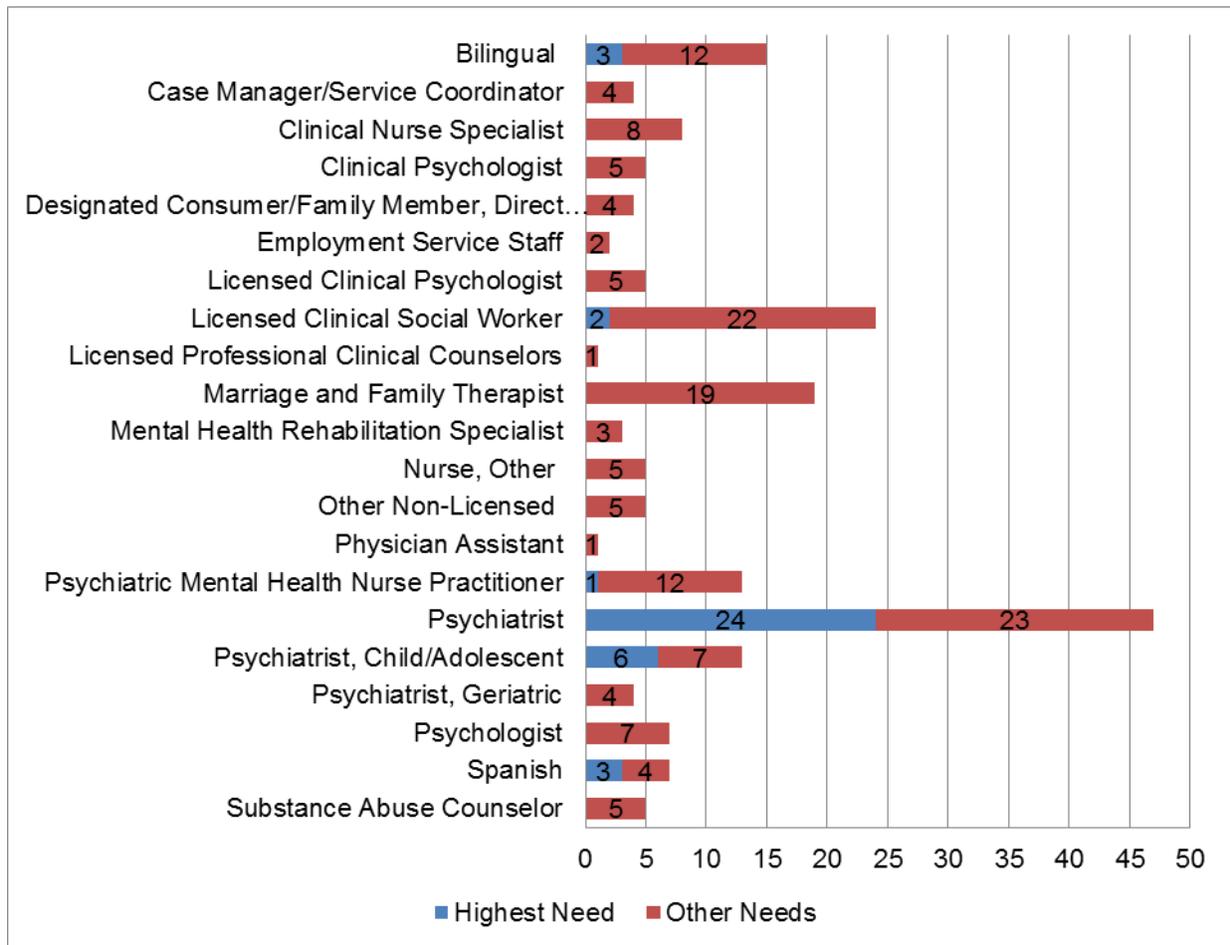
Large counties also reported Psychiatrists as their greatest workforce shortage, both in frequency and as their highest need. Child and Adolescent Psychiatrists ranked highly as well, and represented both highest need and other needs. LCSWs, MFTs, Substance Abuse Counselors, and Geriatric Psychiatrists constituted medium-level demands for large counties. Bilingual shortages were cited frequently and as a highest need.

Hard-to-Fill, Hard-to-Retain Positions

Data on Hard-to-Fill and Hard-to-Retain Positions comes from the Hard-to-Fill, Hard-to-Retain Positions section of the County-Reported Needs Assessments. Counties were asked to list their top seven mental/behavioral health workforce positions that were hard-to-fill or retain in order of highest need. As in other sections, needs 2-7 were grouped under a category of “other needs” while the highest need position remained separated.

Hard-to-Fill and Hard-to-Retain Positions Overall Trends

Figure 12: Overall Hard-to-Fill, Hard-to-Retain Positions (n=41)

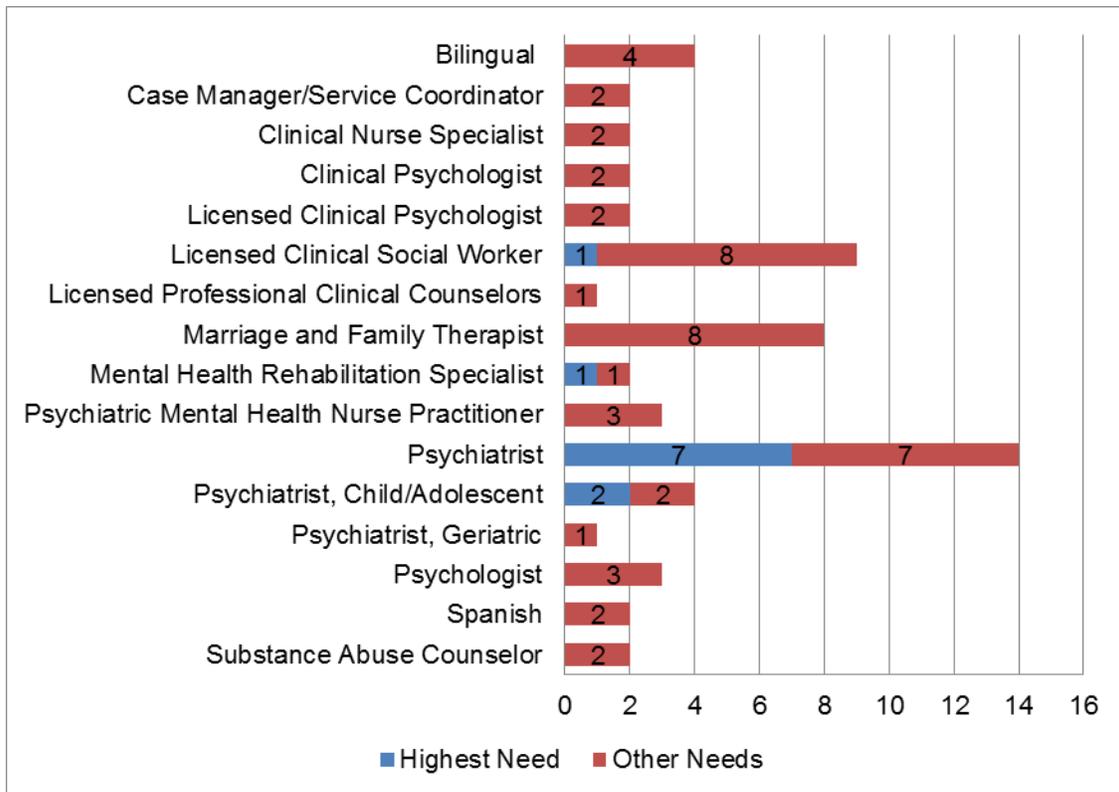


Overall, hard-to-fill and hard-to-retain positions reflected the needs identified in the workforce shortage section of the Needs Assessment. As with workforce needs, Psychiatrists (including non-specified age groups, Child/Adolescent Psychiatrists, and Geriatric Psychiatrists) constituted the majority of hard-to-fill, hard-to-retain positions—ranked 64 times overall and as “highest need” 30 times. Licensed Clinical Social Workers (LCSWs) (24 counts), Marriage and Family Therapists (MFTs) (19 counts), and bilingual and Spanish-speaking staff (together accounting for 22 counts) constituted the next most commonly mentioned hard-to-fill, hard-to-

retain positions. Psychiatric Mental Health Nurse Practitioners were mentioned 13 times, and Clinical Nurse Specialists and Other Nurses together totaled 13 counts. The only Designated Consumer and/or Family Member positions cited as hard-to-fill or hard-to-retain were direct service positions, cited four times.

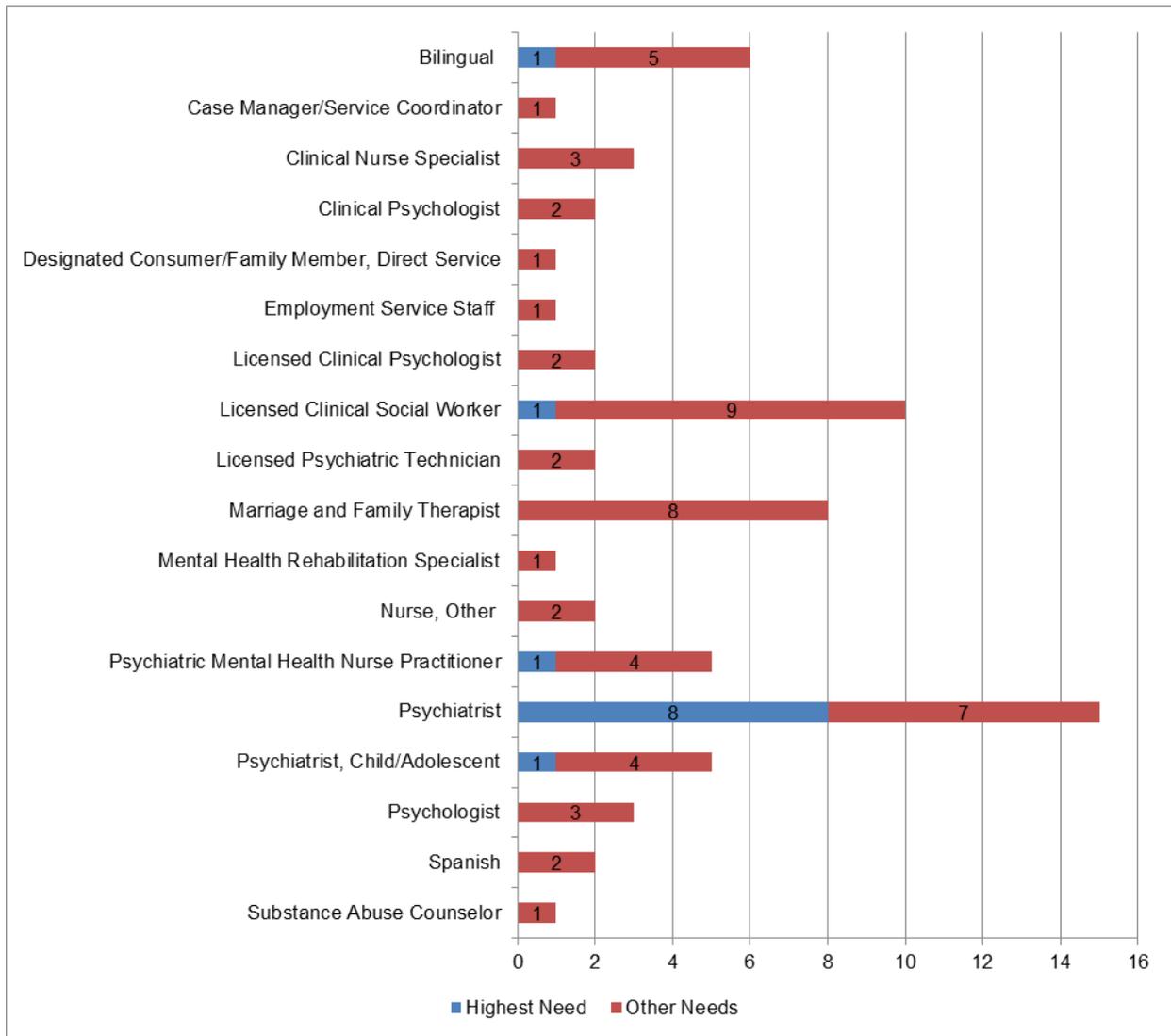
Hard-to-Fill and Hard-to-Retain Positions Trends by Region

Figure 13: MHSA Bay Area Region Hard-to-Fill, Hard-to-Retain Positions (n=9)



MHSA Bay Area region hard-to-fill, hard-to-retain positions were generally reflective of the overall statewide trends, with Psychiatrists, LCSWs, and MFTs listed with the highest frequency. No MHSA Bay Area region counties cited Consumer and/or Family Member positions as being among the hardest-to-fill or retain.

Figure 14: MHSA Central Region Hard-to-Fill, Hard-to-Retain Positions (n=16)



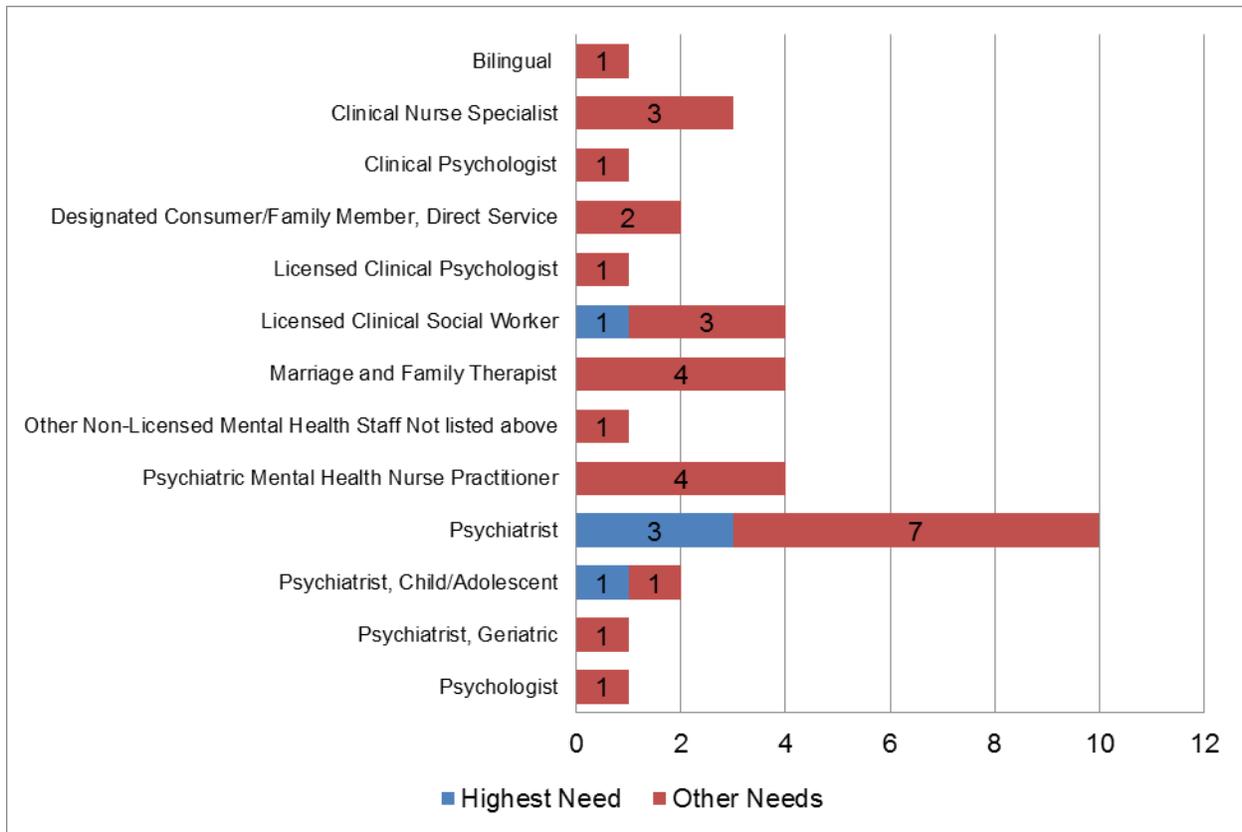
Almost all of the Central Region hard-to-fill, hard-to-retain positions correspond to statewide averages and frequencies, with Psychiatrists, LCSWs, and MFTs being listed with the highest frequency.

Table 4: MHSA Los Angeles Region Hard-to-Fill, Hard-to-Retain Positions (n=1)

Los Angeles Region Hard-to-Fill, Hard-to-Retain Positions	
1.	Psychiatrist
2.	Child Psychiatrist
3.	Nurse, Other Registered Nurse
4.	Other Licensed (Mental Health Clinician)
5.	Other Non-licensed (Pre-licensed Mental Health Clinician)
6.	Certified Alcohol and Other Drug Abuse (AOD) Counselor

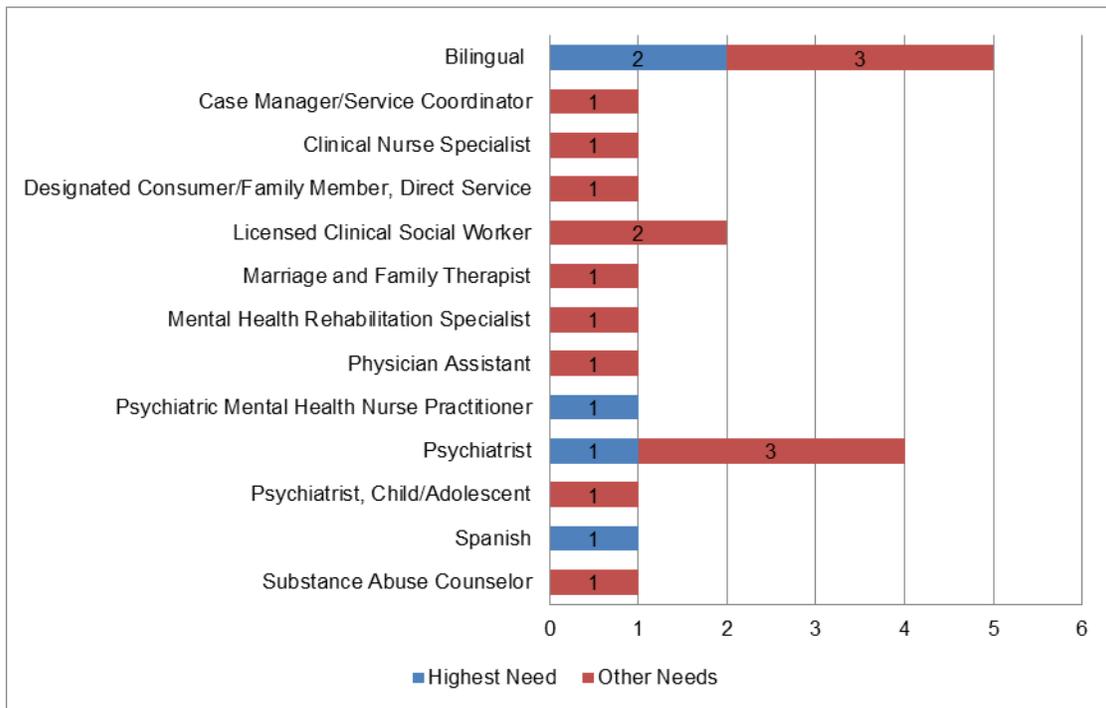
Los Angeles reported six hard-to-fill, hard-to-retain positions, depicted in Table 5. Psychiatrist was the highest need hard-to-fill, hard-to-retain position in Los Angeles, followed by Child Psychiatrist.

Figure 15: MHSA Southern Region Hard-to-Fill, Hard-to-Retain Positions (n=8)



Southern Region counties also listed Psychiatrists as the highest need and highest frequency hard-to-fill, hard-to-retain position. LCSWs, MFTs, and Psychiatric Mental Health Nurse Practitioners were listed with the next highest frequency. Interestingly, Spanish-speaking positions were not mentioned as hard-to-fill, hard-to-retain positions in the Southern Region, though bilingual staff in general were listed.

Figure 16: MHSA Superior Region Hard-to-Fill, Hard-to-Retain Positions (n=7)



As an interesting departure from any of the other regions, Superior region counties reported bilingual positions as the most frequent and highest need hard-to-fill and hard-to-retain type of position. Psychiatrists constituted the next most commonly mentioned hard-to-fill, hard-to-retain position, followed by LCSWs. Positions that were commonly reported by other regions as second tier most common needs were not reported at the same rate in the Superior region; MFTs, Substance Abuse Counselors, Child/Adolescent Psychiatrists, and the remaining positions in Figure 16 were only reported once each.

Hard-to-Fill and Hard-to-Retain Positions Trends by County Size

Figure 17: Overall Hard-to-Fill, Hard-to-Retain Positions by County Size (n=41)

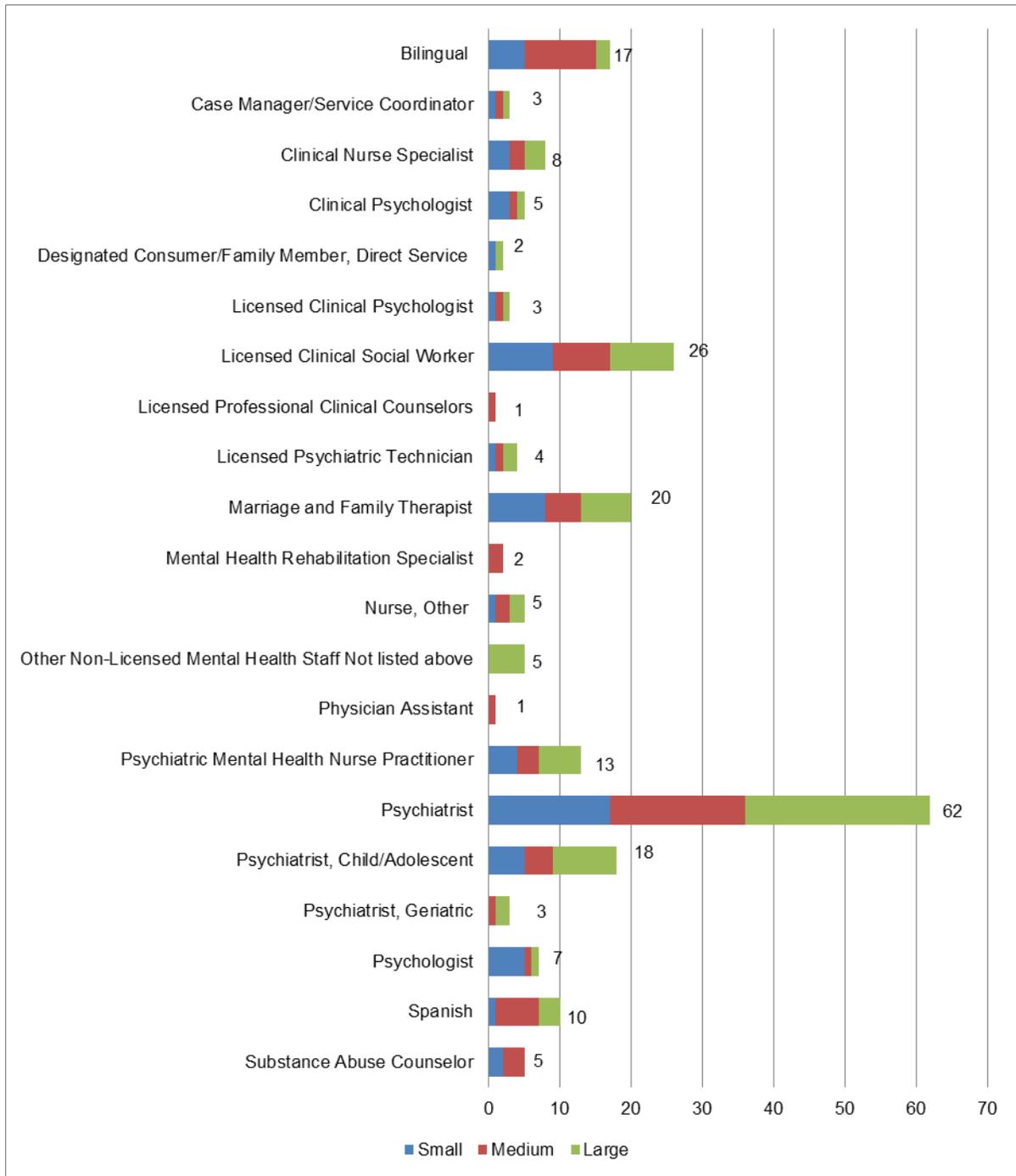
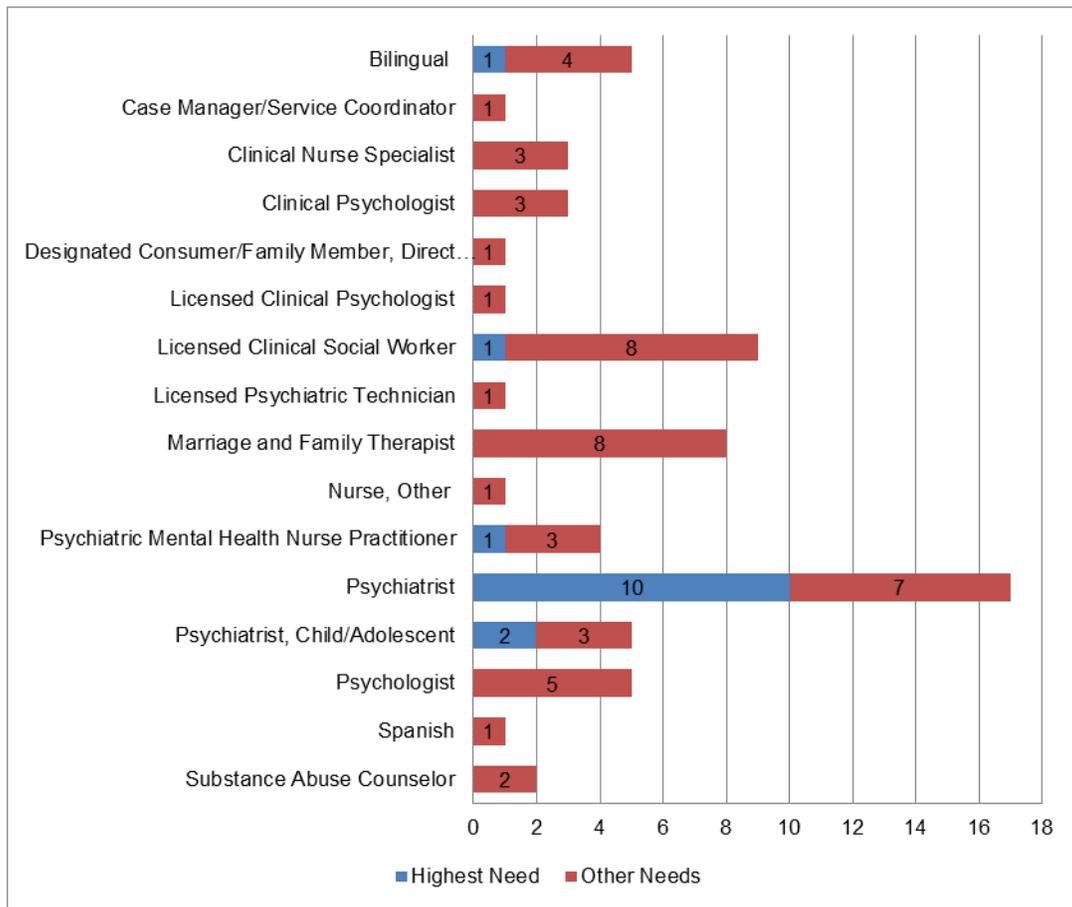


Figure 17 depicts reported counts of hard-to-fill and hard-to-retain positions by county size. Reported need of Psychiatrists appeared to be relatively similar by county size, with a somewhat higher number of large counties reporting Psychiatrists as a hard-to-fill, hard-to-retain position. Similar numbers of small, medium, and large counties listed LCSWs, MFTs, Licensed

Clinical Psychologists, and Case Managers/Service Coordinators as hard-to-fill, hard-to-retain positions.

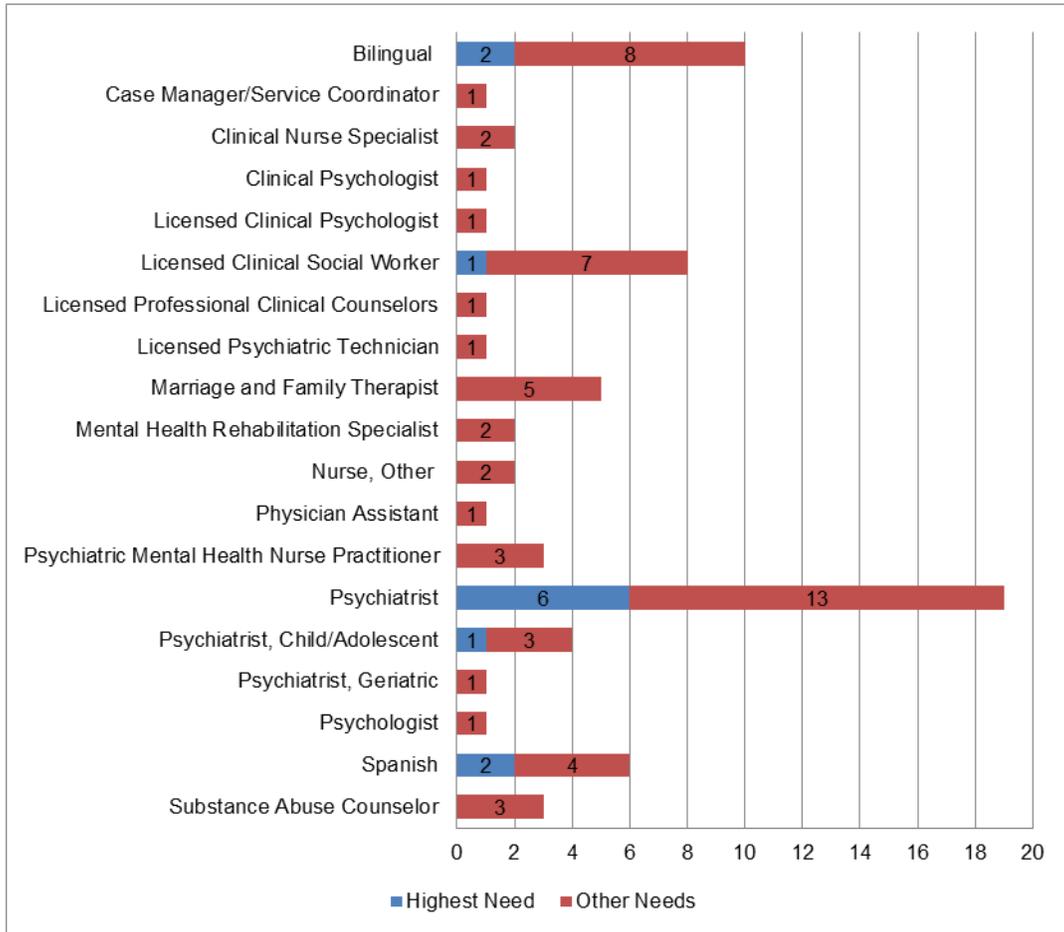
A higher number of large counties reported Child/Adolescent and Geriatric Psychiatrists, as well as other non-licensed mental health staff, as hard-to-fill, hard-to-retain positions. A higher number of medium counties reported that bilingual and Spanish-speaking positions, Substance Abuse Counselors and Mental Health Rehabilitation Specialists were hard-to-fill or hard-to-retain. Higher numbers of small counties reported that Psychologists and Clinical Psychologists were hard to fill or retain.

Figure 18: Small Counties Hard-to-Fill, Hard-to-Retain Positions (n=18)



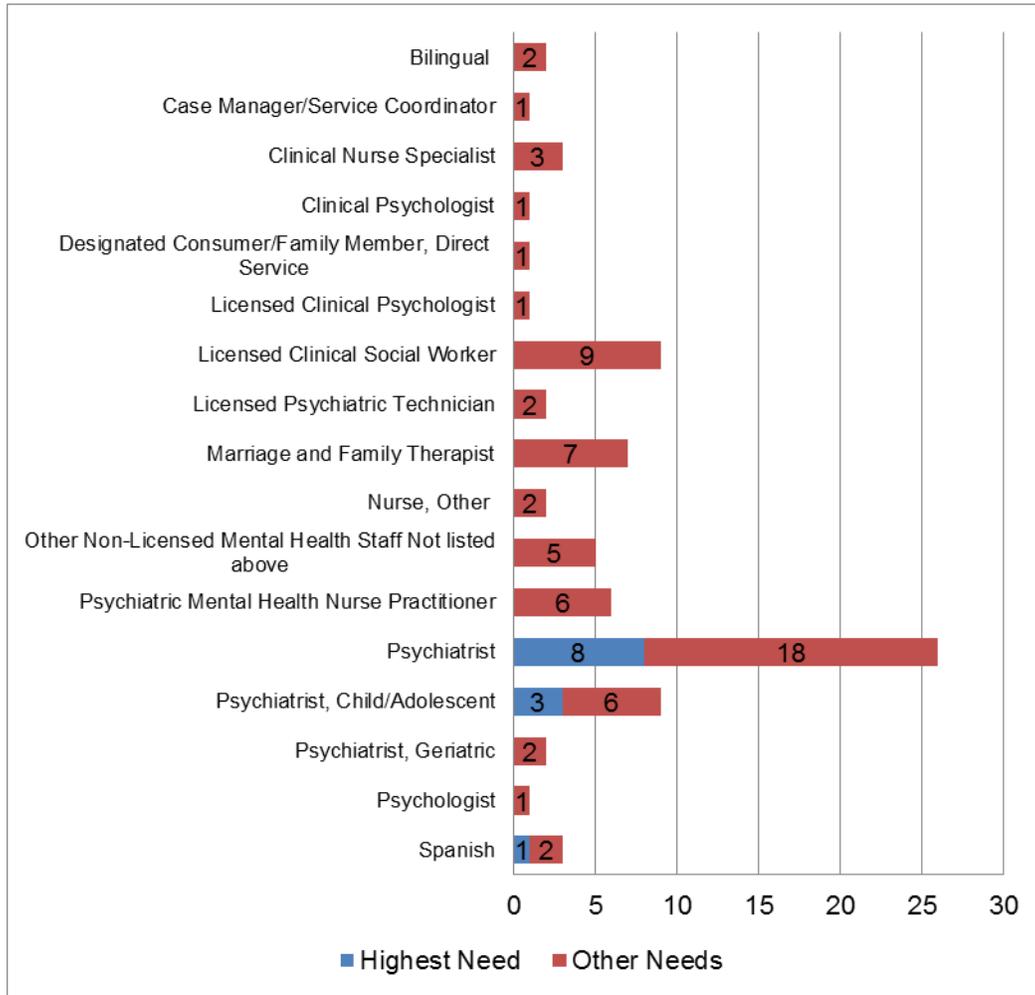
Small counties consistently reported Psychiatrists as their highest need hard-to-fill, hard-to-retain position. Child/Adolescent Psychiatrists, Psychiatric Mental Health Nurse Practitioners, and Bilingual providers were cited among the other highest need positions. By count alone, Psychiatrists, Licensed Clinical Social Workers, Marriage and Family Therapists, and Psychologists were among the top five most frequently cited hard-to-fill, hard-to-retain positions for small counties.

Figure 19: Medium Counties Hard-to-Fill, Hard-to-Retain Positions (n=11)



In medium counties, Psychiatrists were again listed as a hard-to-fill, hard-to-retain position at the greatest frequency and with the highest need. LCSWs and Child/Adolescent Psychiatrists were also among the highest need positions. Interestingly, diversity needs were particularly common among medium counties, with both Spanish and Bilingual cited as hard-to-fill, hard-to-retain positions and highest needs.

Figure 20: Large Counties Hard-to-Fill, Hard-to-Retain Positions (n=12)



Like most of the rest of the state, large counties reported Psychiatrists, Child/Adolescent Psychiatrists, and LCSWs at the highest frequencies and needs. Interestingly, lower numbers of large counties cited Spanish and Bilingual positions as hard-to-fill or retain compared to medium and small counties.

Conclusions: Hard-to-Fill, Hard-to-Retain Positions by County Size

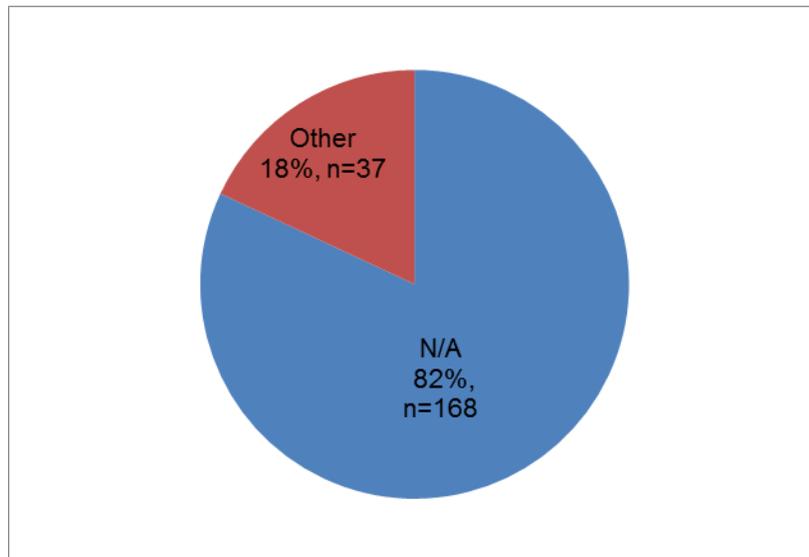
Across county sizes, Psychiatrists were consistently reported as the highest need and most frequent hard-to-fill, hard-to-retain position. However, diversity demand differed among counties of different sizes. Both small and medium counties reported Spanish and Bilingual demands at much greater frequency than large counties, with medium counties having the highest frequency of Bilingual demand.

Declining Needs or Needs Met

Specific data on counties’ declining needs or demands with regard to staffing derive from the County-Reported Needs Assessment section, “Mental/Behavioral Workforce Demands Met.”

Counties were asked to list the top five occupational categories declining in need and/or demand, starting with the position with the lowest need. The following figures represent counties' self-reported data on their declining needs and/or demands by region and county size.

Figure 21: Overall Declining Needs or Needs Met (n=41)



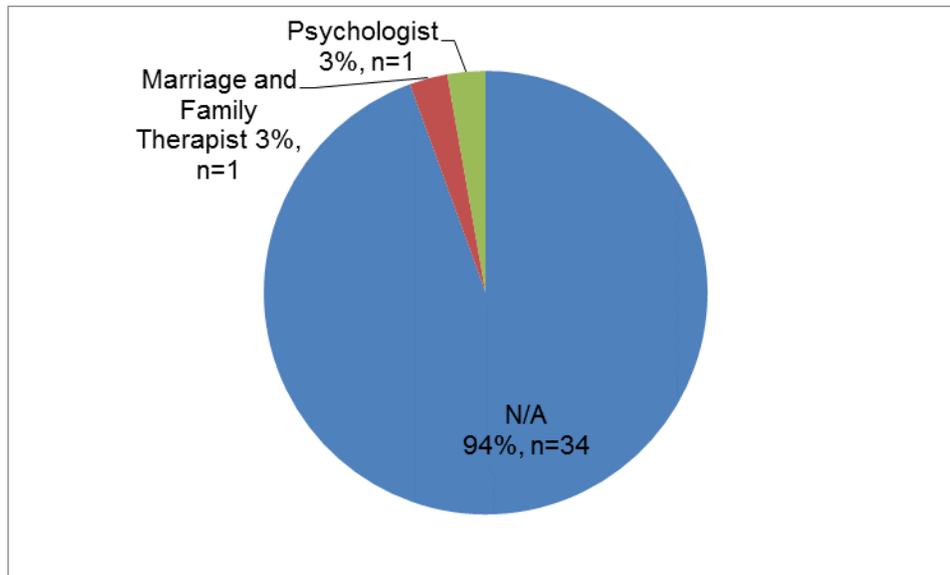
Over 80% of counties reported that declining needs or needs met were “N/A,” or not applicable, suggesting that they perceived no declining or met needs. Eighteen percent of counties identified declining or met needs. The declining or met needs are identified for each region. Because the proportion of counties reporting “N/A” was so high, “N/A” responses are specifically presented and described in the sections below.

Declining Needs or Needs Met Trends by Region

All MHSA regions reported frequently that declining needs or needs met were not applicable, except for the Southern region. The declining needs or needs met that were reported across regions are detailed below.

Bay Area Region

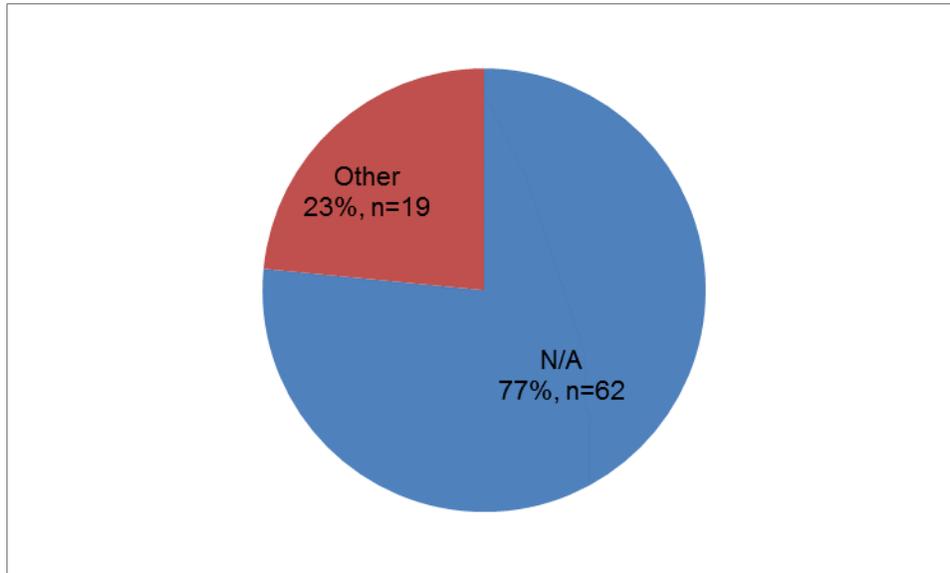
Figure 22: Bay Area Region Declining Workforce Needs/Needs Met Overall (n=9)



Counties in the Bay Area region responded “N/A” at the highest rate in the state (along with the Superior region). Ninety-four percent of Bay Area region counties said there were no applicable responses to declining needs. Three of the remaining 6% of counties responded “Psychologist” and the last 3% cited Marriage and Family Therapists.

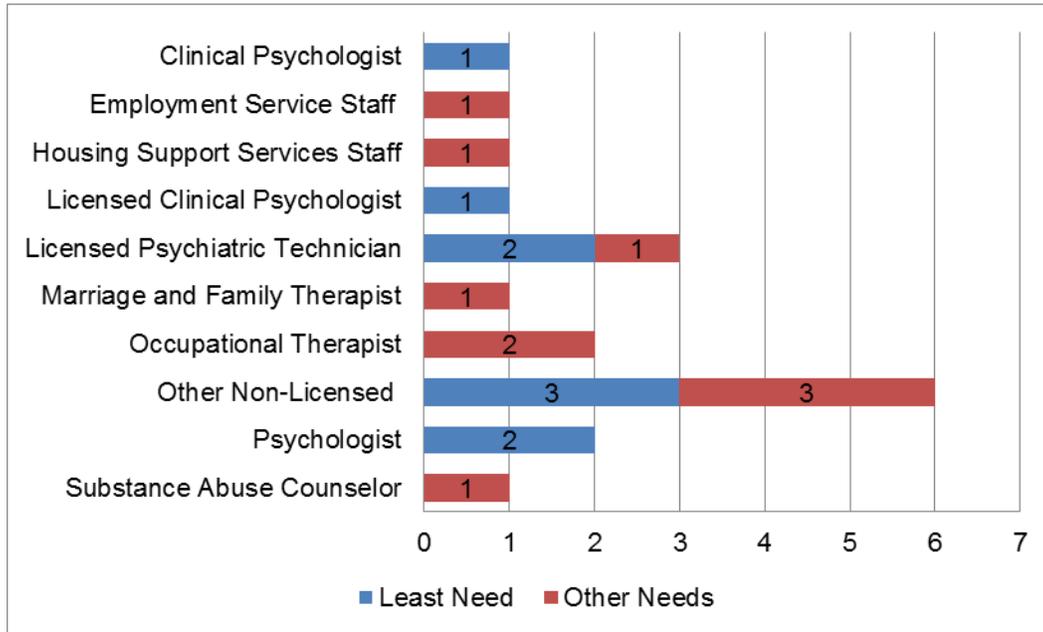
Central Region

Figure 23: Central Region Declining Needs/Needs Met Overall (n=16)



Over three quarters of Central region counties reported no declining needs or needs met. Among the 23% of responses that listed an occupational category, the distribution is shown in the following graph. Non-licensed positions constituted the least need and most frequently cited declining need. Many of the other declining needs or needs met were administrative or support staff roles, such as the housing support staff and employment services staff (one count each).

Figure 24: Central Region Declining Needs/Needs Met (n=16)



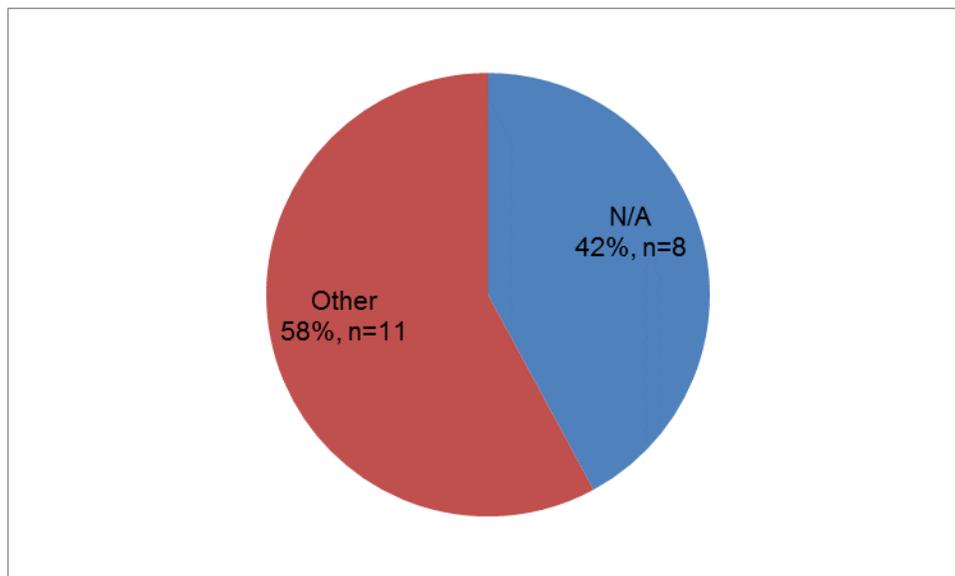
Psychologists and Licensed Psychiatric Technicians were also cited as positions of least need in the Central region.

Los Angeles Region

The Los Angeles region did not report any declining needs or needs met.

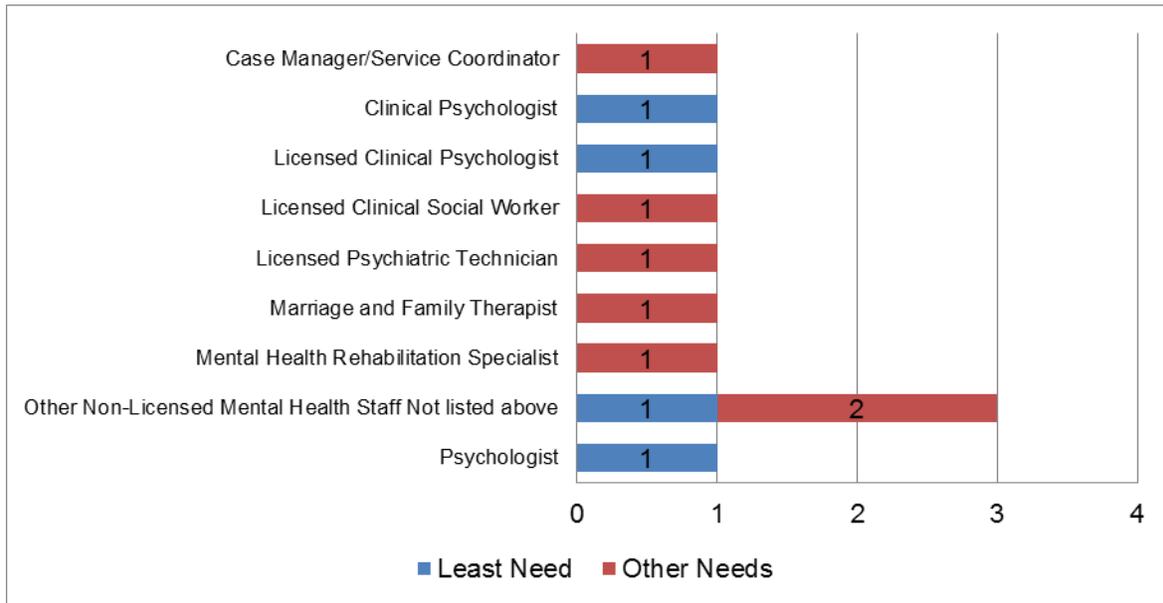
Southern Region

Figure 25: MHSA Southern Region Declining Needs/Needs Met Overall (n=8)



Counties in the MHSA Southern region, contrary to most other regions and the statewide overall rates, noted the majority of identified declining needs or needs met. While still a large proportion of the answers were “N/A” or left blank, the 56% of responses that were given are delineated in Figure 26.

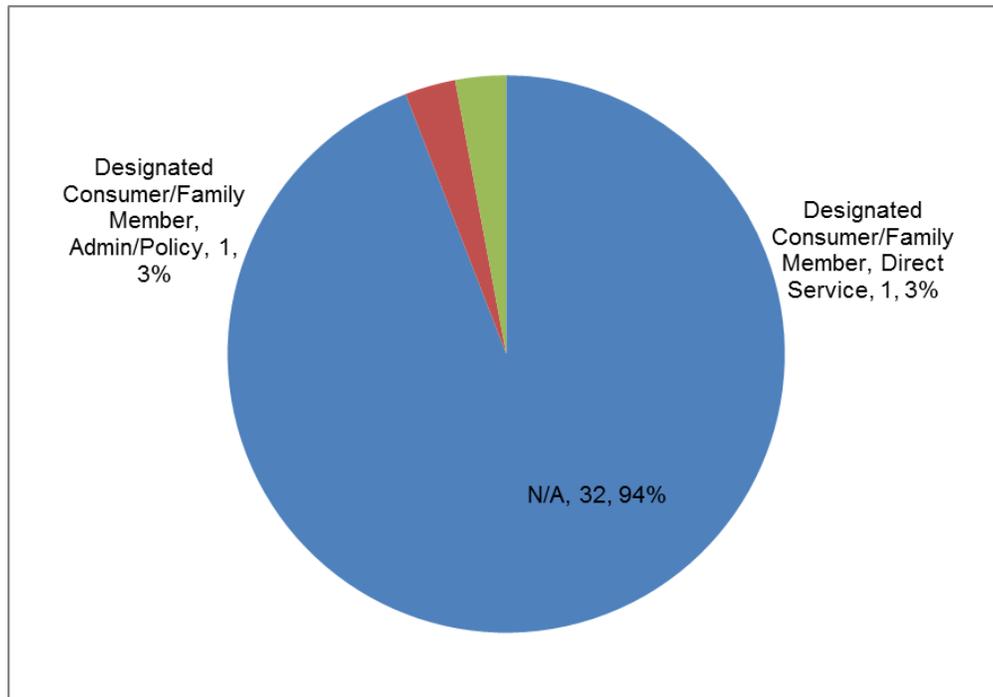
Figure 26: MHSA Southern Region Declining Needs/Needs Met (n=8)



Among the declining needs or met needs, non-licensed staff constituted the greatest frequency, albeit still a low frequency of three times. Clinical Psychologists, Licensed Clinical Psychologists, and Psychologists account for a total of three out of the total 12 cited declining needs in the MHSA Southern region.

Superior Region

Figure 27: Superior Region Declining Needs/Needs Met, Overall (n=7)



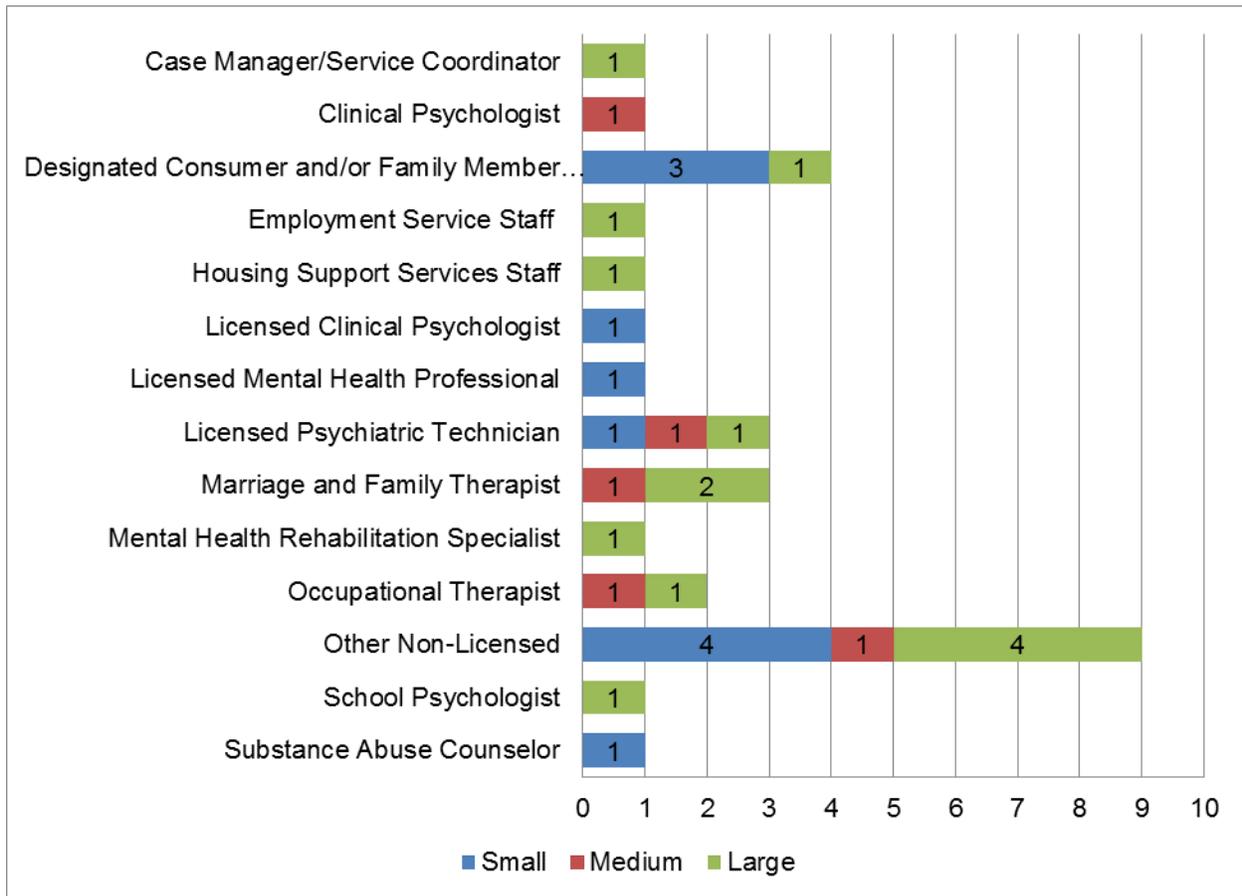
The MHSA Superior region reported that there were no applicable declining needs 94% of the time. Among the few reported declining needs that they cited, 3% of their responses were for Designated Consumer and/or Family positions, Administrative and Policy positions; and the final 3% of declining needs were identified as Designated and/or Consumer Family Member positions, Direct Service.

The MHSA Superior region reported that there were no applicable declining needs 94% of the time. One county, representing 3% of the region, identified Designated Consumer and/or Family positions, Administrative and Policy positions and Designated and/or Consumer Family Member positions, Direct Service as declining need positions.

Declining Needs or Needs Met Trends by Size

Sorted by county size, small counties reported no declining needs with the greatest frequency (78 times of a total of 90). Medium counties reported no declining needs at the second greatest frequency (49 times of a total of 55). While large counties reported no declining needs at the least frequency (40 of a total of 54 times) this still indicates limited decline in needs. Figure 28 details this information.

Figure 28: Overall Reported Declining Needs by County Size (n=41)



Diversity Needs

Sources and Limitations

Data on diversity needs comes from the County-Reported Public Mental/Behavioral Health Workforce Needs Assessment, where counties were presented with an open-ended question that asked them to list their top seven mental/behavioral health workforce diversity needs in order of importance.

In the County-Reported Needs Assessment, some counties responded to the “Diversity Needs” prompt with broad variation. Some respondents listed a category of needs such as “race/ethnicity,” while the most common response was a specific listing of the county’s staffing needs around a particular race/ethnicity, such as “African American.” For ease of interpretation, the following analysis first groups needs by the overarching categories of age, gender, language, physical/mental abilities, race/ethnicity, sexual orientation, socio-economic status, and other needs. Subsequent charts break the composition of each of those categories down by sub-category.

While the County-Reported Needs Assessment contained a designated section to report Language Needs, many counties reported language needs within the Diversity Need section. Those counts are reported in the aggregate in Figure 29, but detailed analysis of language needs is reserved for the Language Needs section.

Summary of Diversity Needs

Figure 29: Summary of Overall Diversity Needs (n=41)

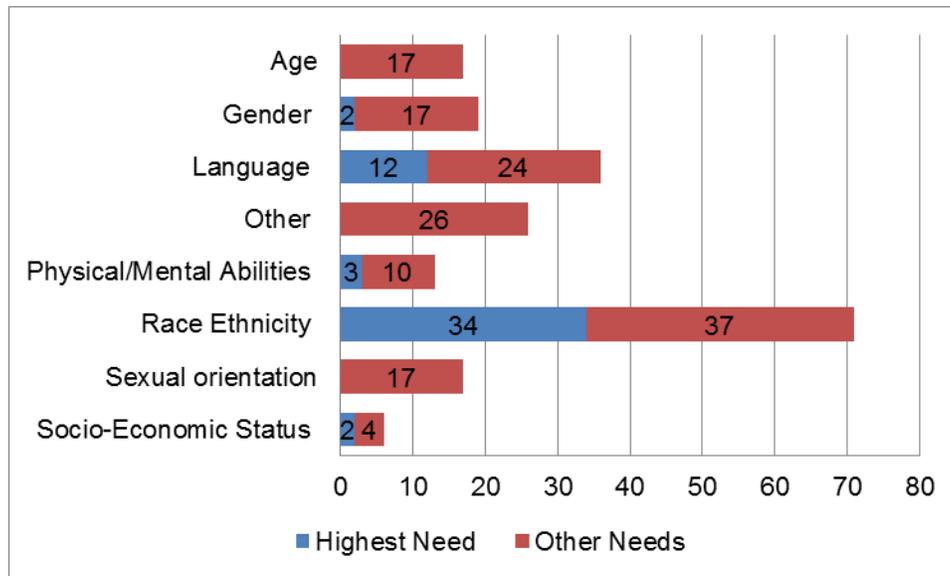


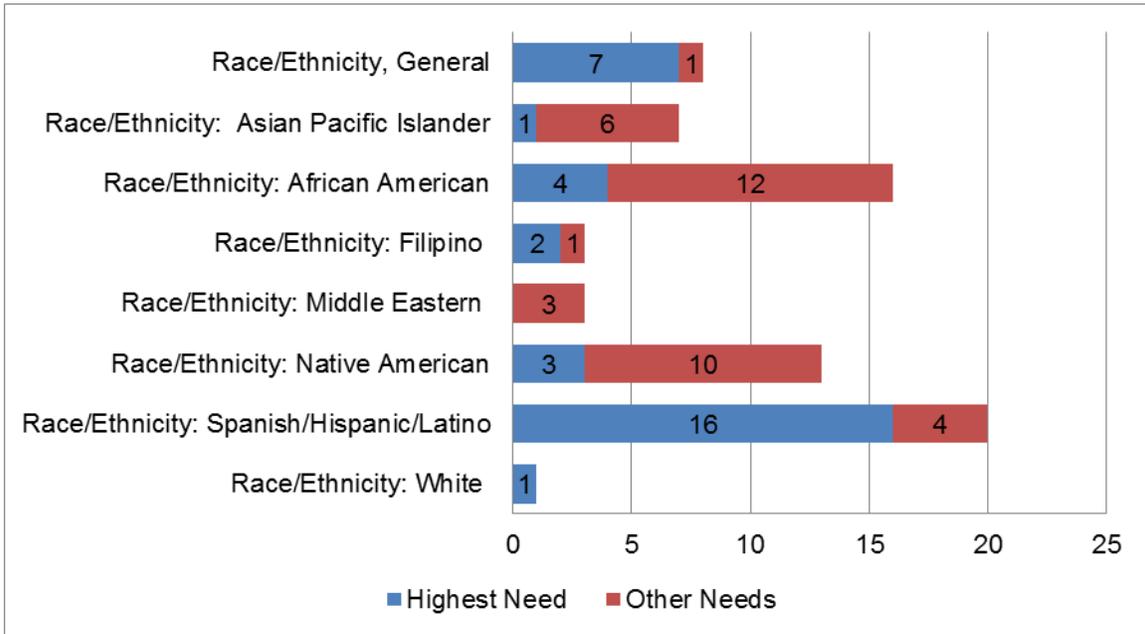
Figure 29 depicts the frequencies with which counties cited responses in each of the above-mentioned categories. Values represent the number of times that category or a sub-category was reported. As counties were instructed to list their top seven needs, the blue shading represents the number of times a category was ranked as a county’s *number one* need, while the red shading represents the number of times a category was included in rankings two through seven. Because the above categories represent a collection of individual subcategories, categories may include more than one response from a particular county.

Race/ethnicity captured the highest frequency of highest need classifications (n=34), followed by language as the second most frequently cited highest need (n=12). While age represented the overall most frequently cited diversity need, no counties listed age as their highest need.

“Other” diversity needs were commonly listed and included: lived experiences (e.g., mental health consumers or family members, rural issues, young children (0-5 years), homeless, veterans, immigrant communities, and newly emerging refugee communities—particularly Iraqi and Afghani refugees).

The following charts depict the breakdown of responses included within each overarching category.

Figure 30: Composition of Race/Ethnicity Diversity Needs (n=41)



Among the counties reporting needs related to race/ethnicity, staffing needs related to the Hispanic or Latino population were the most frequently cited. Hispanic/Latino needs were cited 20 times and were identified as a highest need 16 times. African American diversity needs were also among the most common at a total of 16 counts. Asian Pacific Islanders were the next most commonly cited need (seven), and specific needs for Filipinos were listed three times.

Figure 31: Gender Composition of Diversity Needs (n=41)

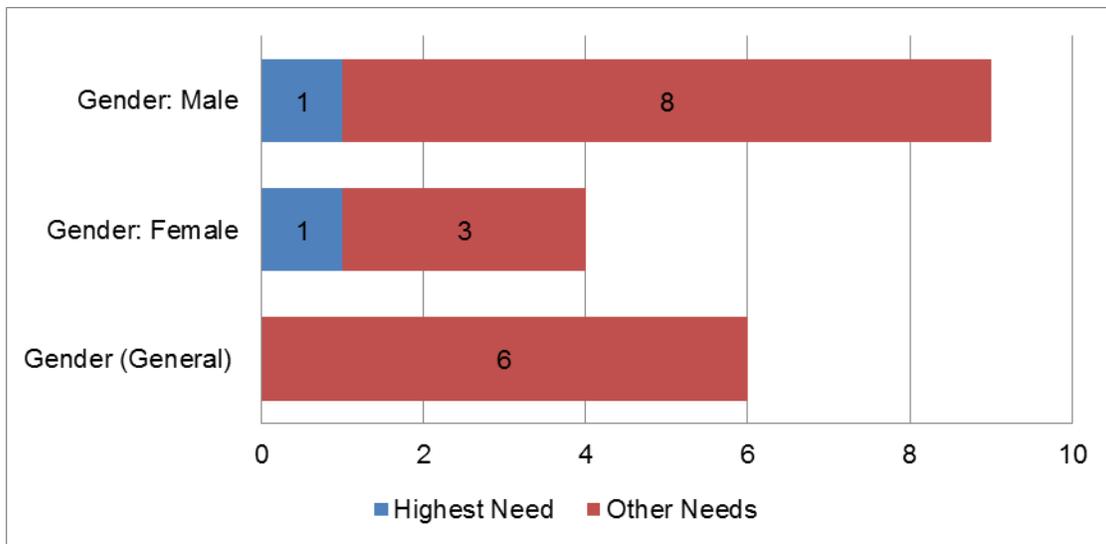
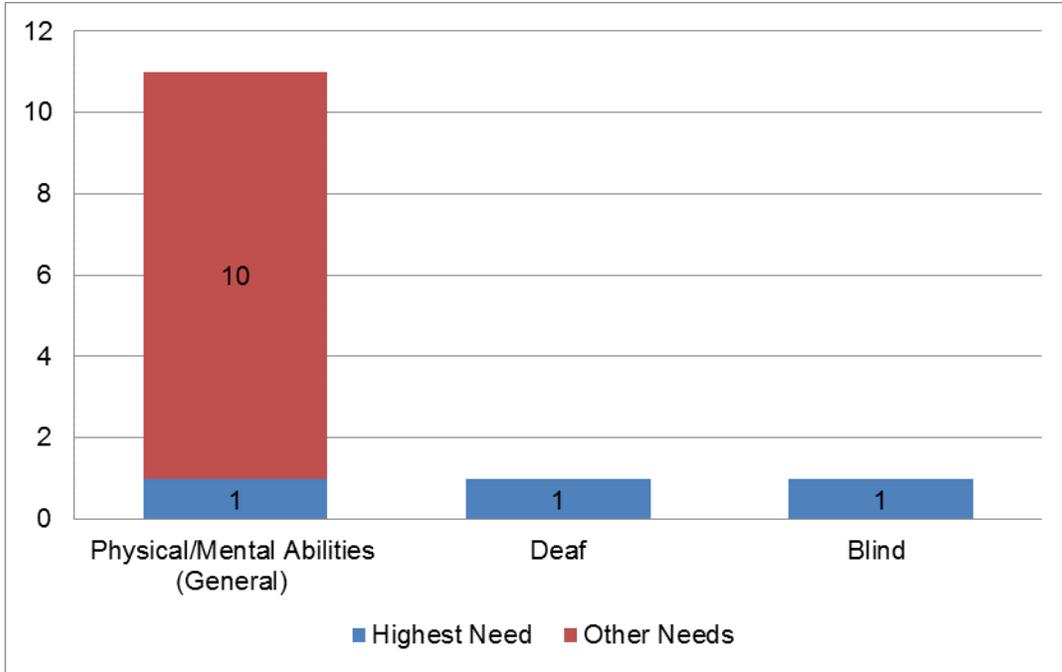


Figure 31 displays the composition of the gender diversity needs reported across the state. Gender was cited as an overall need (with no specification of the type of gender) six times. Of

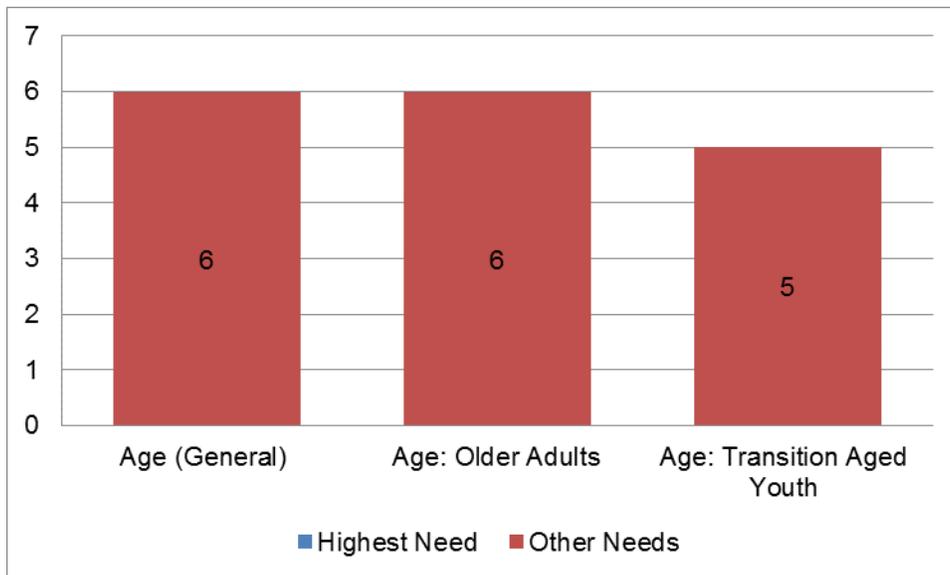
those counties that listed a need related to a specific gender, males were cited with greater frequency (nine times) than were females (four times).

Figure 32. Overall Physical/Mental Ability Needs (n=41)



Staffing needs related to physical or mental disabilities in general were mentioned 11 times. Specific citations of needs related to deaf or hard of hearing and blind populations were each made only once as a highest need.

Figure 33: Age Composition of Diversity Needs (n=41)



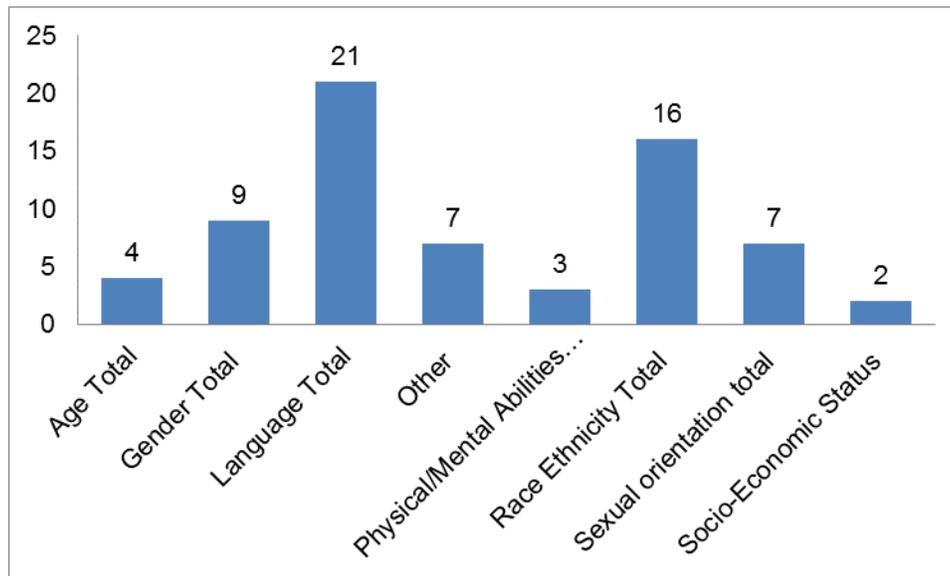
Staffing needs related to age in general (with no specification of age group) were mentioned six times. Staffing needs related to older adults were also listed six times. Needs related to Transition Age Youth (TAY) were cited a total of five times. Notably, none of the age diversity needs was categorized as a highest need classification.

Trends by Region

The following charts depict staffing diversity needs by MHSA region.

Bay Area Region

Figure 34: Bay Area Region Diversity Needs (n=9)



Counties in the Bay Area region reported race/ethnicity diversity needs more than any other need. There was substantial variation in the race/ethnicity needs specified by different counties, as shown in Figure 34. Counties in this region tended not to specify a particular age group when citing age-related staffing needs, with just one county specifying a staffing need related to Transition Aged Youth. Gender-related responses referred either to gender in general or to males. Needs related to socio-economic status were not specified, nor were needs related to physical and/or mental abilities.

Figure 35: Bay Area Region Race/Ethnicity Needs (n=9)

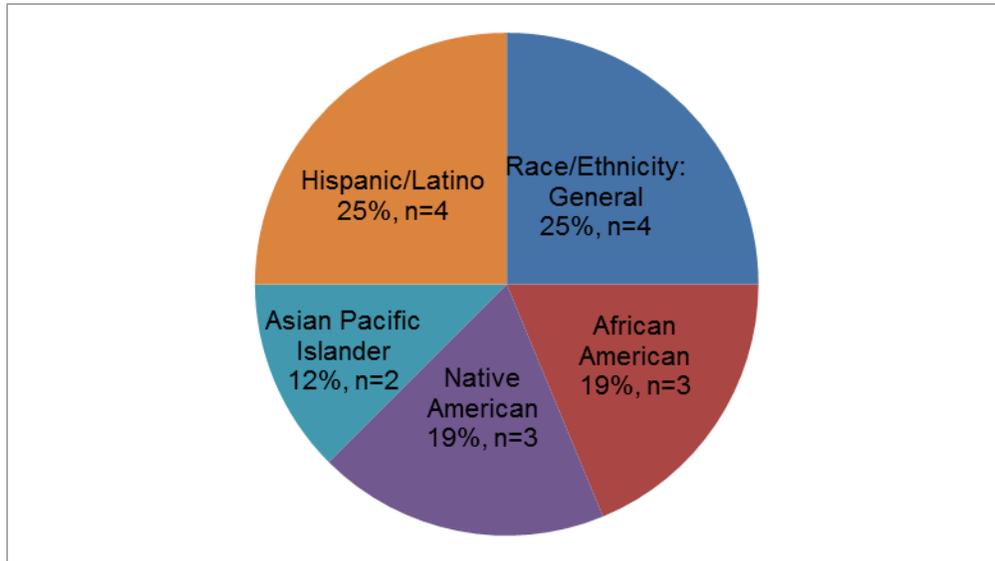
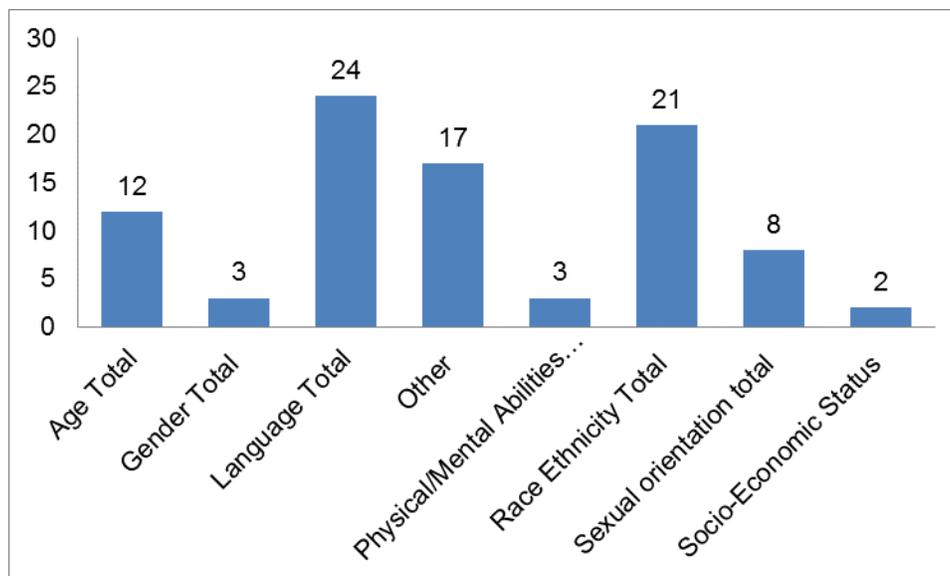


Figure 35 depicts the specific racial or ethnic groups reported as a diversity need by Bay Area counties. General race/ethnicity needs accounted for 25% of race/ethnicity needs. Specified race/ethnicity needs in the Bay Area region reported Hispanic/Latino needs (25%), followed by African American (19%), Native American (19%), and Asian (including Asian Pacific Islander) (12%).

Central Region

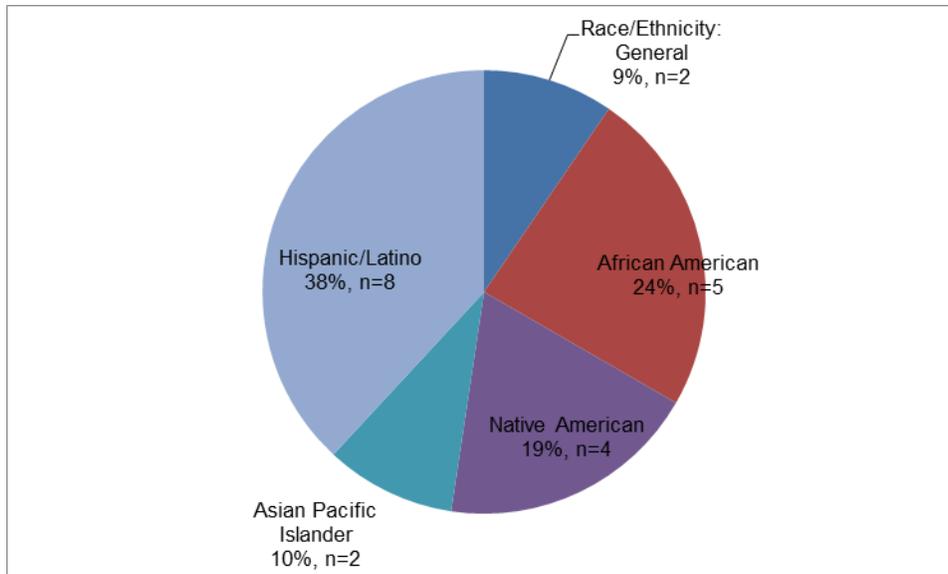
Figure 36: MHSA Central Region Overall Diversity Needs (n=16)



Language was the most commonly reported diversity need reported in the Central region (n=24). This was followed by needs related to race/ethnicity, cited 21 times. Needs related to

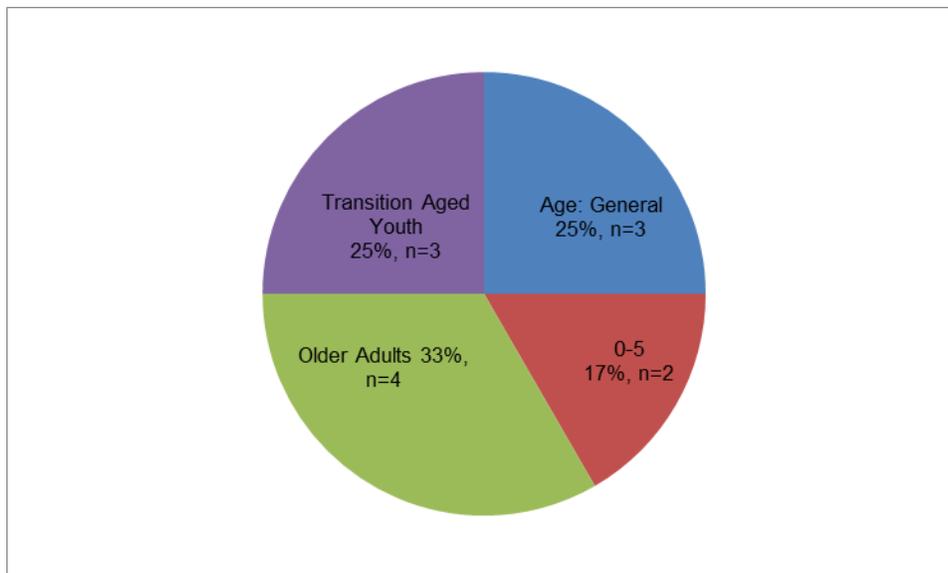
age were reported 12 times, sexual orientation were eight times, gender and physical/mental abilities three times each, and socio-economic status two times.

Figure 37: Central Region Race/Ethnicity Needs (n=16)



Of the race/ethnicity needs reported in the Central region, a need for Hispanic/Latino staff was reported with the highest frequency at 38% of total race/ethnicity needs (eight counts). African Americans were the second most frequently cited population (five counts), followed by Native Americans (five counts). Asian Pacific Islanders and general race/ethnicity were each reported two times.

Figure 38: Central Region Age Needs (n=16)



Central region counties referred to Older Adults 33% of the time. The next highest percentages referred to Transition Age Youth and age, general, 25% of the time. Counties reported early childhood needs, or 0-5 years, 17% of the time.

Los Angeles Region

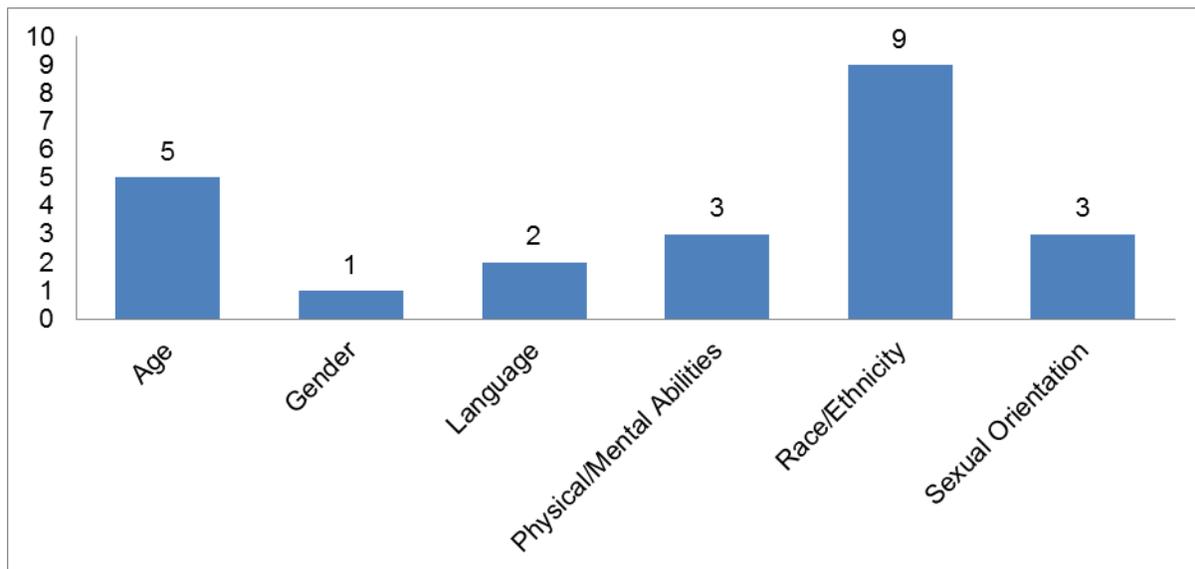
Table 5: Los Angeles Region Reported Diversity Needs (n=1)

Type of Diversity Need	Diversity Need
Race/Ethnicity	5
Sexual Orientation	1
Other	1

The Los Angeles region reported seven total diversity needs. Race/Ethnicity needs accounted for five of those needs, including the highest diversity need, “Latino.” Los Angeles also listed African/African/American, Asian Pacific Islander, Native American, and Middle Eastern/Eastern European. Listed in the “other” diversity need category were peers, parents, and/or family members.

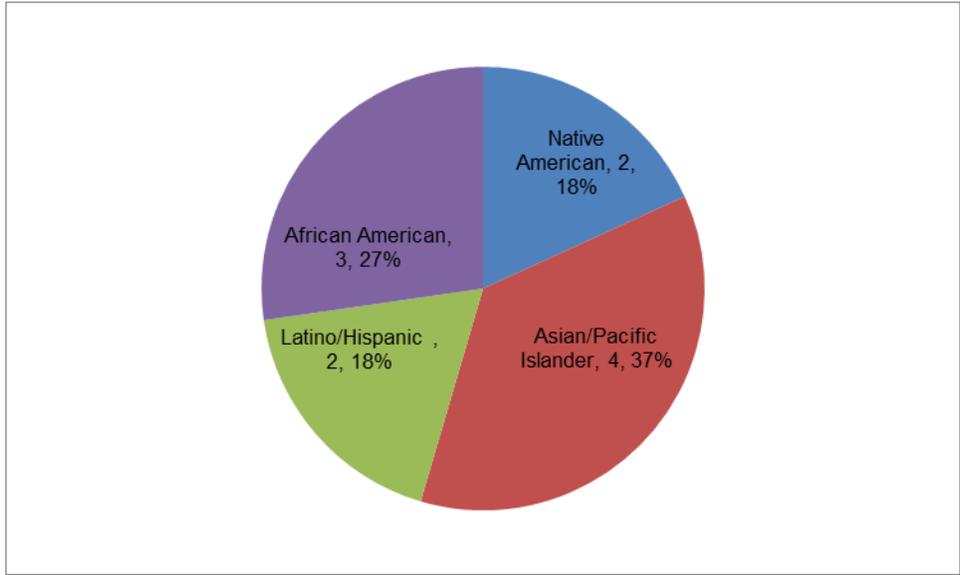
Southern Region

Figure 39: Southern Region Overall Diversity Needs (n=8)



Southern region counties reported race and ethnicity needs as the most common diversity need. The composition of reported needs related to race/ethnicity is outlined in Figure 40. Among the age-related needs reported, counties listed either “age” in general or “age, transition age youth” (two counts). Needs related to physical or mental abilities included deaf and hard of hearing (n=2) and visually impaired (n=1). Gender was exclusively reported as “gender”. Needs related to sexual orientation, reported a total of four times, referred either to sexual orientation in general, or when specified, always to LGBTQI (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex) communities.

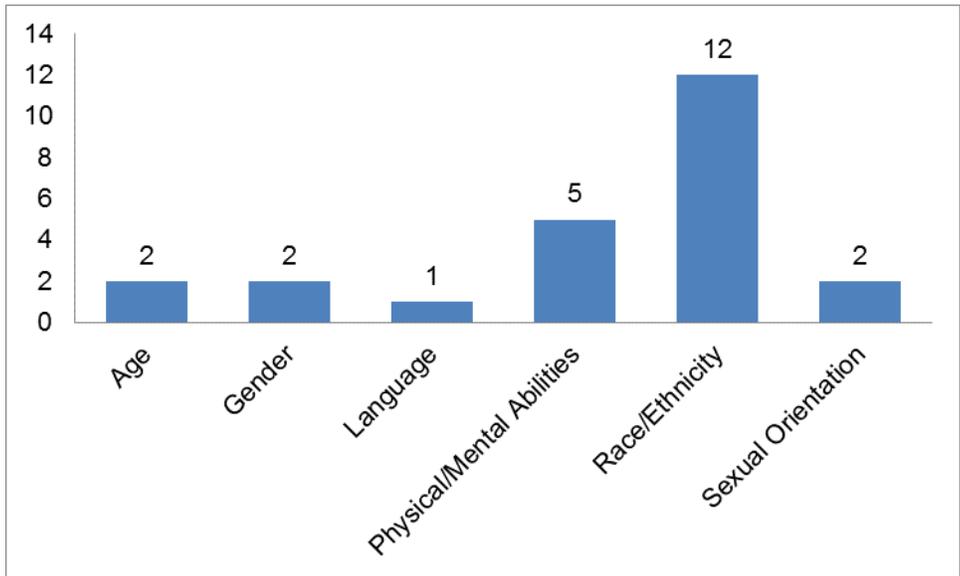
Figure 40: Southern Region Race/Ethnicity Needs (n=8)



Counties in the Southern region reported Asian Pacific Islanders as the most common race/ethnicity need (n=4), closely followed by African Americans (n=3). Needs related to Hispanic/Latinos and Native Americans were each reported two times.

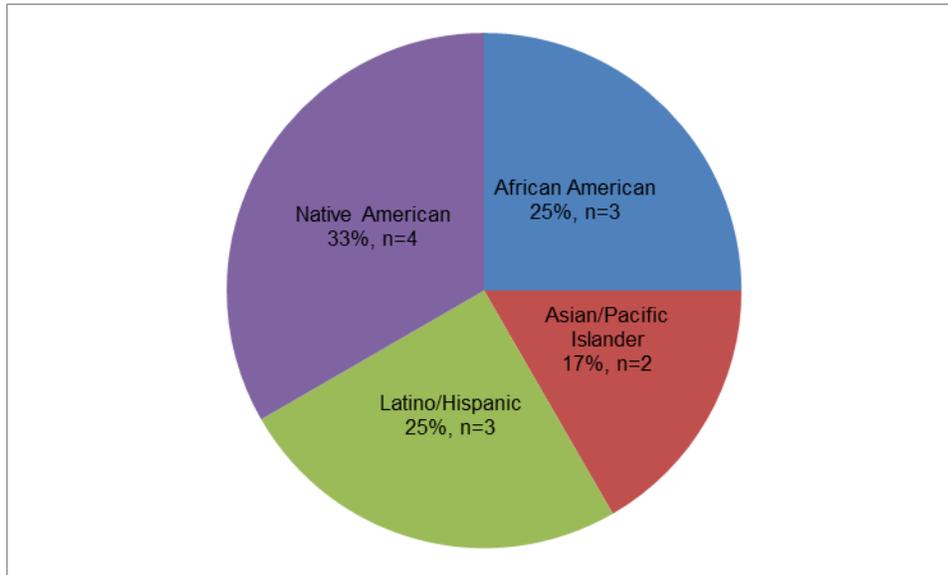
Superior Region

Figure 41: Superior Region Overall Diversity Needs (n=7)



In the Superior region, race/ethnicity needs were reported with the greatest frequency—at least three times more frequently than other needs, including physical/mental abilities (n=5), age (n=2), gender (n=2), sexual orientation (n=2) or language (n=1).

Figure 42: MHSA Superior Region Race/Ethnicity Needs (n=7)



Among Superior region counties that specified needs related to particular racial/ethnic groups, one third of counties (33%) mentioned Native Americans. This was followed by African American and Latino/Hispanic needs at 25% each, and Asian/Asian Pacific Islander needs at 17%.

Summary of Region Diversity Needs

Overall, diversity needs across almost all regions showed demand for specific racial and ethnic backgrounds, as well as age experience needs. Latinos and African Americans were the overall most highly rated needs, but the “second tier” of needs for Native Americans, Asian/Pacific Islanders, and Middle Eastern diversity needs was not far behind in frequency. The racial/ethnic categories listed by counties in the Superior region were unique from the other California regions. Whereas in most other regions, Latino/Hispanic and African Americans and needs constituted the bulk of reports, in the Superior region, Native Americans were cited at the highest frequency (33%). Asians and Asian Pacific Islanders were cited 17% of the time.

Age constituted the most frequent demand, despite never being ranked as a highest need. Counties consistently cited staffing needs related to older adults and Transition Aged Youth. This data complements the frequently reported need for Child and Adolescent Psychiatrists in the Workforce Shortages and Hard-to-Fill, Hard-to-Retain sections of this report.

A few counties cited socio-economic status as a need. Likewise, sexual orientation (which when specified almost always referred to LGBTQI communities), was infrequently cited as a diversity need and was never cited as a highest need.

Language Needs

Sources and Limitations

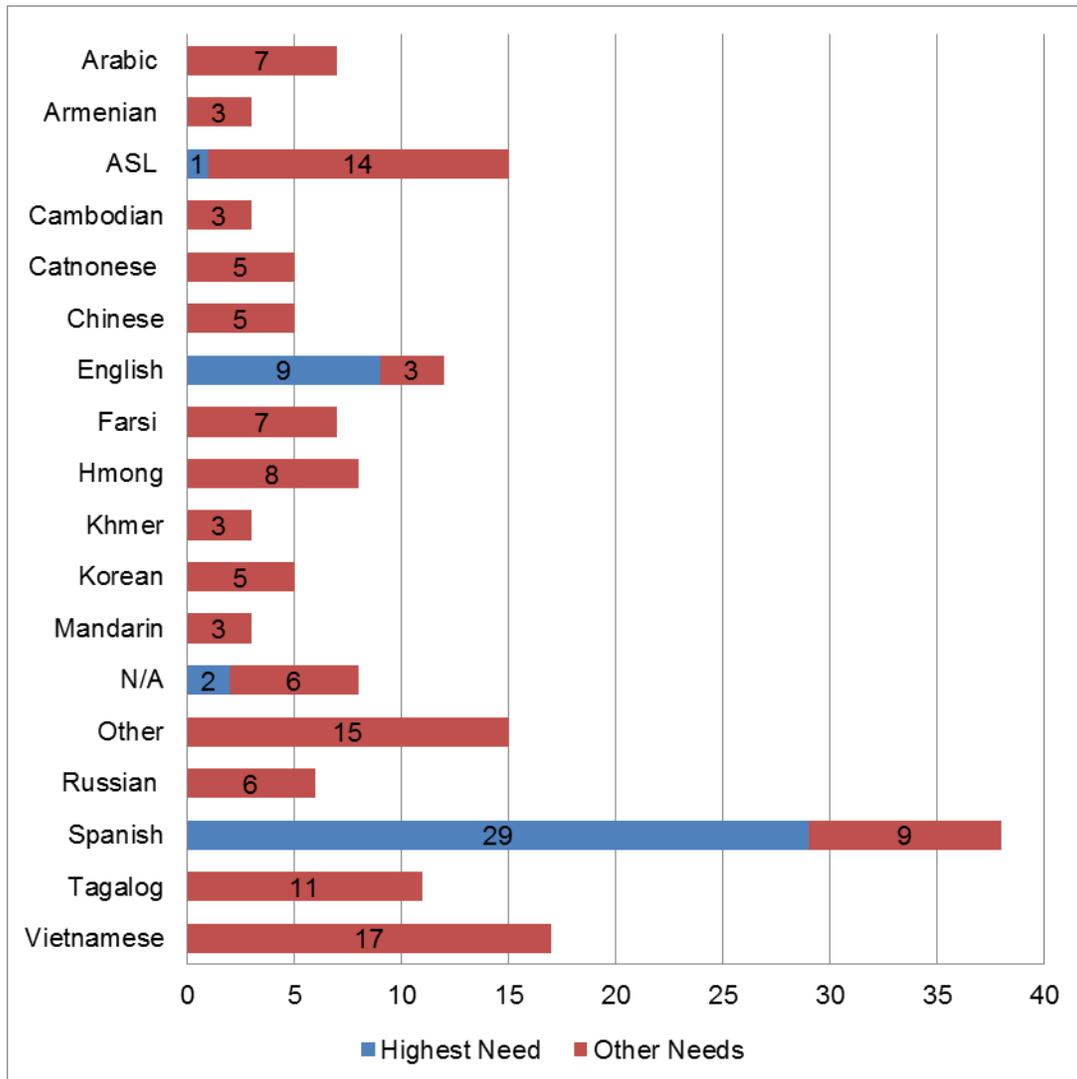
Counties were asked directly in the County-Reported Needs Assessment to list their workforce language needs. This data is analyzed below by overall statewide language needs, trends by MHSA region, and trends by county size.

Using the County-Reported Needs Assessment data, statewide language needs are depicted in Figure 43. As in earlier sections, the blue shading represents counties listing a particular language as the *number one* need, while red shading represents instances where a language was listed but not as the highest need.

Spanish was by far the highest and most frequently cited need, surpassing the second most frequently cited language need (Vietnamese) by over 20 counts. In addition to Vietnamese, Sign Language (ASL) was also frequently cited (15 counts). Interestingly, English was also cited with some frequency (12 counts).⁴

⁴ Suggesting either that counties listed out their consumers' most frequently used languages, or perhaps there is an influx of non-English speakers into the mental health workforce. Any of these trends could be explored in the ensuing phases of the project.

Figure 43: Overall Language Needs (n=41)



Language Needs Trends by Region

Language needs have many similarities and differences across MHSA regions, as detailed in the following figures.

Figure 44: Overall Language Needs by MHSA Region (n=41)

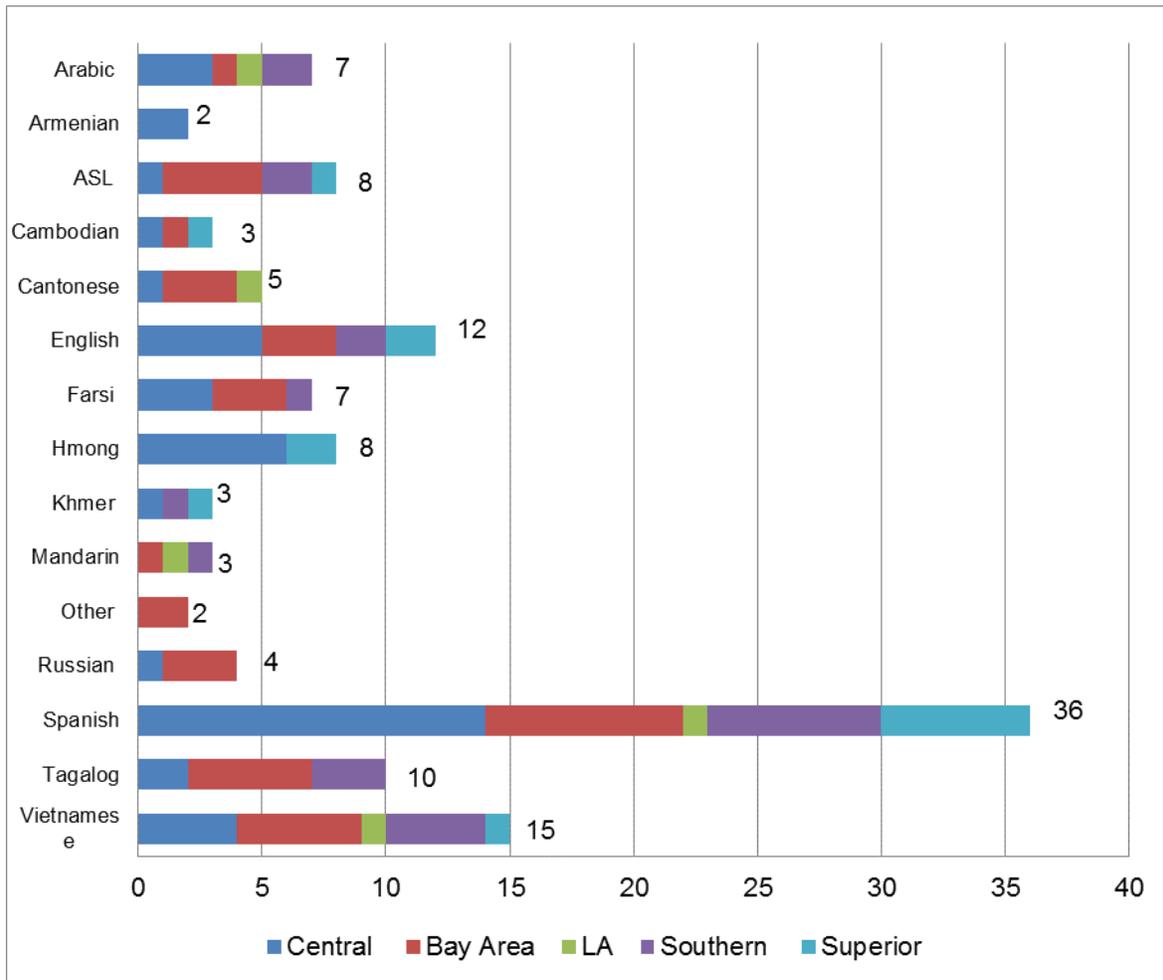


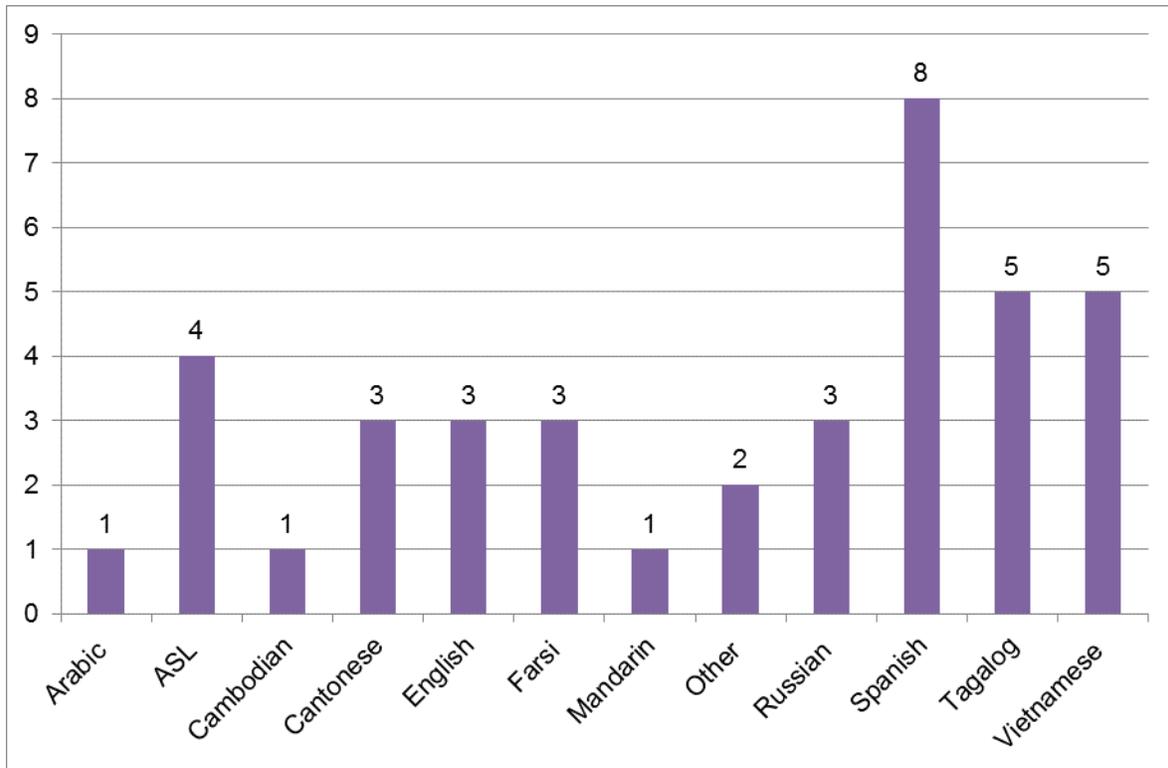
Figure 44 depicts counts of language needs by MHSA region. Across all regions, Spanish was the most frequently cited need. Table 5 includes the values depicted visually in Figure 44.

Table 6: Overall Language Needs by MHSA Region (n=41)

Language Need	Central	Bay Area	Los Angeles	Southern	Superior	TOTAL
Arabic	3	1	1	2	0	7
Armenian	2	0	0	0	0	2
ASL	1	4	0	2	1	8
Cambodian	1	1	0	0	1	3
Cantonese	1	3	1	0	0	5
English	5	3	0	2	2	12
Farsi	3	3	0	1	0	7
Hmong	6	0	0	0	2	8
Khmer	1	0	0	1	1	3
Mandarin	0	1	1	1	0	3
Other	0	2	0	0	0	2
Russian	1	3	0	0	0	4
Spanish	14	8	1	7	6	36
Tagalog	2	5	0	3	0	10
Vietnamese	4	5	1	4	1	15
TOTAL	44	39	5	23	14	125

Bay Area Region

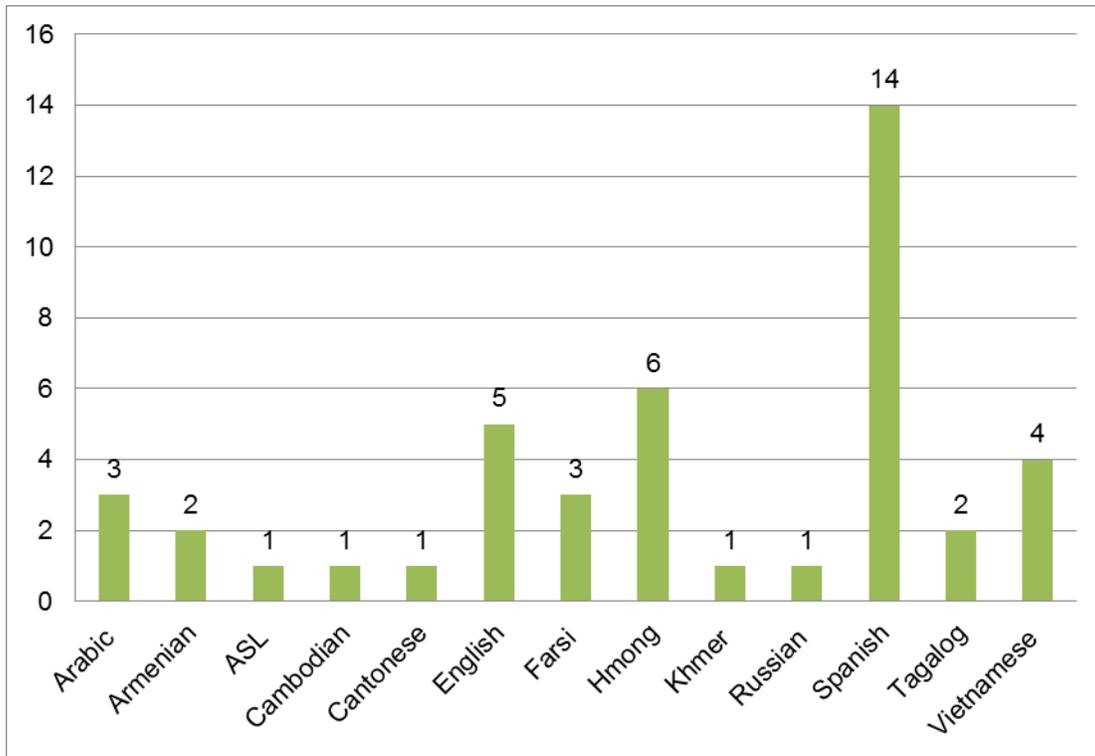
Figure 45: Bay Area Region Language Needs (n=9)



Spanish was the most frequently cited language need in the Bay Area region, reported eight times. This was followed by Tagalog and Vietnamese, each reported five times. ASL was reported four times, while remaining languages were reported three times or fewer.

Central Region

Figure 46: Central Region Language Needs (n=16)



Counties in the Central region most frequently cited Spanish as a language need, with Hmong, English, and Vietnamese reported as other common need languages. Arabic and Farsi were also cited, representing some of the Middle Eastern language needs. ASL, Cambodian, Cantonese, Khmer, and Russian were each cited once.

Los Angeles Region

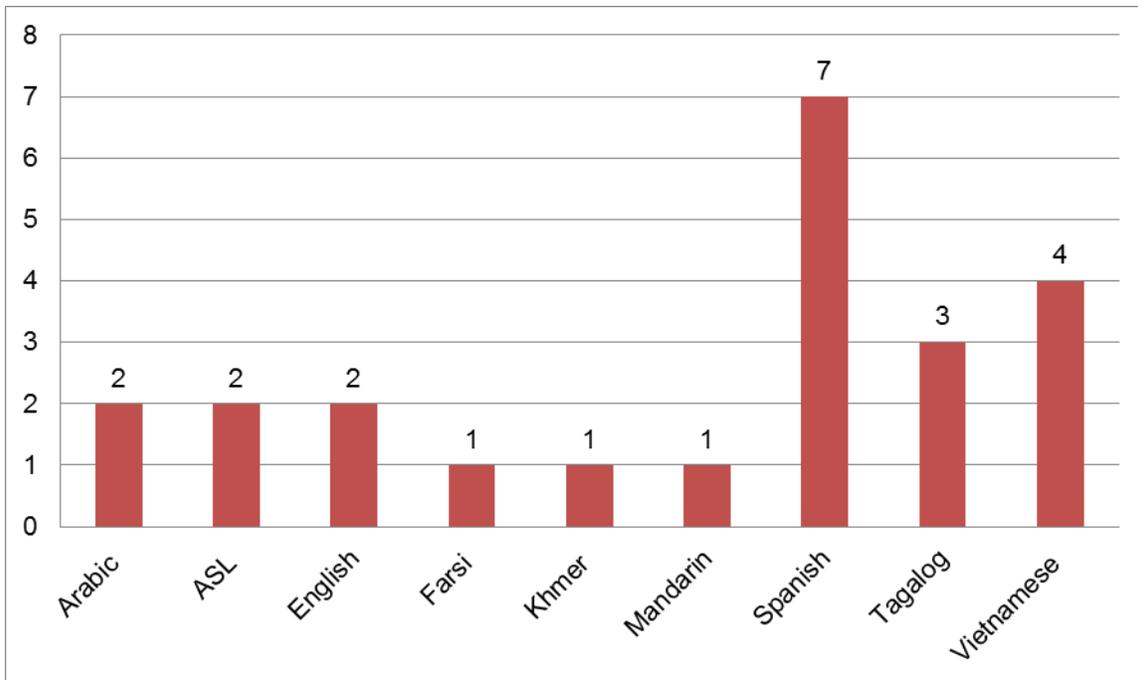
Table 7: Los Angeles Region Language Needs (n=1)

Los Angeles Region Language Needs (in order of rank)	
1.	Spanish
2.	Armenian
3.	Cantonese
4.	Vietnamese
5.	Korean
6.	Mandarin
7.	Arabic

Los Angeles region reported seven language needs, listed in rank order in Table 7. Spanish was the highest priority language need.

Southern Region

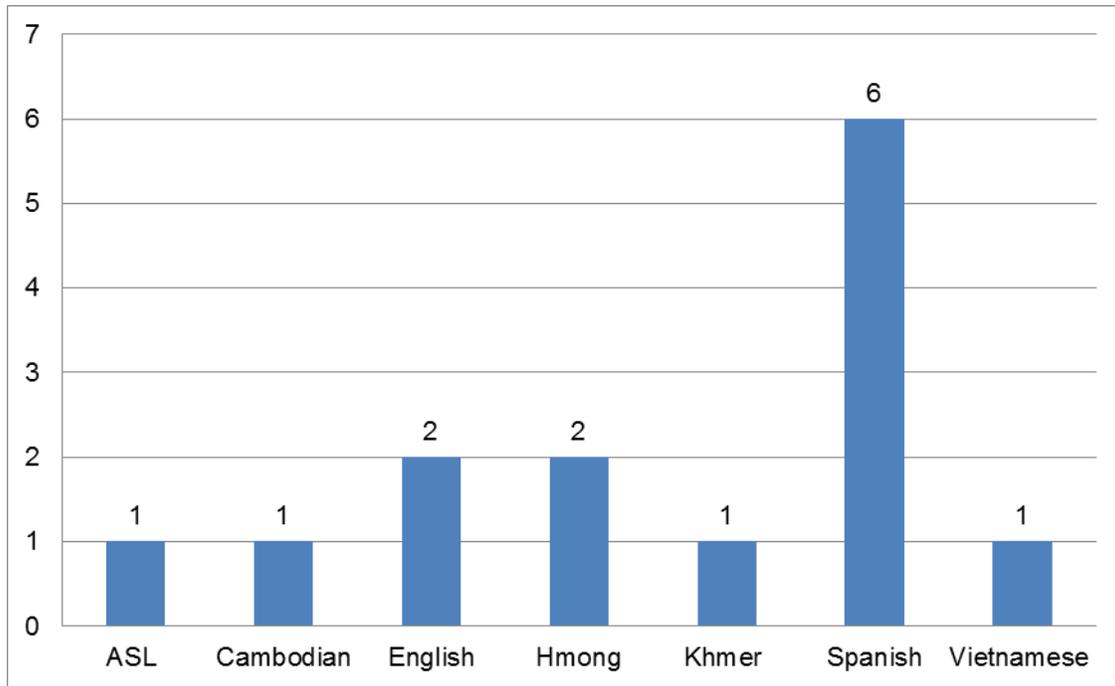
Figure 47: Southern Region Language Needs (n=8)



Spanish constituted the most commonly reported language need in the Southern region. Vietnamese and Tagalog were cited at the second highest needs, while Arabic, ASL, English were each cited twice.

Superior Region

Figure 48: MHSA Superior Region Language Needs (n=7)

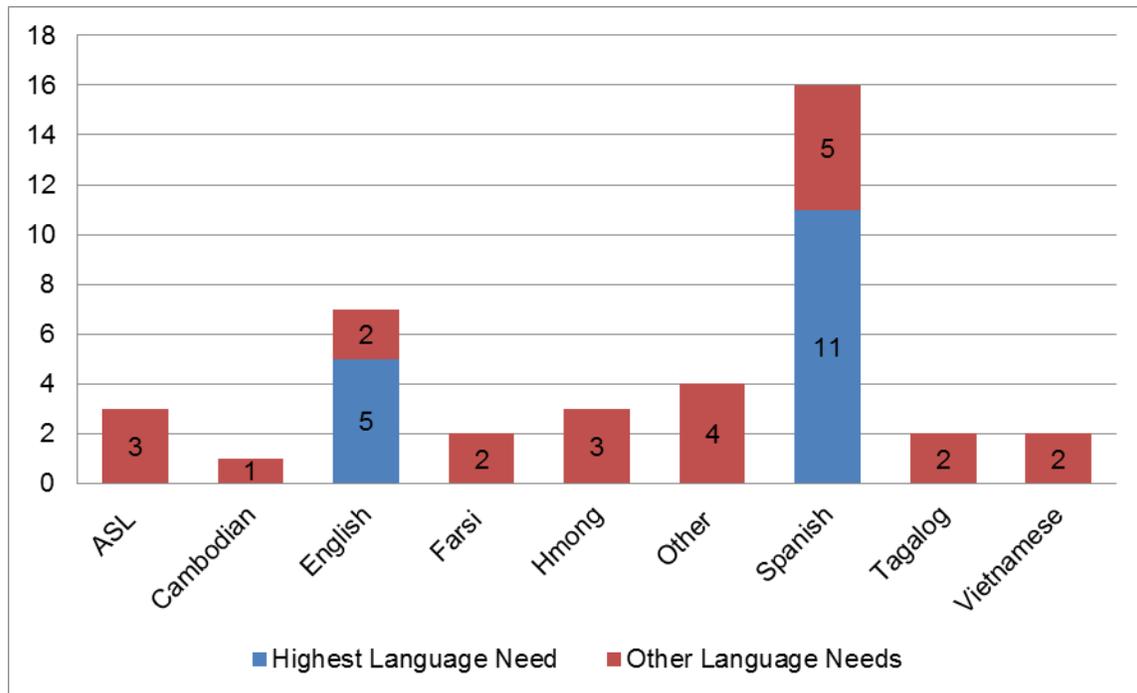


In the Superior region, counties were consistent with the California trend of Spanish appearing as the highest frequency need. English and Hmong then represented the second most frequently cited language needs, followed by ASL, Cambodian, Khmer, and Vietnamese. Interestingly, with the exception of Spanish and English, the MHSA Superior region counties cited exclusively Southeast Asian languages.

Language Needs Trends by Size

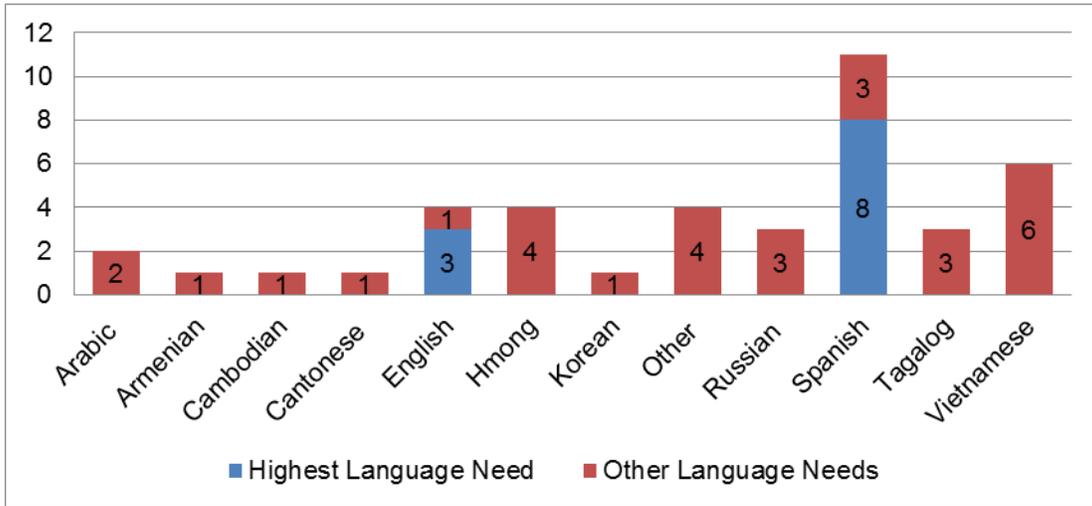
The following charts present reported language needs according to county size. As in previous sections, blue shading represents highest-need reports, while red shading represents reports other than highest need. Across all county sizes, Spanish was the most commonly cited need.

Figure 49: Language Needs of Small Counties (n=18)



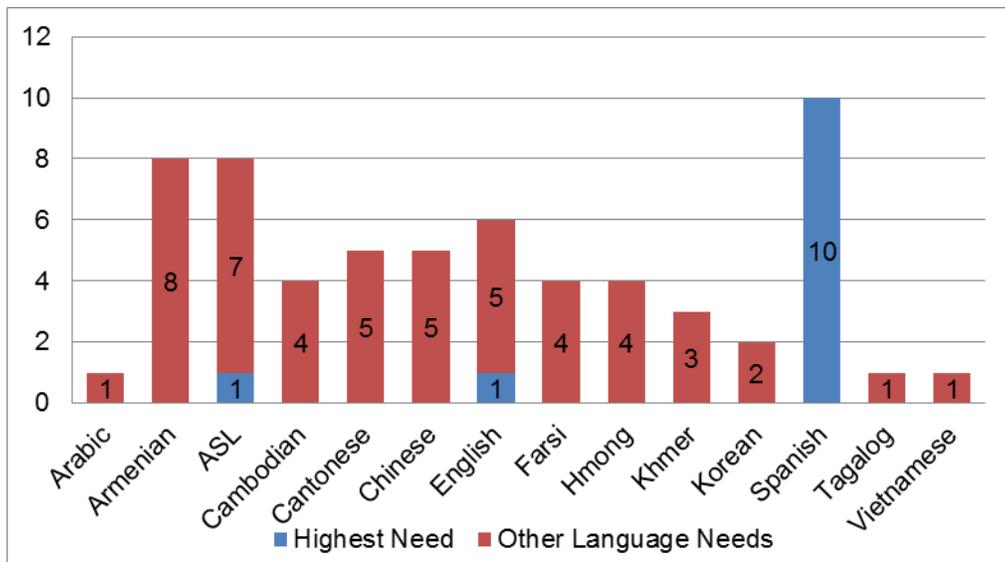
Among small counties, Spanish and English were cited as the highest language needs. Sign Language and Hmong were cited second most frequently, while Tagalog, Vietnamese, Farsi, and Cambodian represented other needs.

Figure 50: Language Needs of Medium Counties (n=11)



Among medium counties, both Spanish and English were again cited as the highest need languages. Vietnamese, Tagalog, Russian, Hmong, and Arabic were reported in the mid-range frequency among other needs. Armenian, Cambodian, Cantonese, and Korean were each reported once among other needs.

Figure 51: Language Needs of Large Counties (n=12)



Spanish was the highest and most frequently reported need in large counties, cited 10 times. ASL and Armenian were also commonly reported (eight times), followed by Chinese, English, Cambodian, Farsi, and Hmong. Khmer, Korean, Arabic, Tagalog, and Vietnamese were each mentioned three times or fewer.

Language Needs Summary

Spanish language needs are in highest demand across the state. Spanish was consistently identified as a language need when stratifying the counties by both MHSA regions and the various county sizes.

Positions for Consumer and/or Family Members

Sources and Limitations

The County-Reported Needs Assessment, County Annual Updates, and Community Forums provide feedback and information on opportunities for consumer and/or family members. This analysis focuses on the County-Reported Needs Assessment; the report titled, “MHSA WET Five-Year Plan Assessment: Summary of Stakeholder Feedback,” in Report 2 – Stakeholder Feedback explores the data collected in Community Forums. The County Annual Updates provided very different types of information on Consumer and/or Family member opportunities, making a systematic analysis virtually impossible. Some counties chose to provide qualitative stories of how consumers and/or family members are currently being integrated into county employment, others chose to share the challenges and barriers to integrating consumer and/or family members, and some did not report on this topic at all. As a result of the wide variation in data reporting in the County Annual Updates, the information in the Annual Updates is not analyzed in this report. The focus instead is on the data in the County Reported Needs Assessment, as outlined below.

In the County-Reported Needs Assessment, counties were prompted to provide descriptions of any currently designated positions and specific roles for consumer and/or family member positions. Counties were also asked to provide a description of future roles that consumers and/or family members could fulfill in their county.

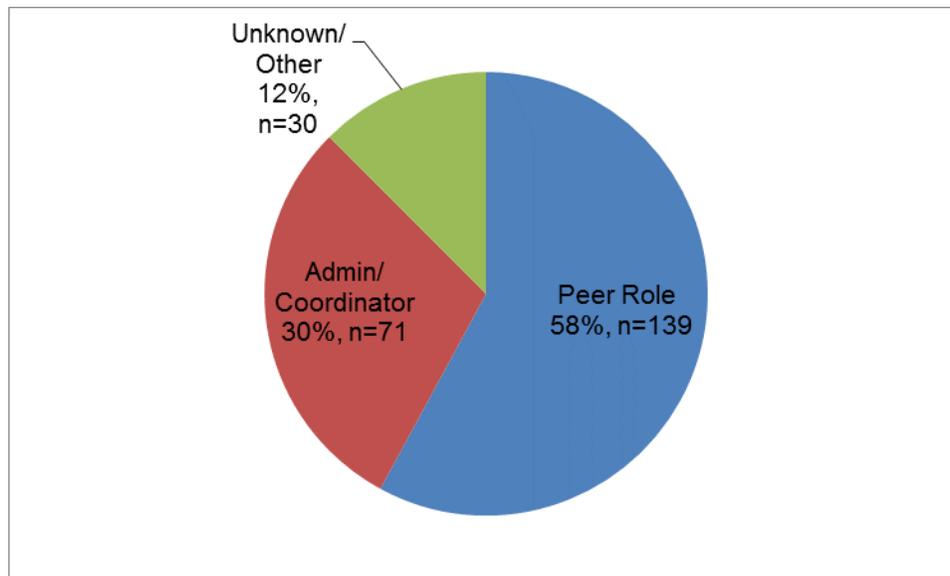
Counties responded in a variety of forms. Some responded in list form with titles only, so an answer may look like “Peer Specialist,” or “Mental Health Specialist.” Some included descriptions along with titles, such as the location of the position (e.g., Wellness Centers, Behavioral Health department).

In order to proceed with the data, RDA constructed the following set of rules to consistently assess counties’ diverse set of responses. First, if the reported title was ambiguous, such as Mental Health Specialist, and without a description, the position was classified as a Peer. This decision was based on the Annual Update descriptions of how consumer and/or family members are most typically engaged as specialists. Second, when counties did disclose job descriptions, position descriptions often diverged from the OSHPD classifications of Designated Consumer and/or Family Member Position types (Direct Service Provider, Training and Education, Advocacy, and Administrative/Policy and Planning). Position descriptions appeared to fall into two categories, representing direct service and administration roles. For the purpose of analysis we thus condensed the OSHPD categories into two classifications: “Peer,” which indicates any type of support, training, or coordination of peer programs; and “Administrative/Clerical,” which refers to non-service positions.

Counties also varied in how they quantified the types and number of positions available, with only some specifying an exact number of available positions available. Given the differences in how data were reported, two separate analyses are presented below—one set with the quantified data, and one set with the unspecified data. The latter is meant to provide a sense of counties where there were positions available, but where it would be methodologically unsound to assign an exact number of positions.

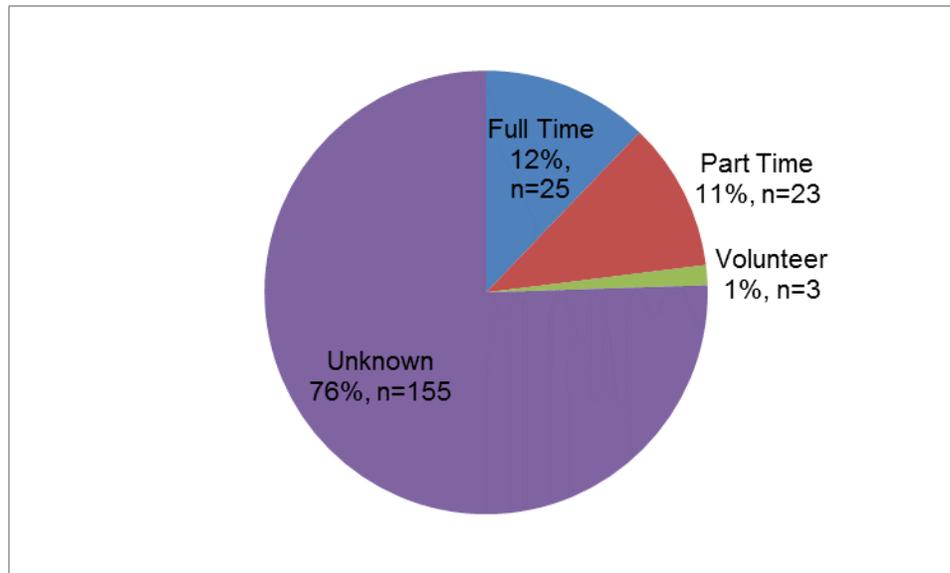
Finally, some counties reported certain positions filled by consumers and/or family members that were not included in the designated list of positions. To understand the extent to which consumers and/or family members were represented in designated versus non-designated positions in the county, RDA has analyzed those separately as well. Since the prompt asked for designated positions, they are assumed designated unless otherwise specified.

Figure 52: Role Type of Consumer and/or Family Member Positions (n=41)



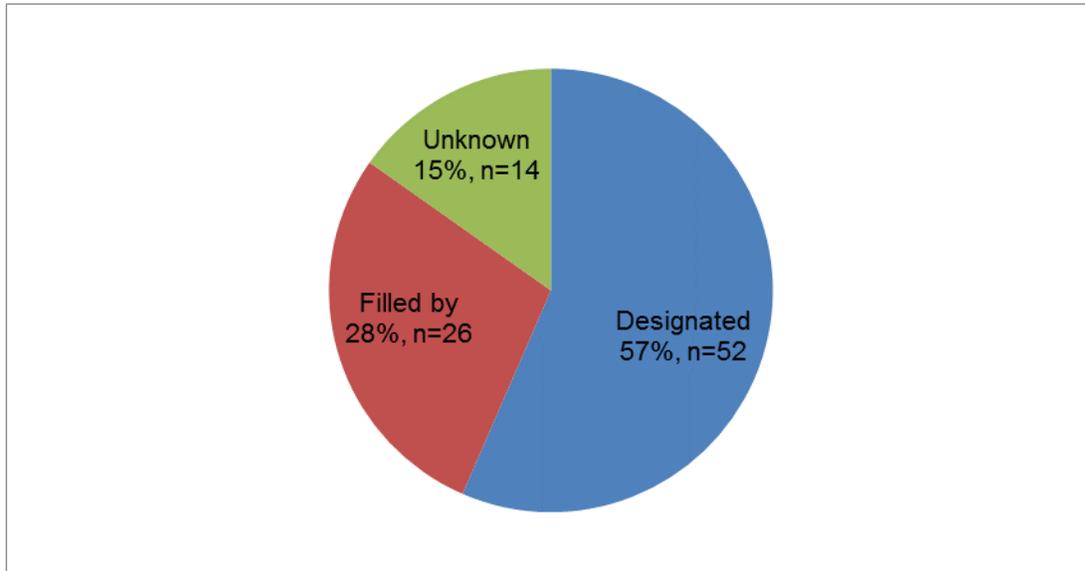
As Figure 52 shows, a majority of the available consumer and/or family member positions were Peer positions (58%). Peer positions included any peer support, peer specialist, peer advocate, parent advocate, cultural specialist, or other service-related position. Another 30% of consumer and/or family positions were categorized as Administrative or Clerical. These positions included office support, technical support, transportation support, or administrative roles such as receptionists. The remaining 12% of consumer and/or family member positions were classified as “Other or Unknown.” RDA used this categorization when counties reported that they had designated consumer and/or family positions but did not specify any other information.

Figure 53: Consumer and/or Family Member Positions by Employment Type (n=41)



The strong majority of listings for consumer and/or family member positions did not specify the employment type, whether full time, part-time, or volunteer, of the position. Among the times that it was designated, 12% of the overall consumer and/or family member opportunities were listed as full time, 11% as part time, and 1% as volunteer positions.

Twenty-five percent of responding counties discussed the importance of a peer certification program in the Statewide Recommendations section of the County-Reported Needs Assessments. For example, one county wrote, “Having a California State standard, so that the credential is applicable across counties and represents the same core knowledge, would benefit this process, and avoid duplication of efforts or a smattering of credentials that may or may not have county reciprocity. The qualifications to test for certification should include a period of mentored practice, similar to the supervision requirement of licensed Therapists. Upon development of such certification, training standards could also be developed as well as the related supports to encourage peers to study and become certified.” Another county wrote, “Develop state wide certification for Peer Support Specialists which would provide standards for qualifications, training, and billing capability.”

Figure 54: Designation Status of Consumer and/or Family Positions (n=41)

Many counties noted that they did not have positions specifically designated as Consumer and/or Family Member positions, but that they did have consumers and/or family members currently working in the county or in a county agency. Those distributions are captured here. Fifty-seven percent of the Consumer and/or Family Member positions listed were specifically designated by counties for consumer and/or family members. Twenty-eight percent of the positions listed were not explicitly designated as Consumer and/or Family Member positions, but were being filled by consumers/family members at the time of data collection. Fifteen percent of listed consumers and/or family member positions were unknown.

Unknown includes instances where counties reported, “Our wellness center hires peers,” – but without any specific designations of the number or type. Unknown also includes other instances, “We have plans to hire more peers in the future,” or when county listed “peer specialists” without a specific number. Since the calculations rely on percentages of the total, assigning numbers to those “unknowns” would have skewed the data.

Participation in Statewide WET Programs

Sources and Limitations

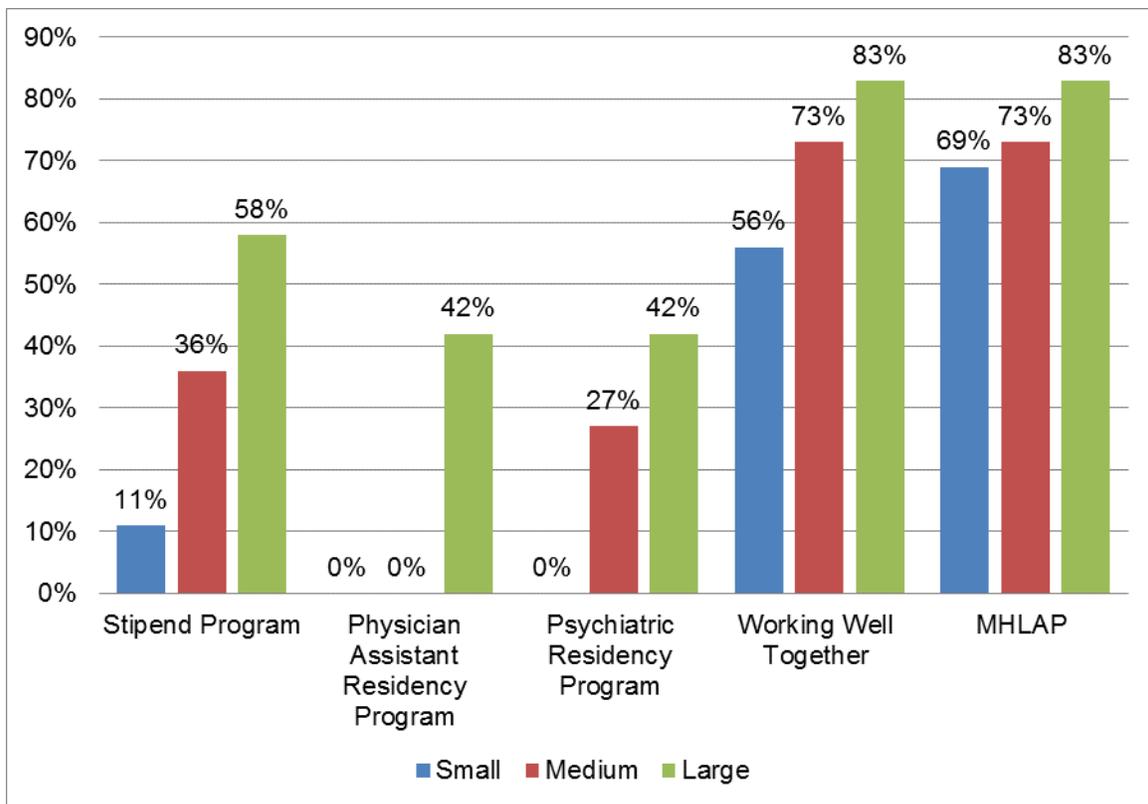
There are five statewide WET programs explored in this section of the report: Stipend Program, Mental Health Loan Assumption Program (MHLAP), Working Well Together, Psychiatric Residency Program, and Physician Assistant Residency Program. These programs and participation in these programs are discussed in the County-Reported Needs Assessment, the County Annual Updates, and the OSHPD-led Community Forums. The analysis of the Community Forums data is presented in Report 2 – Stakeholder Feedback, specifically the report titled, “MHSA WET Five-Year Plan Assessment: Summary of Stakeholder Feedback.”

Again, wide variation in the content of the Annual Updates prohibited substantive analysis. Some counties were detailed in their participation in these programs, with some counties even reporting the number of awardees and participants in each program. Other counties did not mention these programs in the Annual Updates. For this reason, the Annual Updates are not analyzed here. Instead, below we provide an analysis of reported participation in the five statewide WET programs using data from the County-Reported Needs Assessment.

Counties were designated as participants if they explicitly stated they participated or they had awardees from the county, or if their qualitative feedback showed that they were active participants in the application process for any of the programs. Counties were designated as “non-participants” if their qualitative feedback explicitly stated that they do not use the program, or if these sections were left blank.

The following figures first present an overview of participation in the five programs by region and county size, followed by an examination of participation in each individual program by region and county size.⁵

Figure 55: Participation in Statewide WET Programs by County Size (n=41)



Overall, the analysis showed a strong relationship between county size and participation in these programs, as depicted in Figure 55. Large counties participated the most, followed by

⁵ Los Angeles is both a county and an MHSA region; therefore, participation rates for Los Angeles will appear as either 100% or 0%.

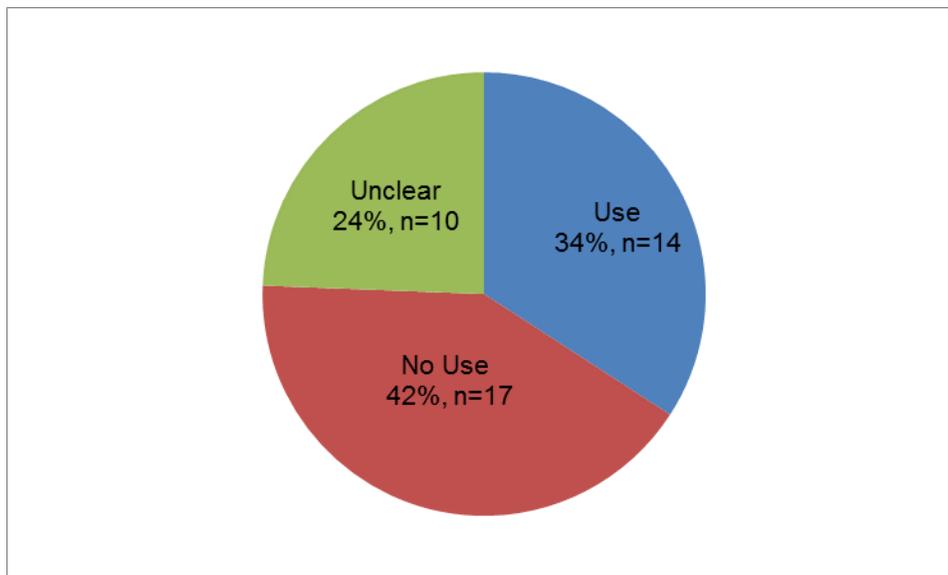
medium counties, and small counties participated the least or not at all. These patterns are most evident for the programs that require university and student engagement: the Stipend program, Psychiatric Residency Program, and Physician Assistant Residency Program.

County Participation in Stipend Programs

The statewide Stipend Program is available for graduate students studying Clinical Psychology, Marriage and Family Therapy, Psychiatric Mental Health Nurse Practice, and Social Work. In exchange for the stipend, students must commit to at least one year of work as a Marriage and Family Therapist Intern, Social Worker, or Nurse Practitioner in the public mental health system after graduation.

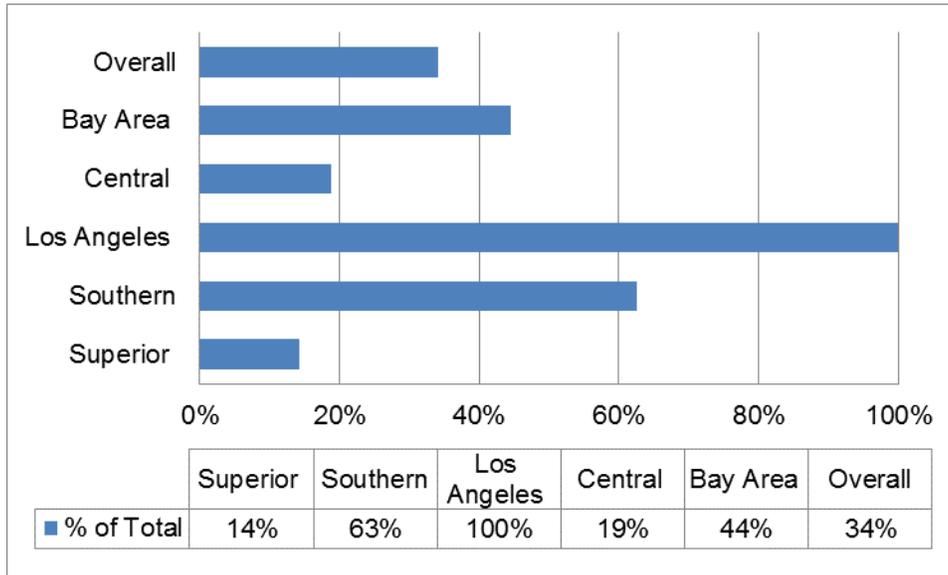
Data on stipend participation was drawn from the County-Reported Needs Assessment, where counties were asked to comment on their current use of the stipend program and to provide any comments and recommendations. Blank responses were interpreted as non-participation in the program.

Figure 56: Overall Stipend Program Participation (n=41)



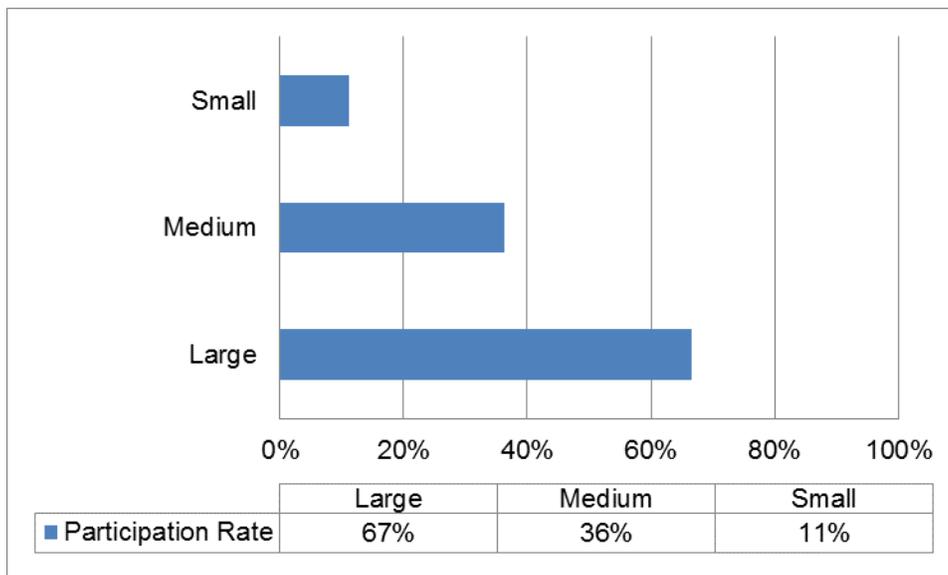
As shown in Figure 56, 34% percent of counties responded that they were participating in the stipend program. Forty-two percent of counties responded that they were not participating in the stipend program or left this section blank. At times respondents commented on the stipend program, but did not make clear whether their county was in fact participating in the program. In such cases, responses regarding participation were logged as “unclear,” which was the case for 24% of counties.

Figure 57: Stipend Program Participation by MHSAs Region (n=41)



The Los Angeles and Southern regions demonstrated the highest proportions of counties taking part in the stipend program. Over 60% of counties in the Southern regions reported participating in the program. This was followed by over 40% of the Bay Area region, 19% of counties in the Central region, and 14% of counties in the Superior region.

Figure 58: Stipend Program Participation by County Size (n=41)



As Figure 58 depicts, rates of participation in the stipend program increased with county size. Only 11% of small counties reported participating in the stipend program, while 36% of medium counties and 67% of large counties participated.

County Participation in Physician Assistants Residency Program

The Physician Assistant Residency Program added a specific mental health track to a healthcare wide Song-Brown Physician Assistant Residency Program. The program is meant to enhance the mental health workforce, especially to strengthen the number of individuals who can oversee psychiatric treatment plans and administer medication to mental health patients. Physician Assistant residency programs that train second-year residents to specialize in mental health are eligible to apply for augmented funding.

Only 12% of counties (five counties) reported participation in the Physician Assistant Residency Program, making it the least utilized statewide WET program.

Figure 59: Physician Assistant Residency Program Overall Participation (n=41)

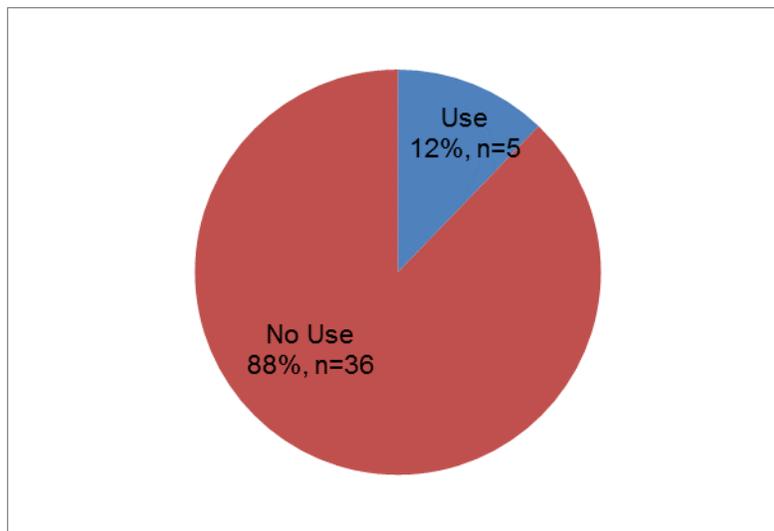


Figure 60: Participation in Physician Assistant Residency Program by MHA Region (n=41)

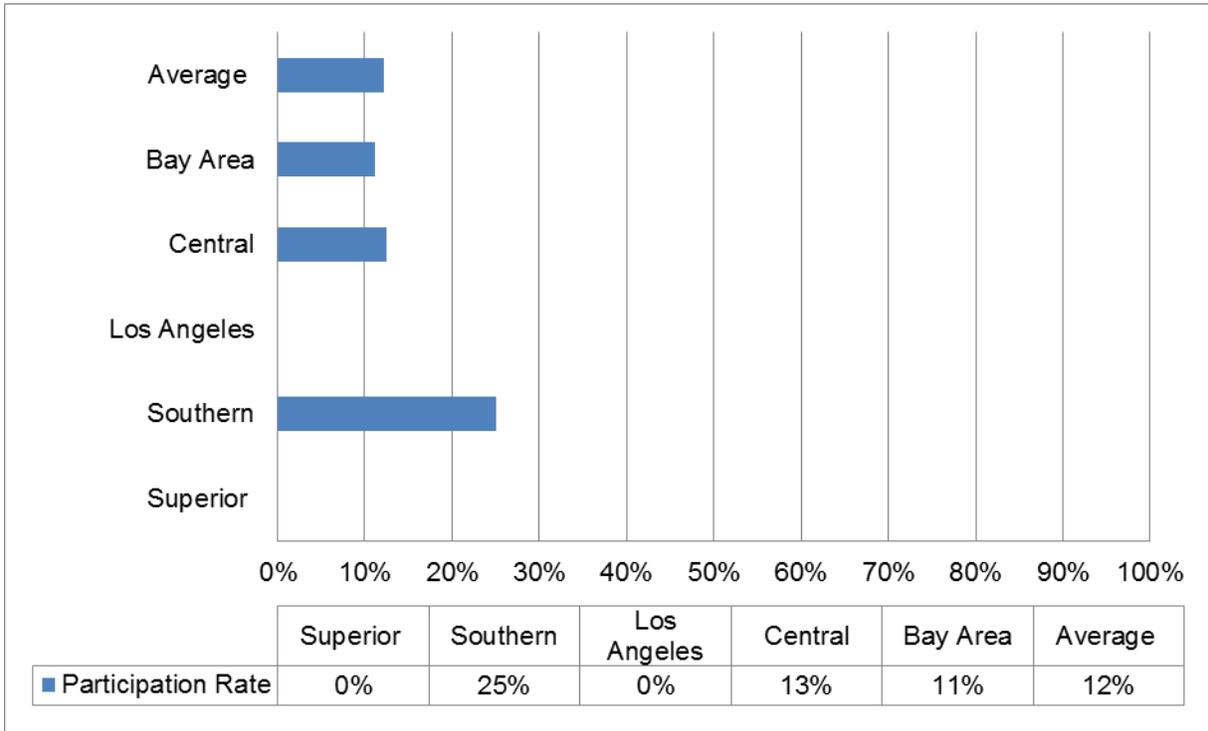
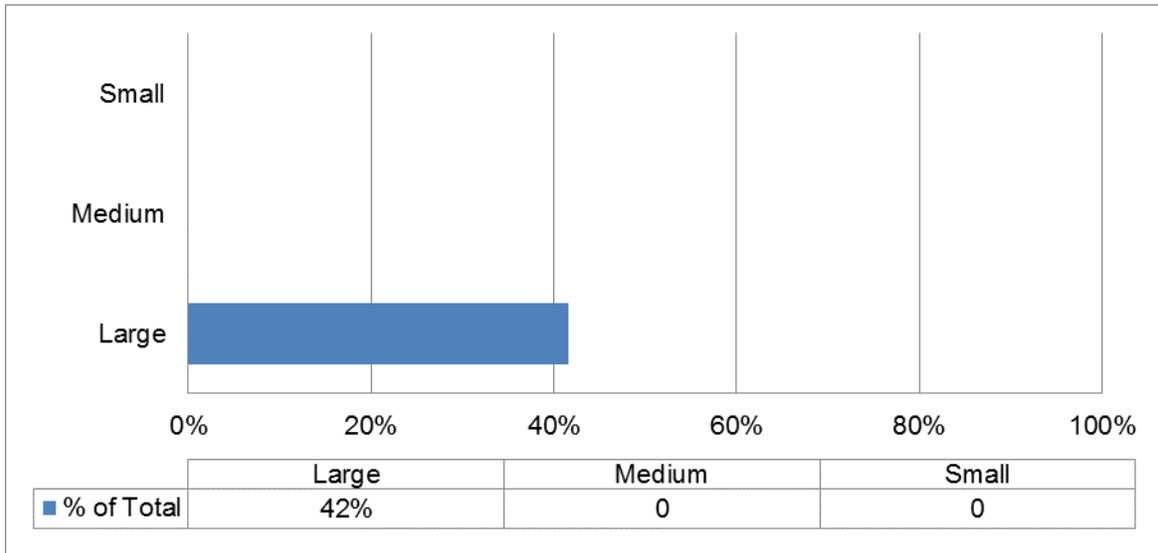


Figure 60 illustrates participation in the Physician Assistant Residency Program rate by MHA region. A total of five counties reported participation in the Physician Assistant Residency Program. Twenty-five percent of the Southern region counties (two counties) participated, constituting the largest regional participation rate for this program. Thirteen percent of MHA Central region counties (two counties) participated, and 11% of counties in the Bay Area region participated in the Physician Assistant Residency Program. Similar to the Psychiatric Residency program, there was no participation reported from the Los Angeles or Superior regions.

Figure 61: Physician Assistant Residency Program Participation Rate by County Size (n=41)

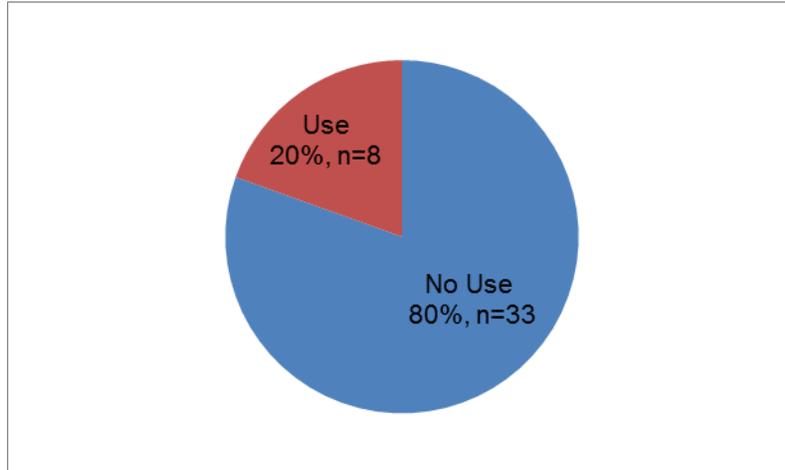


All of the counties participating in the Physician Assistant (PA) Residency program were large counties, which translates to 42% of all MHSA large counties. It should be noted that many of the awardees of the PA residency were located in large counties and therefore, the large counties participated in that program.

County Participation in Psychiatric Residency Program

The Psychiatric Residency Program trains psychiatric residency students in the public mental health system and specifically prepares them to work with the community’s most needed demographics. The Psychiatric Residency Program ensures that the psychiatric residents receive training in the public mental health system, working with the populations prioritized by that community. Further, the psychiatric residents are encouraged to continue working in the California public mental health system after their rotations end.

Figure 62: Overall Psychiatric Residency Program Participation (n=41)



Overall, only 20% of counties (eight counties) reported using the statewide Psychiatric Residency Program.

Figure 63: Psychiatric Residency Participation Rate by MHSA Region (n=41)

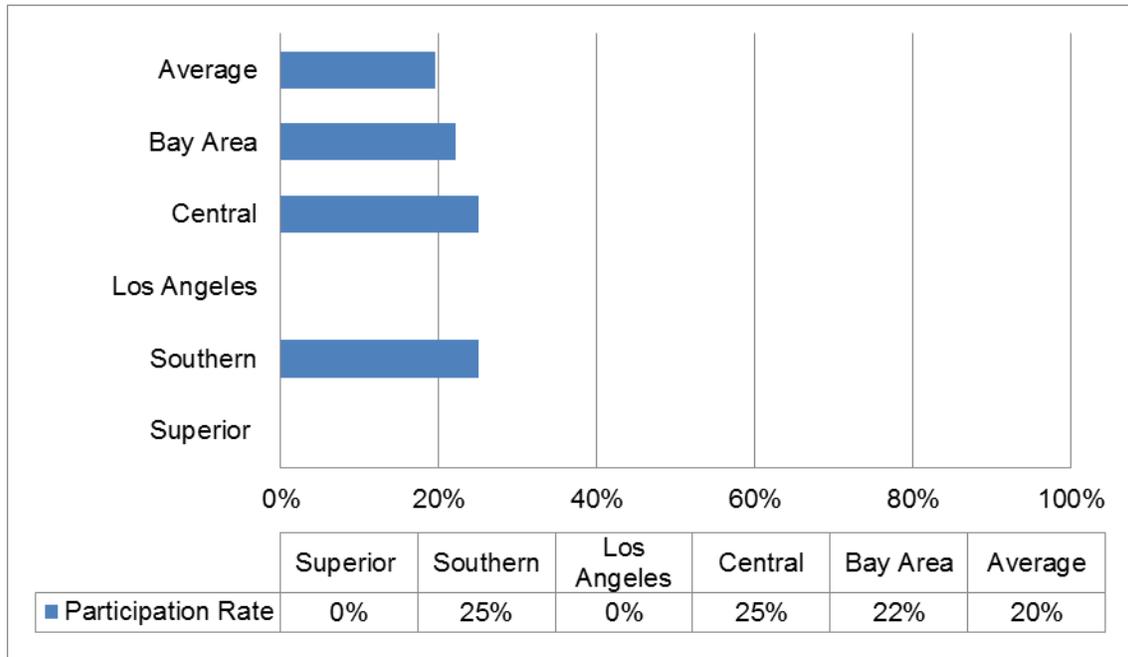
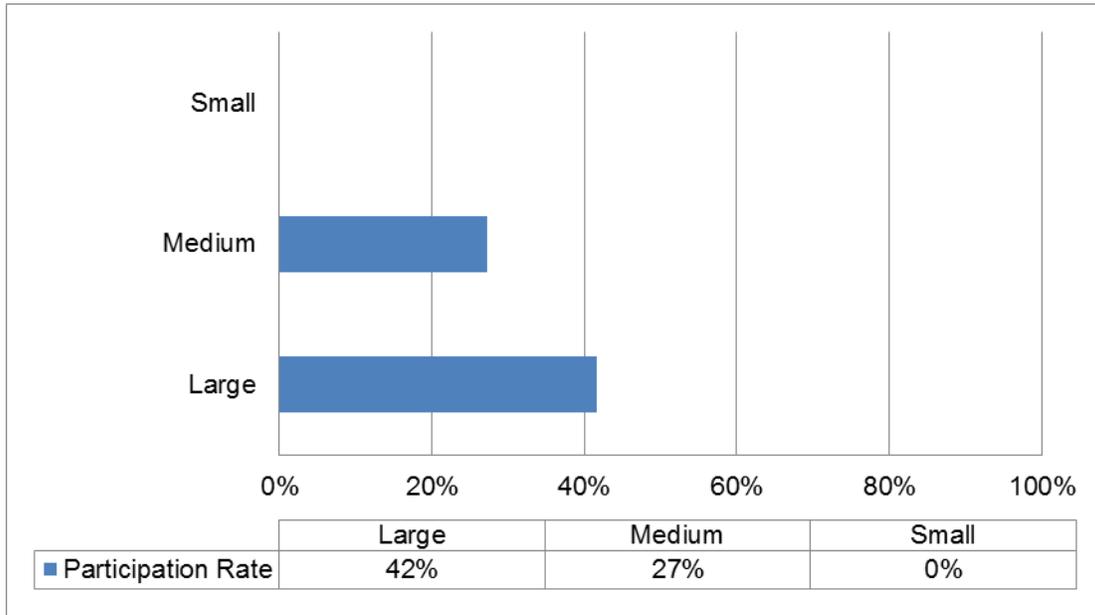


Figure 63 depicts participation in the psychiatric residency program by region. One quarter (25%) of counties in the Central and Southern regions reported participating in the program, followed by 22% of counties in the Bay Area region. In both the Los Angeles and Superior regions, there were no counties reporting participation in the program.

Figure 64: Psychiatric Residency Participation Rate by County Size (n=41)

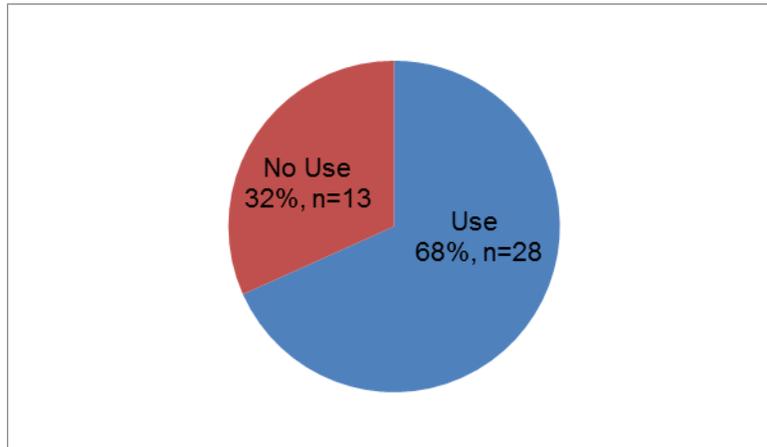


As with the stipend program, participation in this statewide program appears to be related to county size, as no small counties participated, 27% of medium counties participated, and 42% of large counties participated.

County Participation in Working Well Together (WWT)

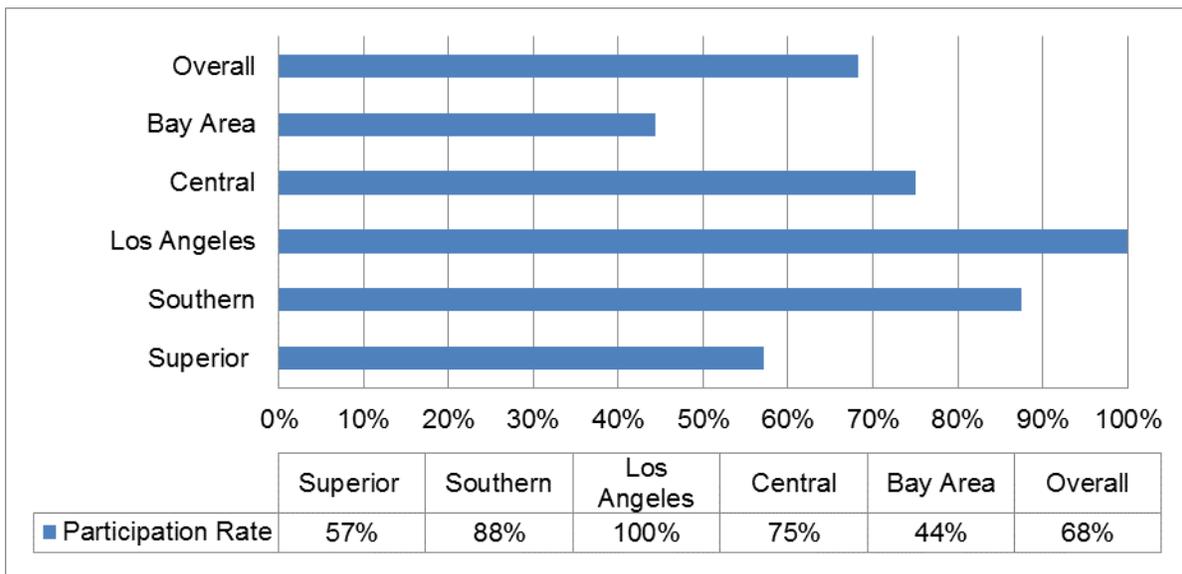
The California Statewide Technical Assistance Center, more commonly known as Working Well Together (WWT), is a resource for training and technical assistance to California’s public mental health agencies regarding “recruitment, hiring, retention, and support of current and future employees with personal experience receiving public mental health.” County participation in WWT was determined by county responses in the County-Reported Workforce Needs Assessment. Counties were asked to provide a description of their use of the program and any recommendations to enhance the program.

Figure 65: Overall Use of Working Well Together Programs (n=41)



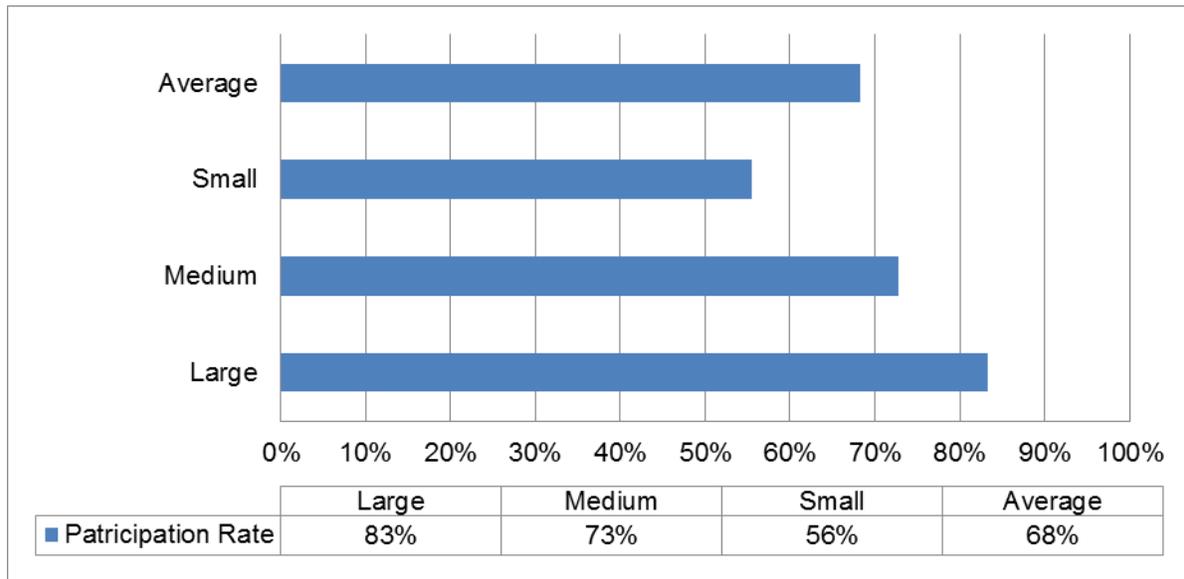
Over two thirds of counties reported previous and/or continuing use of the statewide WWT Programs (68% of counties). Of these, nine counties reported that consumer and/or family member providers participated in those trainings.

Figure 66: Working Well Together Participation Rate by MHSA Region (n=41)



Looking at WWT participation by region, Los Angeles county reported participating in the program, as did 88% of Southern counties. This was followed by 75% of counties in the Central region, 57% of Superior region counties, and 44% of Bay Area region counties.

Figure 67: Working Well Together Participation Rate by County Size (n=41)



Again, as seen in previous sections, participation rates for WWT appeared to be related to county size. Large counties participated at the highest rate (83% of large counties), followed by 73% of medium counties, and 56% of small counties.

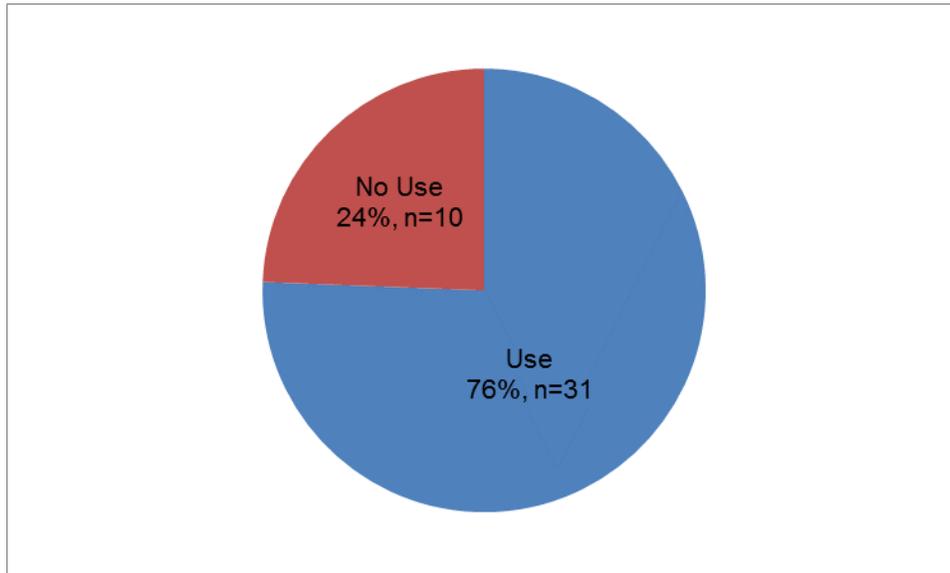
Qualitative Feedback

Counties provided qualitative feedback and suggestions for WWT trainings that were largely positive. As an example, some counties thanked specific WWT staff for their help and engagement. Among the areas of improvement, counties suggested that WWT include more regionally-based trainings, as well as improving the program’s website and overall marketing. Counties also noted that the WWT staff and programs tended to focus more heavily on improving peer support and training for consumers and/or family members, and could benefit from enhancing training related to operations and administration of public mental health services.

County Participation in Mental Health Loan Assumption Program

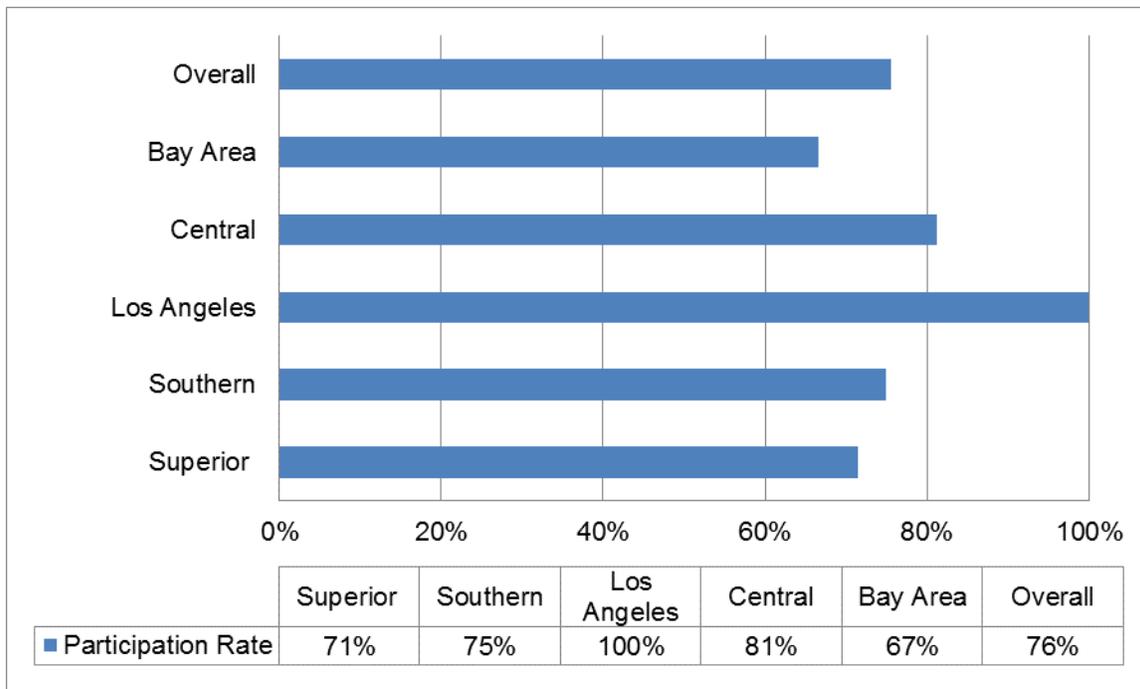
The Mental Health Loan Assumption Program (MHLAP) provides loan repayments to public mental health workers in hard-to-fill, hard-to-retain positions in exchange for a year commitment to work in the PMHS.

Figure 68: Overall MHLAP Participation (n=41)



MHLAP had an overall participation rate of 76%, representing 31 counties. MHLAP had the highest engagement rate of all statewide WET programs. Its participation rate exceeds the next highest used program by 8%.

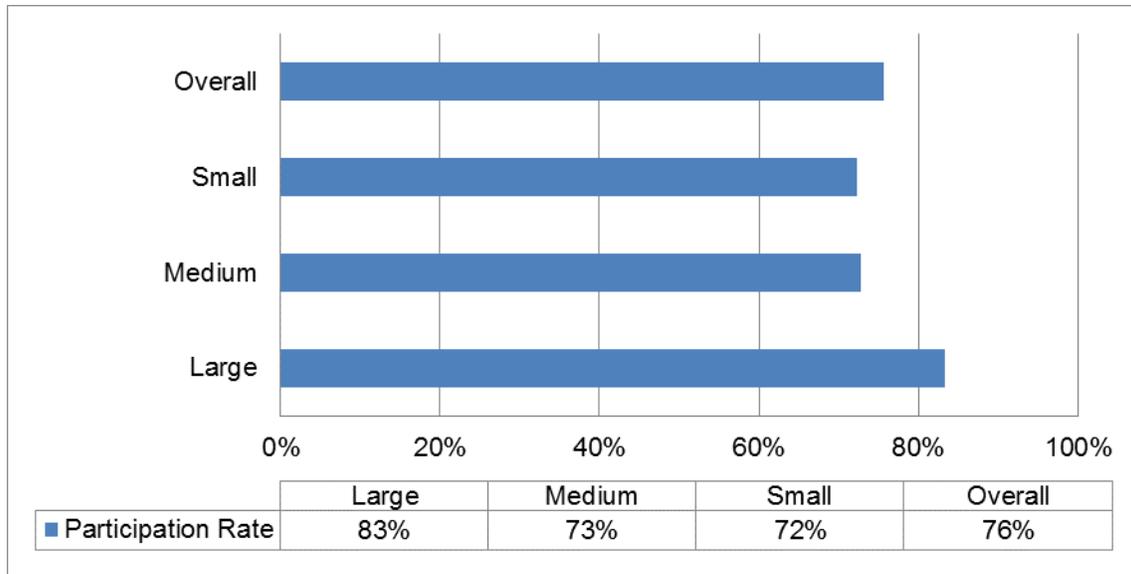
Figure 69: MHLAP Participation Rates, by MHSA Region (n=41)



In all regions, over 60% of counties participated in MHLAP. In addition to the full participation of the Los Angeles region, over 80% of counties in the Central region participated in the MHLAP,

followed by three quarters of the counties in the Southern region and over 70% of counties in the Superior region. Two thirds (67%) of Bay Area counties participated in the program.

Figure 70: MHLAP Participation Rates, by County Size (n=41)



When looking at participation by county size, participation followed a similar trend as seen in other sections, with larger counties participating at a higher rate. Eighty-three percent of large counties participated in MHLAP, followed by 73% percent of medium counties and 72% of small counties.

Qualitative Feedback

Qualitative feedback reflected the popularity of MHLAP across regions and size cohorts. Most counties commented that MHLAP had been very useful, and recommendations usually ran along the lines of requesting maintenance or expansion of the program. Counties also consistently highlighted MHLAP participation in their Annual Updates, and many counties were able to cite the exact number of county staff who had applied for and received MHLAP awards in the past year.

The most frequent suggestions from participating counties included targeting administrative and leadership staff at county mental health departments and improving information about MHLAP on brochures and in emails.

Additional Recommendations for Statewide WET Programs

Counties were given an opportunity in the Needs Assessment to provide any other comments or recommendations for statewide WET programs. Most of those comments have been integrated into the analyses above, but an additional area that did not have any specific section is the issue of succession planning.

Succession planning was the most commonly requested need, across counties and regions. Counties discussed an aging and soon-to-rotate workforce, especially in their highest ranking leadership positions. Providing counties with succession planning resources and guides should be a consideration for future endeavors.

Other comments focused on the continued need for more training. Although counties reported high levels of engagement with county and regionally-based training programs in the Annual Updates and the Needs Assessments, many emphasized the need for continued training for cultural competency. Many statewide programs, such as WWT and the Regional partnerships, have laid a strong foundation for training, as is evidenced by the detailed descriptions of trainings and training engagement in the Annual Updates. However, counties still feel the need for trainings in cultural competency and leadership development.

Another area of need is data analysis and evaluation. Counties that noted this request acknowledged that the need for evaluation reports and continual program monitoring requires a workforce that understands data, technology, and evaluation as a whole. Training data analysts to work in the public mental health workforce could be of help to those counties.

Synthesis of Findings

The distribution of California's public mental health user population, workforce needs, graduation rates from mental health-related programs, and statewide WET programs presents many interesting points of note. Examination of the data by MHSA region and/or county size provides cross-sections of the data that can be compared across topic areas. Cross-cutting findings contribute to increased understanding of California's public mental health workforce and identification of particular areas of need that can be targeted for further exploration. Several key findings emerged from this County-Reported Needs Assessment across three categories: 1) public mental health workforce needs, and 2) statewide WET programs.

Public Mental Health Workforce Needs

- **Counties' identification of their workforce shortages is consistent with their hard-to-fill, hard-to-retain positions.** Across MHSA regions and county sizes, Psychiatrists were noted as the highest workforce shortage, followed by child/adolescent Psychiatrists, Licensed Clinical Social Workers, persons with bilingual capabilities, and Marriage and Family Therapists, respectively. The near identical trend was found across MHSA regions and county sizes for the hard-to-fill, hard-to-retain positions for each county: Psychiatrists were noted most frequently, followed by child/adolescent Psychiatrists, persons with bilingual/Spanish capabilities, Licensed Clinical Social Workers, and Marriage and Family Therapists. The consistency of counties' workforce shortages and their hard-to-fill, hard-to-retain positions is expected – the assumption is that hard-to-fill, hard-to-retain positions are difficult to hire for and keep filled. Therefore, if those positions are not filled, a shortage is created due to the necessity and absence of those types of personnel. This logical trend has proven true in California's public mental health workforce.

- **The Superior region, small counties, and medium counties identified persons with bilingual capabilities as workforce shortages and hard-to-fill, hard-to-retain positions more often than any other MHSA region or large counties.** The Superior region, small counties, and medium counties are also the counties with the lowest proportions of users from minority populations. Therefore, the identification of bilingual capabilities by these counties is notable. Even though these counties' public mental health system user populations are predominantly White, they still recognize the importance of bilingual capabilities in their service providers. This demonstrates counties' understanding of the importance of providing culturally competent services for traditionally unserved/underserved populations, one of MHSA's guiding principles.
- **Most counties did not identify any declining workforce needs or needs met, except for the Southern region counties.** Most counties are not experiencing declining workforce needs; therefore, it can be assumed that their current workforce needs are not being met. The Southern region's high presence of declining needs coincides with the fact that most of the educational institutions producing graduates with mental health-related degrees/certificates are located in that same region. If the graduates from the Southern region enter the public mental health system in the same region and not elsewhere in the state, it can be inferred that they are contributing reduced workforce needs in that region.
- **Of those counties that identified declining workforce needs or needs met, non-licensed mental health staff members were most frequently noted.** Licensed mental health professionals are in higher demand than non-licensed mental health staff, thus signifying the importance of training and licensing individuals in mental health-related occupations. Licensed mental health professionals provide levels of service and expertise that are higher and more technical than non-licensed professionals. This more advanced level of service is in higher demand by the counties.
- **Workforce race/ethnicity diversity needs identified by the counties coincide with the race/ethnicity compositions of the public mental health user populations across the state's MHSA regions.** The Bay Area and Central regions identified Hispanic/Latino diversity as the highest workforce race/ethnicity need – this coincides with the relatively low proportions of Hispanic/Latino users in those MHSA regions, thus suggesting the importance of assembling a workforce that can outreach to and meet the language needs of Hispanic/Latino populations. The Superior region identified Native American diversity as its highest workforce race/ethnicity need – this corresponds with the Superior region's highest proportion of Native American users compared to other MHSA regions. Lastly, the Southern region (including Los Angeles County) identified African American diversity as its highest workforce race/ethnicity need – this aligns with the Southern/Los Angeles region having the highest proportion of African American users compared to all other MHSA regions.
- **Workforce language diversity needs identified by the counties are reflective of the race/ethnicity compositions of the public mental health user populations across**

the state's MHSA regions. The Superior region identified the lowest variety of workforce language needs – this coincides with the very large White population in that region. Minority (non-White) populations, and their corresponding language needs, comprise one-third of the Superior region's public mental health system user population. Across all other MHSA regions, minority populations constitute more than 55% of their user populations.

- **The Southern region has a workforce that is largely meeting the language needs of its Hispanic/Latino public mental health system user population.** The Southern region has the largest proportion and number of Hispanic/Latino public mental health system users, compared to the other MHSA regions. However, only two counties in the Southern region identified language as a workforce diversity need – this coincides with this region's identification of bilingual workforce shortages and hard-to-fill, hard-to-retain positions least frequently compared with all other regions. While it cannot be stated that the Southern/Los Angeles region is meeting the language needs of its Hispanic/Latino public mental health system user population, it can be inferred that its workforce has made great progress in bridging this gap.
- **Counties' designated positions for consumers and/or family members are largely reserved for peer and administrative/clerical positions, not provider/professional positions, and do not come with set wages.** Nearly 90% of positions designated for consumers and/or family members are peer-based or administrative/clerical in nature. Twenty-three percent of positions have clear wages set, meaning they are full or part-time positions; therefore, 77% of positions do not have clear wages set, meaning they are volunteer or other non-paid positions. Counties' professional service provider workforce populations are largely not comprised of individuals identifying as consumers or family members. In order to create a workforce that includes individuals with backgrounds similar to its consumers, significant funding and efforts are necessary to aid in the education and training of consumers and family members to become professional service providers in the public mental health user system.

Statewide WET Programs

- **Statewide-WET programs are mostly being utilized by large counties.** Across the board, statewide-WET programs are being utilized by a majority of the state's large counties, followed by medium counties, and much less frequently by small counties. In particular, small counties rarely used the Stipend Program and did not use the Psychiatric and Physician Assistant Residency Programs. Accordingly, counties from the Superior region (which is comprised mostly of small counties) participated the least in the Stipend Program and not at all in the Psychiatric and Physician Assistant Residency Programs. Qualitative feedback across programs showed that small and rural counties struggle to build partnerships with universities, recruit students into workforce training programs, and utilize statewide resources for their current staff. To this end, Working Well Together has developed specific trainings and resources for small counties.

- **The WET Stipend Program’s participation across the MHSA regions reflects the state’s distribution of graduates with mental health-related degrees or certificates.** The MHSA Southern and Los Angeles regions have the highest number of graduates with mental health-related degrees or certificates – this corresponds with these regions also having the highest participation rates in the Stipend Program. The remaining MHSA regions’ relative quantity of graduates also coincides with the rate of participation by those counties in the Stipend Program; in decreasing order from Bay Area, Central, to Superior regions.
- **The WET Psychiatric Residency Program is underutilized compared to the counties’ desire for Psychiatrists.** Only 20% of counties use the Psychiatric Residency Program; however, Psychiatrists were uniformly identified as the largest workforce shortage and hardest-to-fill, hardest-to-retain positions. The disconnect between counties’ need for Psychiatrists and their participation in the Psychiatric Residency Program is a major point for further exploration.
- **Los Angeles County has the highest number of graduates with mental health-related degrees or certificates, but it does not participate in the WET Psychiatric and Physician Assistant Residency Programs.** Los Angeles County does not use the Psychiatric Residency Program, but it has the highest number of graduates with mental health-related degrees or certificates. Additionally, Los Angeles County produces the most Physician Assistant graduates, but the county does not participate in the Physician Assistant Residency Program. County between the large number of mental health-related graduates and Physician Assistants it produces and its non-participation in the Psychiatric and Physician Assistant Residency Programs is major point for further exploration.
- **The WET Mental Health Loan Assumption Program (MHLAP) is utilized by most counties, especially the large ones.** 76% of counties are using the MHLAP. All of the counties not utilizing the MHLAP did not know about the program. Targeting the advertisement of MHLAP to the appropriate leadership and administrative staff members in the non-participating counties would be an effective strategy, particularly given that all other counties who have heard of the program are also participating in it. Please note that all counties receive an MHLAP allocation based on a population driven formula.

Section 2: County Needs Assessment Follow-Up Survey

Background and Purpose of OSHPD WET County Needs Follow-Up Survey

In June 2013, the California Office of Statewide Health Planning and Development (OSHPD) asked the California counties' mental/behavioral health departments to complete an assessment reporting their county public mental health system workforce needs. The findings from that assessment were documented in Section 1 of this report which identified workforce shortages by occupational category, workforce demands that have been met and/or declined, hard-to-fill and hard-to-retain positions, diversity needs, language needs, and current opportunities for Consumer and/or Family Members in the workforce.

To further understand the hard-to-fill and hard-to-retain positions in California's public mental health workforce, OSHPD conducted an online follow-up survey in September 2013 of county mental health departments and key contractors to assess the factors that influence hard-to-fill and hard-to-retain positions, reasons people leave positions, and how vacancies are addressed.

This report provides a detailed assessment of the OSHPD WET County Needs Follow-Up Survey. Survey analyses are presented in this report: (1) at the state level as a whole; (2) by MHSA Region; and (3) by county size cohort (based on the 2012 Census Bureau population sizes and MHSA designated size thresholds), where applicable.⁶ The components of this report are as follows, in order of presentation:

- **Methodology:** Information regarding the data source and its limitations.
- **Data Cross-Sections:** A description of the three different analytical cross-sections: statewide, MHSA regions, and size-based county cohorts.
- **Overall Hard-to-Fill/Hard-to-Retain Positions:** Identification of the overall top hard-to-fill and hard-to-retain positions, the reasons people left those positions, the agencies people in those position went to when they left, and how staff managed those position vacancies.
- **Individual Hard-to-Fill/Hard-to-Retain Positions:** Analyses of each of the positions counties identified as a top three hard-to-fill or hard-to-retain position. The specific topics to be discussed are: estimated number of current vacancies, potential reasons why position is hard-to-fill or hard-to-retain, labor substitutions, and qualitative findings.

⁶ California Mental Health Oversight and Accountability Commission. (2014) *Priority Indicators Report "Small Counties" Designation (<200,000 Residents) per the 2010 U.S. Census*. Retrieved from: http://www.mhsoac.ca.gov/Evaluations/docs/Eval_PriorityIndicators_SmallCountiesList.pdf;
United States Census Bureau. (2014) *State and County QuickFacts*. Retrieved from: <http://quickfacts.census.gov/qfd/index.html>

- **Consumer and Family Members as Paraprofessionals:** This report will provide further description of recruitment strategies used to recruit, orient, and train consumers and family members for public mental health positions within counties.
- **Synthesis of Findings:** A synopsis of the overarching findings and linkages generated from this report.

Methodology and Limitations

Methodology

OSHPD WET County Needs Assessment Follow-Up Survey responses were transcribed from individual online reports into a single spreadsheet, capturing all of the responses. This report analyzed the data in Microsoft Excel. Data analysis methods are further described below in Data Cross-Sections and briefly re-introduced in the relevant sections where the data is used.

Limitations

The primary limitation of this data source was the low response rate. Only 24 of the 58 California counties participated in the OSHPD WET County Needs Follow-Up Survey compared to 41 of the 58 counties participating in the initial county survey in June 2013. This report combined all county-level data to estimate the needs of hard-to-fill and hard-to-retain positions across the state of California. However, as a result of limited county participation, only 41% (24/58) of California's counties were represented in the analysis. Based on 2012 Census population estimates, the combined total population of the 24 participating counties represented 68% of the statewide population.⁷

Second, there existed a large variation in MHSA regional representation. The Superior region was represented by only 13% of its counties whereas the Central region was represented by 60% of its counties. The variation in regional representation affected the ability to compare variables across regions.

Third, the OSHPD WET County Needs Assessment Follow-Up Survey included nine optional, open-ended text-box questions. Response rates for these questions ranged from 17% to 50%, thus the qualitative information provided by the responding counties may not be representative of their respective MHSA Region or county-size cohort.

Data Cross-Sections

Where applicable, this report will present the data through three different analytical cross-sections: (1) across all participating counties in California as an aggregate; (2) by MHSA Region; and (3) in cohorts based on county size.

⁷ United States Census Bureau. (2014) *American FactFinder*. Retrieved from: <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml>

State Level

The OSHPD WET County Needs Follow-Up Survey was distributed to all 58 California counties. Of those 58 counties, 24 participated in the survey. This report will present the aggregate data from those 24 completed surveys as California statewide results. A complete list of participating counties by MHSA Region and by county size is available in Appendix 2.

MHSA Regions

The MHSA program divides California's counties into five regions: Bay Area, Central, Los Angeles, Southern, and Superior. The MHSA Los Angeles Region includes only Los Angeles County. Figure 71 shows the geographic distribution and boundaries of the five MHSA Regions.

Figure 71: California MHSA Regions

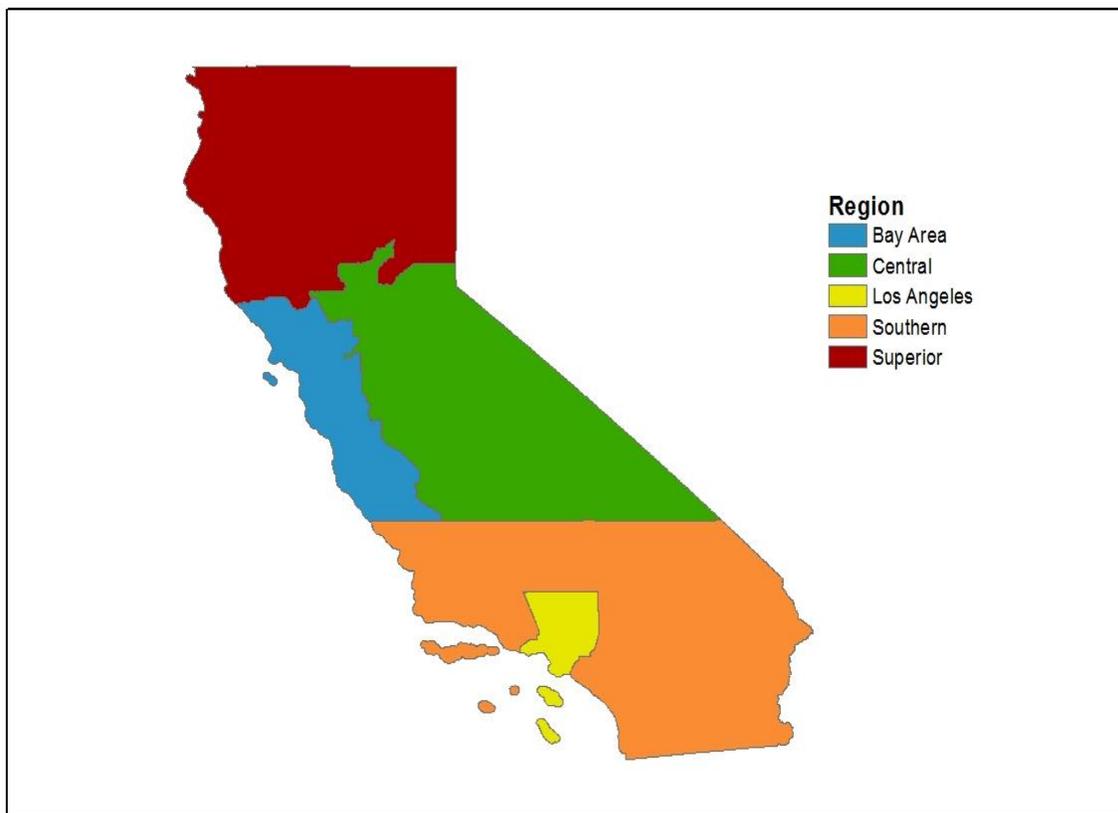


Table 8 shows the distribution of county participation in the county needs follow-up survey by MHSA Region. Participation greatly varied across the five regions. The Los Angeles region, comprised of only one county, had the highest participation rate (100%), whereas the Superior region had the lowest participation rate (13%).

Table 8: Total Survey Participation by MHSA Region (n=24)

MHSA Region	Participating Counties	Total Counties in Region	% Total Participation
Bay Area	4	12	33%
Central	12	20	60%
Los Angeles	1	1	100%
Southern	5	9	56%
Superior	2	16	13%
Grand Total	24	58	41%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

County Sizes

This report will present analyses of cohorts based on county size; these cohorts are determined by 2010 total population for each county: large counties are those with more than 800,000 persons; medium counties have 200,000-800,000 residents; and small counties are those with less than 200,000 persons.

Table 9 presents participation rates by county size. Small, medium, and large counties are similarly represented in total county participation, with nine, seven, and eight participating counties each, respectively. In context of the total count of each county size, the large county size is most represented (62%) and the small county size is least represented (30%).

Table 9: Total Survey Participation by County Size (n=24)

County Size	Participating Counties	Total Counties by Size	% Total Participation
Small	9	30	30%
Medium	7	15	47%
Large	8	13	62%
Grand Total	24	58	41%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

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

Top Seven Hard-to-Fill/Hard-to-Retain Positions

This section identifies the top seven hard-to-fill or hard-to-retain positions, as determined by total response count. The top seven positions are ranked in decreasing order of count of responses at the state level as a whole; by MHSA Region; and by county size cohort.

Statewide Trends

Table 10 presents reported statewide trends for hard-to-fill or hard-to-retain positions in California. Psychiatrist (n=20), Licensed Clinical Social Worker (n=19), and Marriage and Family Therapist (n=16), constituted the most frequently cited hard-to-fill or hard-to-retain positions. The top seven positions accounted for 79% of all the hard-to-fill or hard-to-retain positions named in the survey. Comments identified Spanish-speaking staff positions (Clinical Therapists, Promotores/Navigators, Mental Health Clinicians, and Behavioral Health Specialists) as hard-to-fill or hard-to-retain.

Table 10: Top Seven Hard-to-Fill/Hard-to-Retain Positions across California, by Count (n=24)

Position	Count of Responses	% of Total Responses
Psychiatrist	20	16%
Licensed Clinical Social Worker	19	15%
Marriage and Family Therapist	16	13%
Clinical Nurse Specialist	13	10%
Child/Adolescent Psychiatrist	12	10%
Psychiatric Mental Health Nurse Practitioner	12	10%
Geriatric Psychiatrist	7	6%
TOTAL	99	79%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Hard-to-Fill/Hard-to-Retain Position Trends by MHSA Region

Each region's list of top seven hard-to-fill or hard-to-retain positions was compared to reported statewide trends (see Table 10). An asterisk next to a position in the following tables indicates that the position was not captured in these statewide trends.

Bay Area Region

Table 11 displays the Bay Area region's top seven hard-to-fill or hard-to-retain positions. Consumer/Family Member/Peer Position, Licensed Clinical Social Worker, and Psychiatrist were the positions identified as most difficult to fill or retain (ns=3).⁸ The Bay Area region mirrored statewide trends in the reported difficulty of filling or retaining Licensed Clinical Social Workers and Psychiatrists. The region diverged with the inclusion of Consumer/Family Member/Peer Position, a position not included in statewide trends. The top seven positions presented in the table accounted for 89% of all the hard-to-fill or hard-to-retain positions named by the Bay Area region. Comments noted Public Health Nurse, Primary Care Physician, and

⁸ This report employs the abbreviation "ns" to indicate shared sample size values. For example, in the Bay Area, Consumer/Family Member/Peer Position, Licensed Clinical Social Worker, and Psychiatrist each received three counts as top seven hard-to-fill/hard-to-retain positions. Instead of including "n=3" after each position, this report uses "ns=3" after the listed positions to denote that they share the same count.

Spanish-speaking mental health clinicians, and Promotores/Navigators as other hard-to-fill or hard-to-retain positions.

Table 11: Bay Area Region Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=4)

Position	Count of Responses	% of Total Responses
Consumer/Family Member/Peer Position*	3	16%
Licensed Clinical Social Worker	3	16%
Psychiatrist	3	16%
Child/Adolescent Psychiatrist	2	11%
Geriatric Psychiatrist	2	11%
Marriage and Family Therapist	2	11%
Substance Abuse/Alcohol and Other Drug Counselor*	2	11%
TOTAL	17	89%

*Statewide trends did not include Consumer/Family Member/Peer Position and Substance Abuse/Alcohol.

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Central Region

The Central region's top seven hard-to-fill or hard-to-retain positions are included in Table 12. The Central region named Licensed Clinical Social Worker (n=10), Psychiatrist (n=9), Clinical Nurse Specialist (n=8), and Marriage and Family Therapist (n=8) as the most hard-to-fill or hard-to-retain positions. The top seven positions accounted for 80% of all the hard-to-fill or hard-to-retain positions the Central region, making Central the least representative of the five regions. The Central region shared a similar assessment of hard-to-fill or hard-to-retain positions as that of the state; the top seven positions were the same, varying only in ranking.

Table 12: Central Region Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=12)

Position	Count of Responses	% of Total Responses
Licensed Clinical Social Worker	10	15%
Psychiatrist	9	14%
Clinical Nurse Specialist	8	12%
Marriage and Family Therapist	8	12%
Child/Adolescent Psychiatrist	7	11%
Psychiatric Mental Health Nurse Practitioner	6	9%
Geriatric Psychiatrist	4	6%
TOTAL	52	80%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Los Angeles Region

Table 13 presents the Los Angeles region's top seven hard-to-fill or hard-to-retain positions. The Los Angeles region provided a total of seven hard-to-fill or hard-to-retain positions, each with one response (ns=1). Unlike the statewide trends, the Los Angeles region found Licensed Clinical Psychologist to be among their most hard-to-fill or hard-to-retain positions.

Table 13: Los Angeles Region Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=1)

Position	Count of Responses	% of Total Responses
Child/Adolescent Psychiatrist	1	14%
Geriatric Psychiatrist	1	14%
Licensed Clinical Psychologist*	1	14%
Licensed Clinical Social Worker	1	14%
Marriage and Family Therapist	1	14%
Psychiatric Mental Health Nurse Practitioner	1	14%
Psychiatrist	1	14%
TOTAL	7	100%

*Statewide trends did not include License Clinical Psychologist.

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Southern Region

Table 14 shows the Southern region's top seven hard-to-fill or hard-to-retain positions. The Southern region identified Psychiatrist (n=5), Marriage and Family Therapist (n=4), and Licensed Clinical Social Worker (n=3) as the most hard-to-fill or hard-to-retain positions. These top three positions correspond with statewide trends, differing only in the inversion of Marriage and Family Therapist and Licensed Clinical Social Worker as the second and third most hard-to-fill or hard-to-retain positions. The Southern region included Licensed Clinical Psychologist and Licensed Psychiatric Technician in their top hard-to-fill or hard-to-retain positions; these positions are not represented in statewide trends. The top seven positions accounted for 87% of all the hard-to-fill or hard-to-retain positions the Southern region.

Table 14: Southern Region Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=5)

Position	Count of Responses	% of Total Responses
Psychiatrist	5	22%
Marriage and Family Therapist	4	17%
Licensed Clinical Social Worker	3	13%
Child/Adolescent Psychiatrist	2	9%
Clinical Nurse Specialist	2	9%
Licensed Clinical Psychologist*	2	9%
Licensed Psychiatric Technician*	2	9%
TOTAL	20	87%

*Statewide trends did not include Licensed Clinical Psychologist and Licensed Psychiatric Technician.

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Superior Region

The Superior region's top seven hard-to-fill or hard-to-retain positions are displayed in Table 15. Four positions tied for hardest-to-fill or hardest-to-retain: Clinical Nurse Specialist, Licensed Clinical Social Worker, Psychiatric Mental Health Nurse Practitioner, and Psychiatrist (ns=2). The Superior region differed from statewide trends with the inclusion of Licensed Clinical Psychologist and Licensed Psychiatric Technician in the hard-to-fill or hard-to-retain positions. These seven positions accounted for 92% of all the hard-to-fill or hard-to-retain positions named by the Superior region; the most representative of the four multiple-county regions.

Table 15: Superior Region Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=2)

Position	Count of Responses	% of Total Responses
Clinical Nurse Specialist	2	17%
Licensed Clinical Social Worker	2	17%
Psychiatric Mental Health Nurse Practitioner	2	17%
Psychiatrist	2	17%
Licensed Clinical Psychologist*	1	1%
Licensed Psychiatric Technician*	1	1%
Marriage and Family Therapist	1	1%
TOTAL	11	92%

*Statewide trends did not include Licensed Clinical Psychologist and Licensed Psychiatric Technician.

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Hard-to-Fill/Hard-to-Retain Position Trends by County Size

As with each MHSA Region, each county size's list of top seven hard-to-fill or hard-to-retain positions was compared to that of the state of California's (see Table 10). In the following tables, an asterisk next to a position indicates that the position was not captured in the reported statewide trends.

Small Counties

Table 16 displays the small counties' top seven hard-to-fill or hard-to-retain positions. Licensed Clinical Social Worker (n=8), Marriage and Family Therapist (n=7), and Psychiatrist (n=6) constituted the hardest-to-fill or hardest-to-retain positions in small counties. The top seven positions accounted for 76% of all the small county size hard-to-fill or hard-to-retain positions. Small counties agreed with the statewide need for bilingual staff members, and differed in the inclusion of Substance Abuse/Alcohol and Other Drug Counselor and Consumer/Family Member/Peer Position as a top seven hard-to-fill or hard-to-retain positions.

Table 16: Small County Size Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=9)

Position	Count of Responses	% of Total Responses
Licensed Clinical Social Worker	8	17%
Marriage and Family Therapist	7	15%
Psychiatrist	6	13%
Child/Adolescent Psychiatrist	4	9%
Clinical Nurse Specialist	4	9%
Substance Abuse/Alcohol and Other Drug Counselor*	4	9%
Consumer/Family Member/Peer Position*	3	7%
TOTAL	36	78%

*Statewide trends did not include Substance Abuse/Alcohol and Other Drug Counselor, and Consumer/Family Member/Peer Position.

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Medium Counties

Table 17 presents the medium counties' top seven hard-to-fill or hard-to-retain positions. Medium counties reported Clinical Nurse Specialist (n=7), Psychiatric Mental Health Nurse Practitioner (n=6), and Psychiatrist (n=6) as the top hard-to-fill or hard-to-retain positions. Small and medium counties exhibited dissimilar trends, diverging on four of the top seven hard-to-fill or hard-to-retain positions. Clinical Nurse Specialist, the number one position for medium counties, was not even listed in the top seven positions in small counties. Medium counties' inclusion of Licensed Psychiatric Technician was not paralleled in the statewide trends.

Table 17: Medium County Size Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=7)

Position	Count of Responses	% of Total Responses
Clinical Nurse Specialist	7	16%
Psychiatric Mental Health Nurse Practitioner	6	14%
Psychiatrist	6	14%
Child/Adolescent Psychiatrist	5	12%
Licensed Clinical Social Worker	5	12%
Geriatric Psychiatrist	3	7%
Licensed Psychiatric Technician*	3	7%
TOTAL	35	81%

*Statewide trends did not include Licensed Psychiatric Technician.

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Large Counties

The large counties' top seven hard-to-fill or hard-to-retain positions are shown in Table 18. In line with statewide trends, large counties reported Psychiatrist (n=8), Licensed Clinical Social Worker (n=6), and Marriage and Family Therapist (n=6) as the top hard-to-fill or hard-to-retain positions, respectively. Large and small counties reported the same top three positions, differing only in rank order. Large counties varied from statewide trends with the inclusion of Consumer/Family Member/Peer Position as a top hard-to-fill or hard-to-retain position.

Table 18: Large County Size Top Seven Hard-to-Fill/Hard-to-Retain Positions, by Count (n=8)

Position	Count of Responses	% of Total Responses
Psychiatrist	8	22%
Licensed Clinical Social Worker	6	16%
Marriage and Family Therapist	6	16%
Psychiatric Mental Health Nurse Practitioner	4	11%
Child/Adolescent Psychiatrist	3	8%
Clinical Nurse Specialist	2	5%
Consumer/Family Member/Peer Position*	2	5%
TOTAL	31	84%

*Statewide trends did not include Consumer/Family Member/Peer Position.

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Top Three Hard-to-Fill/Hard-to-Retain Positions

Whereas the previous section analyzed hard-to-fill or hard-to-retain positions by total response count, this section further examines trends by focusing on the three hardest-to-fill or hardest-to-retain positions. Counties were asked to submit one position they considered to be the hardest-to-fill or hardest-to-retain, one position they considered to be the second hardest-to-fill or hardest-to-retain, and one position they considered to be the third hardest-to-fill or hardest-to-retain.

Statewide Trends

Table 19 presents reported statewide trends for the hardest-to-fill or hardest-to-retain positions. Over half of the 24 responses for number one hard-to-fill or hard-to-retain position, were for Psychiatrist (n=13). This result, coupled with the ranking of Psychiatrist as the number one of the top seven hard-to-fill or hard-to-retain positions, provides further evidence of the statewide difficulty in filling and retaining Psychiatrists.

Table 19: Number One Hard-to-Fill/Hard-to-Retain Positions, by Count (n=24)

Position	Count of Responses	% of Total Responses
Psychiatrist	13	54%
Child/Adolescent Psychiatrist	5	21%
Licensed Clinical Social Worker	3	13%
Psychiatric Mental Health Nurse Practitioner	2	8%
Licensed Clinical Psychologist	1	4%
TOTAL	24	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

The statewide trends for the second hardest-to-fill or hardest-to-retain positions are displayed in Table 20. Licensed Clinical Social Worker (n=7) and Child/Adolescent Psychiatrist (n=6) received the most responses for the number two hard-to-fill or hard-to-retain positions. One county did not submit a number two hard-to-fill or hard-to-retain position (n=23).

Table 20: Number Two Hard-to-Fill/Retain Position, by Count (n=24)

Position	Count of Responses	% of Total Responses
Licensed Clinical Social Worker	7	30%
Child/Adolescent Psychiatrist	6	26%
Clinical Nurse Specialist	2	9%
Geriatric Psychiatrist	2	9%
Psychiatric Mental Health Nurse Practitioner	2	9%
Psychiatrist	2	9%
Consumer/Family Member/Peer Position	1	4%
Marriage and Family Therapist	1	4%
TOTAL	23	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Table 21 shows the statewide trends for the third hardest-to-fill or hardest-to-retain positions. Marriage and Family Therapist received the most responses (n=5). Three counties did not submit a number three hard-to-fill or hard-to-retain position (n=21).

Table 21: Number Three Hard-to-Fill/Retain Position, by Count (n=24)

Position	Count of Responses	% of Total Responses
Marriage and Family Therapist	5	24%
Psychiatrist	4	19%
Geriatric Psychiatrist	3	14%
Psychiatric Mental Health Nurse Practitioner	3	14%
Licensed Clinical Social Worker	2	10%
Clinical Nurse Specialist	1	5%
Licensed Professional Clinical Counselor	1	5%
Physician Assistant	1	5%
Substance Abuse/Alcohol and Other Drug Counselor	1	5%
TOTAL	21	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

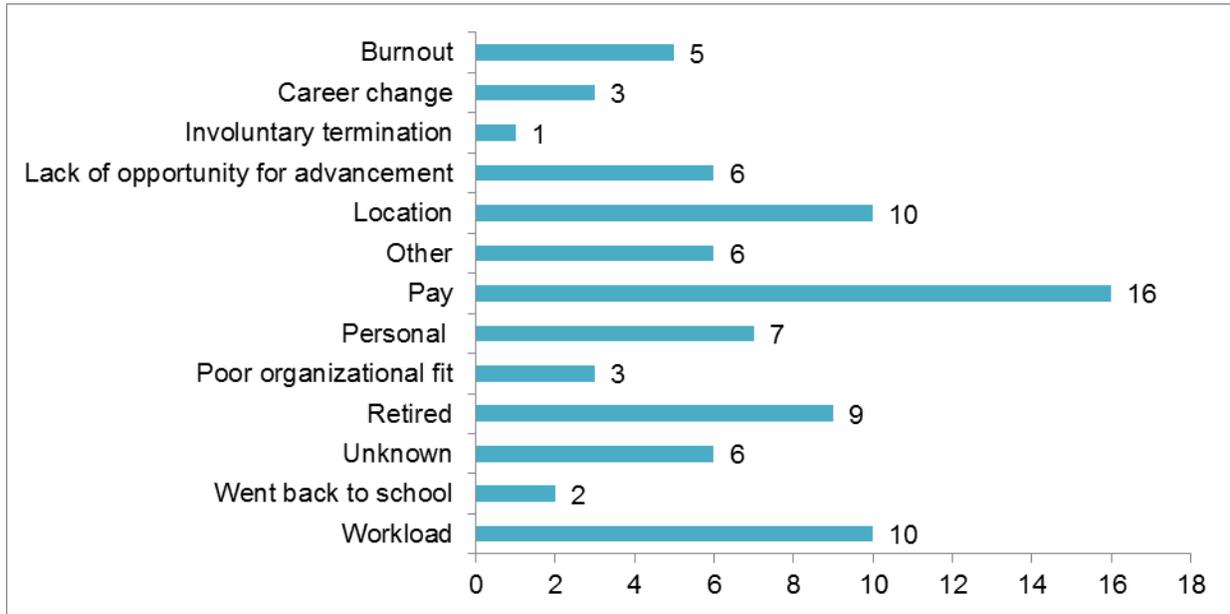
Reasons for Vacating Hard-to-Fill or Hard-to-Retain Positions

This section reports on reasons individuals may have left one of the top seven hard-to-fill or hard-to-retain positions.

Statewide Trends

Figure 72 depicts statewide trends as to why staff vacated the top seven hard-to-fill or hard-to-retain positions. Overall, pay was the number one reason (n=16). Location (n=10), workload (n=10), and retirement (n=9), and were also highly cited.

Figure 72: Reasons Positions Vacated across California, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

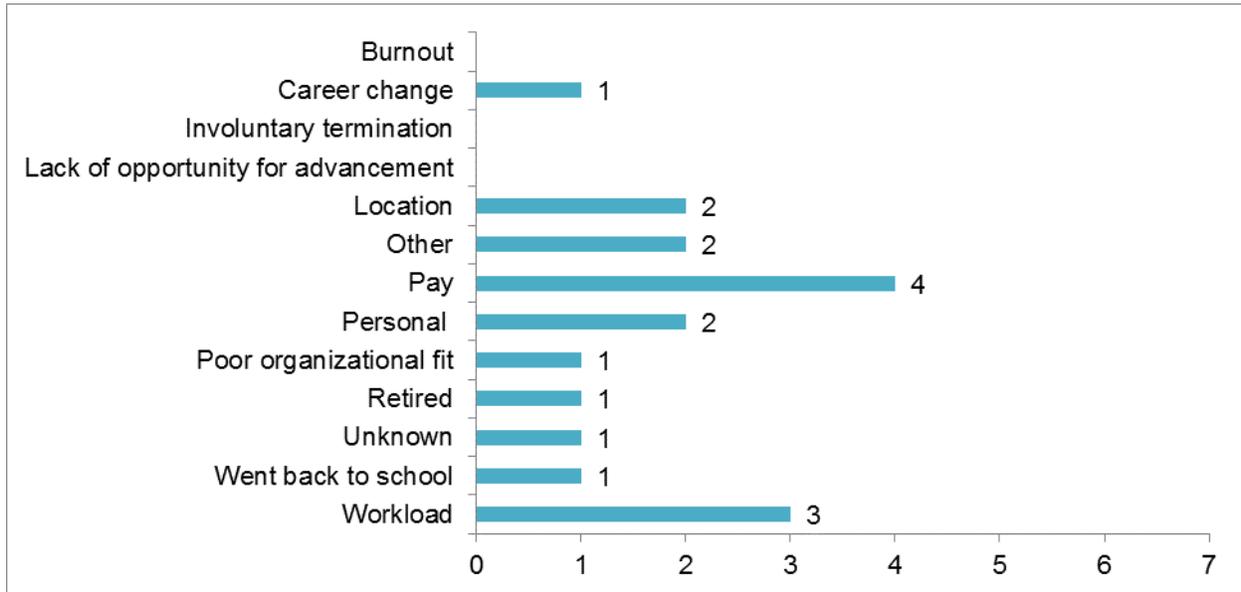
Trends by MHSA Region

The following section describes MHSA region trends as to why staff vacated the top seven hard-to-fill or hard-to-retain positions.

Bay Area Region

Figure 73 presents reported reasons Bay Area region positions were vacated. Consistent with statewide trends, pay was the top reason people left hard-to-fill or hard-to-retain positions (n=4).

Figure 73: Bay Area Region Reasons Positions Vacated, by Count (n=4)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Central Region

The Central region’s reasons for vacating positions are depicted in Figure 74. In the Central region, the top reason for leaving hard-to-fill or hard-to-retain positions was pay (n=7). This finding is consistent with statewide and Bay Area region trends.

Figure 74: Central Region Reasons Positions Vacated, by Count (n=12)

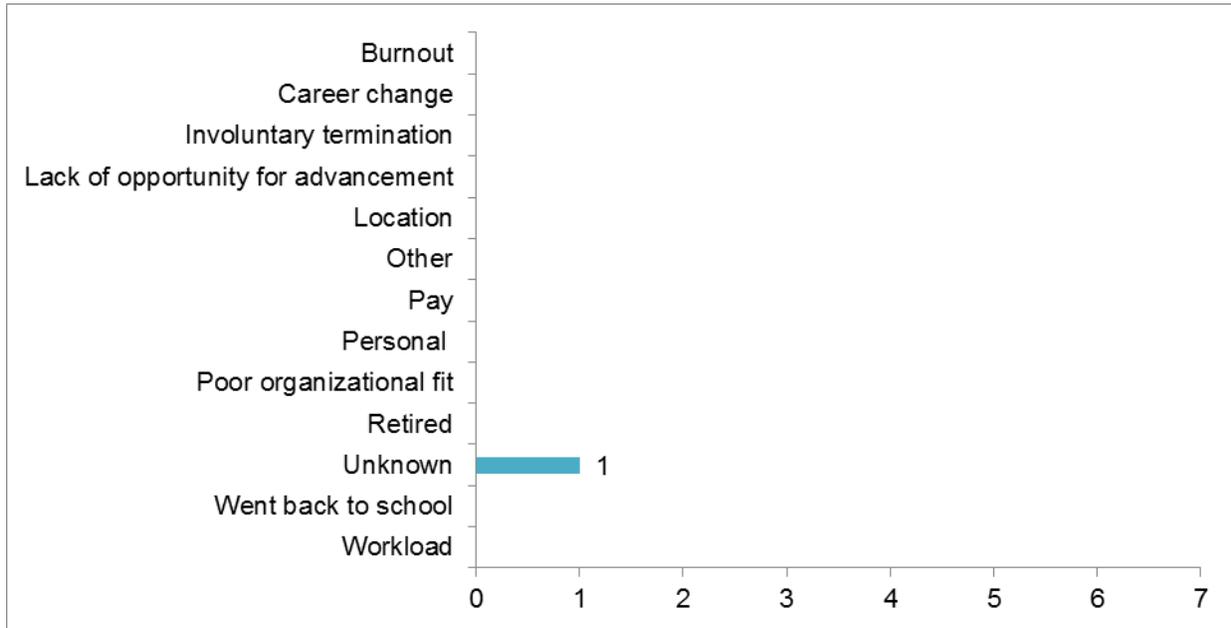


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Los Angeles Region

Figure 75 displays the reason provided by the Los Angeles region for vacating positions. The Los Angeles Region cited a single unknown reason why people in hard-to-fill or hard-to-retain positions have vacated their jobs (n=1). No comments were provided to explain this reason.

Figure 75: Los Angeles Region Reason Positions Vacated, by Count (n=1)

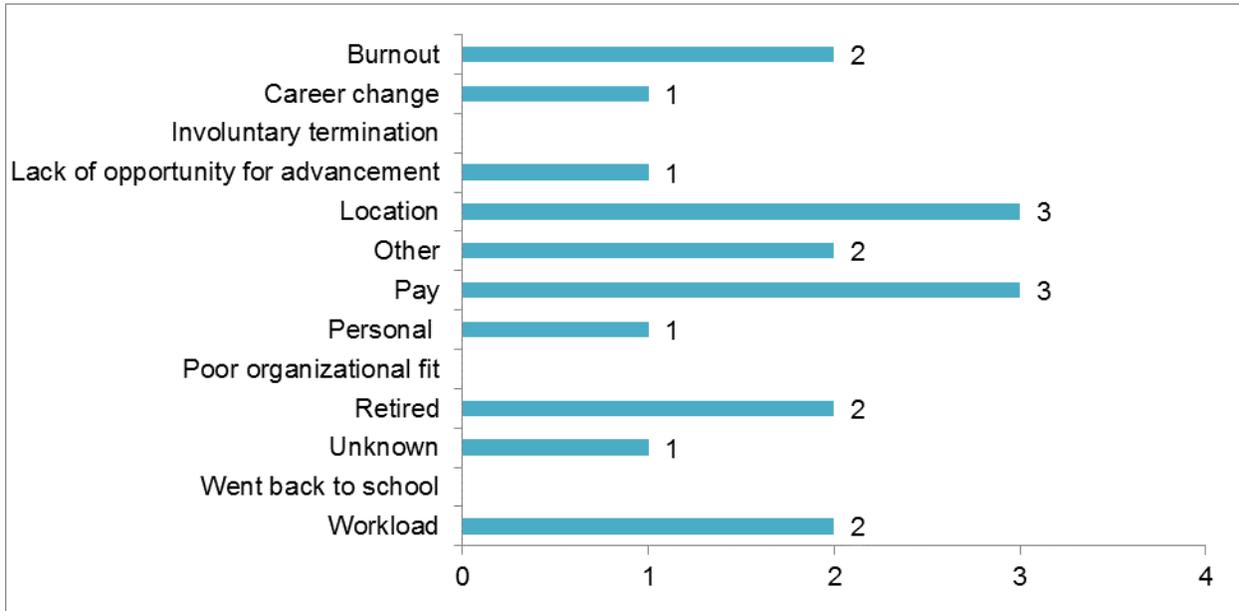


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Southern Region

Figure 76 describes the reasons for Southern region position vacancies. For the Southern region, location and pay were reported as the biggest factors in hard-to-fill or hard-to-retain position vacancies (ns=3). The Southern region's top ranking of pay is in agreement with statewide, Bay Area, and Central regional trends.

Figure 76: Southern Region Reasons Positions Vacated, by Count (n=5)

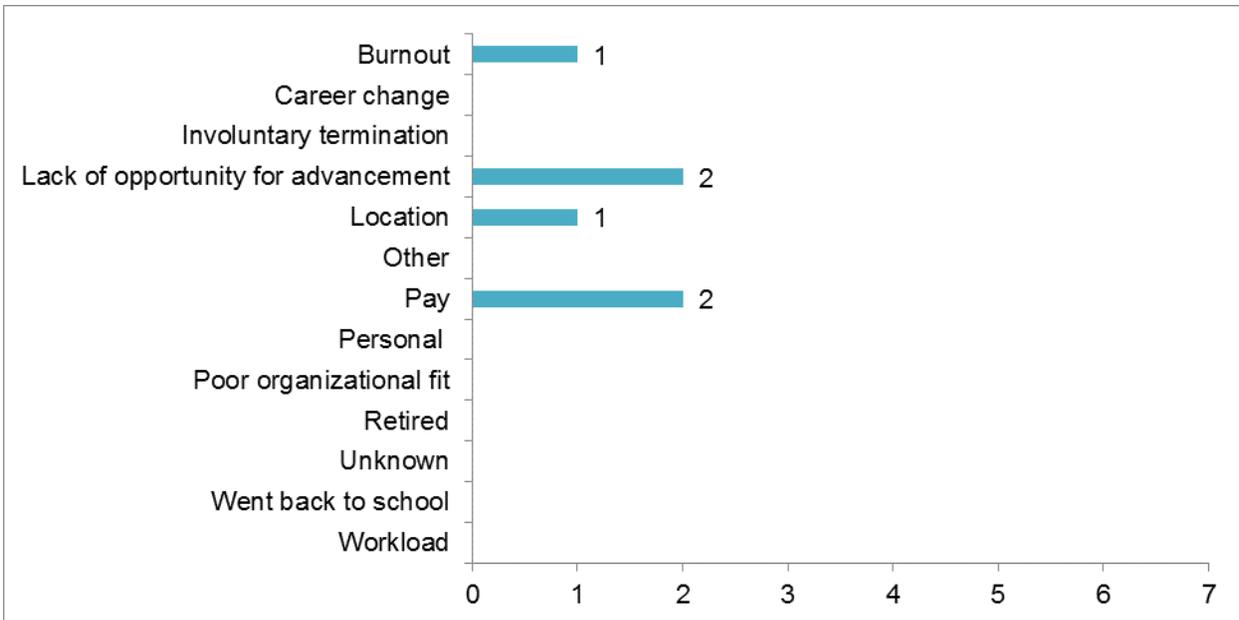


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Superior Region

Figure 77 presents the Superior region's reasons for position vacancies. Lack of opportunity for advancement and pay received the most responses (ns=2). Excluding the Los Angeles region, all MHSA regions indicated that pay was the top reason positions were vacated.

Figure 77: Superior Region Reasons Positions Vacated, by Count (n=2)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

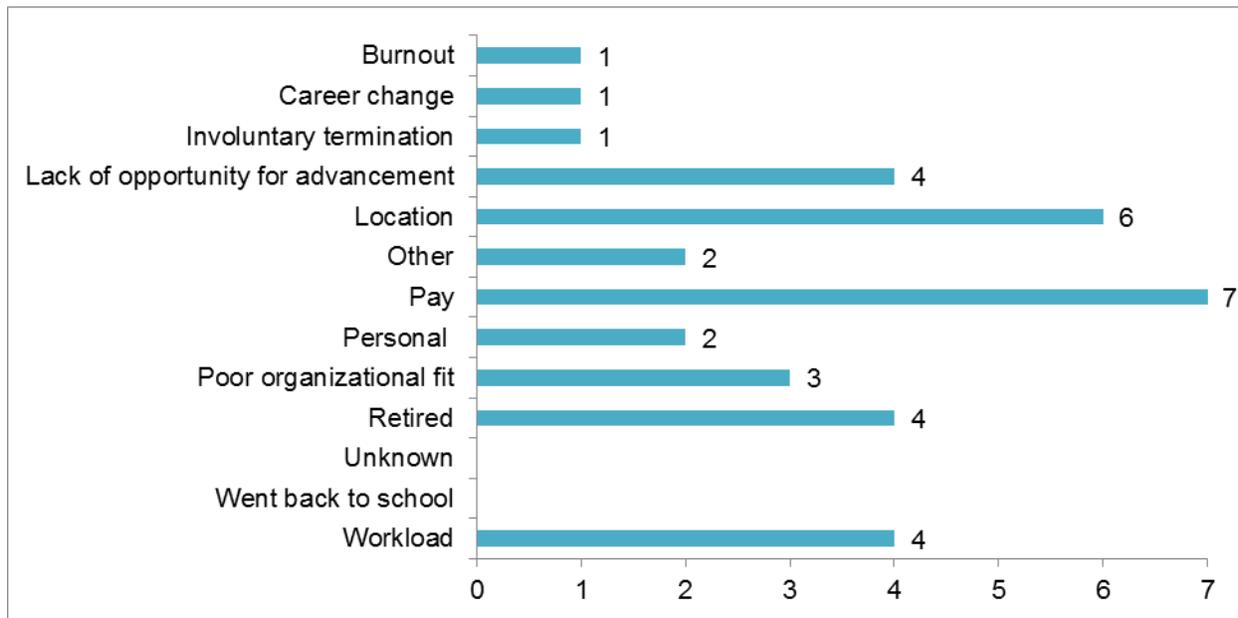
Trends by County Size

The following section describes trends as to why the top seven hard-to-fill or hard-to-retain positions were vacated, by county size.

Small Counties

Figure 78 displays the small county reasons positions were vacated. Similar to the state and regional trends, small counties named pay as the top reason people have left hard-to-fill or hard-to-retain positions (n=7).

Figure 78: Small County Size Reasons Positions Vacated, by Count (n=9)

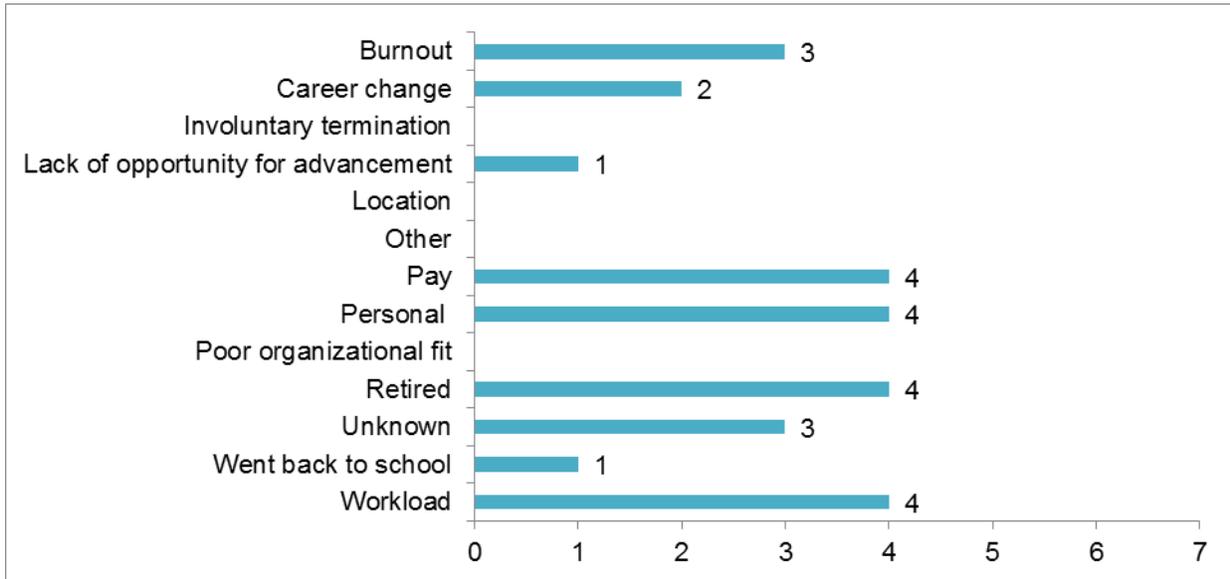


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Medium Counties

Medium county position vacancy reasons are presented in Figure 79. Pay, personal reasons, retirement, and workload tied as the top reasons for hard-to-fill or hard-to-retain position vacancies in medium counties (ns=4). Location, the second most-cited reason provided by small counties, was not listed at all as a medium county reason positions were vacated.

Figure 79: Medium County Size Reasons Positions Vacated, by Count (n=7)

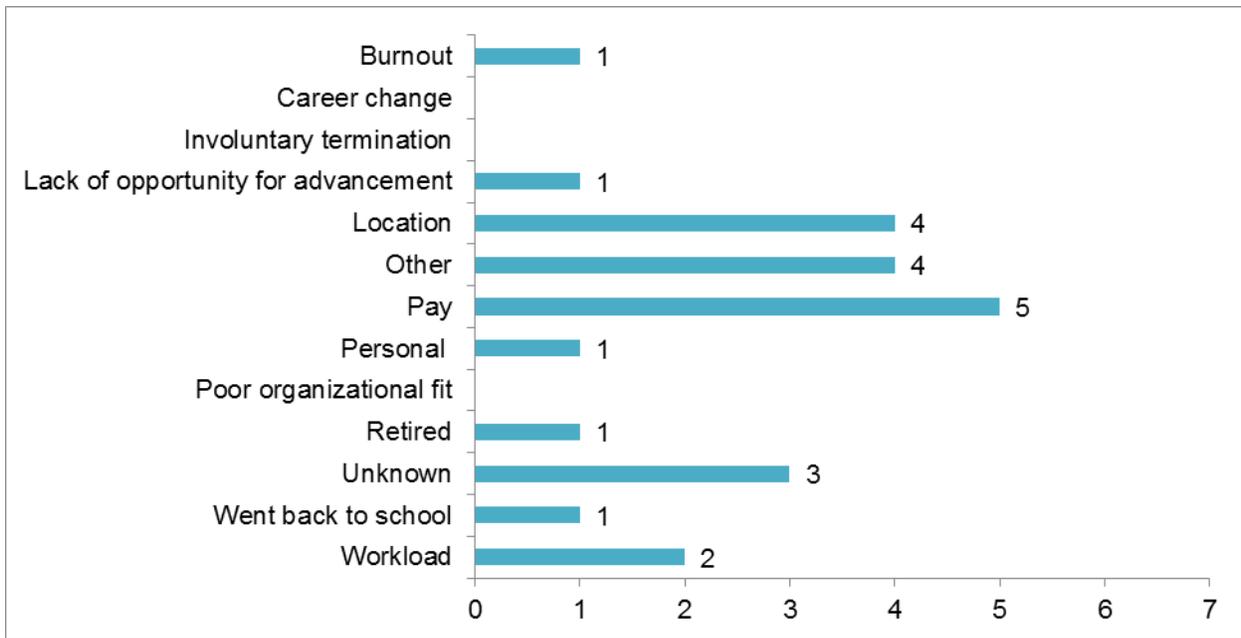


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Large Counties

Figure 80 shows the reasons given for position vacancies in large counties. Aligned with state and regional trends, pay was the most frequently provided reason large counties gave as to why staff left hard-to-fill or hard-to-retain positions (n=5).

Figure 80: Large County Size Reasons Positions Vacated, by Count (n=8)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

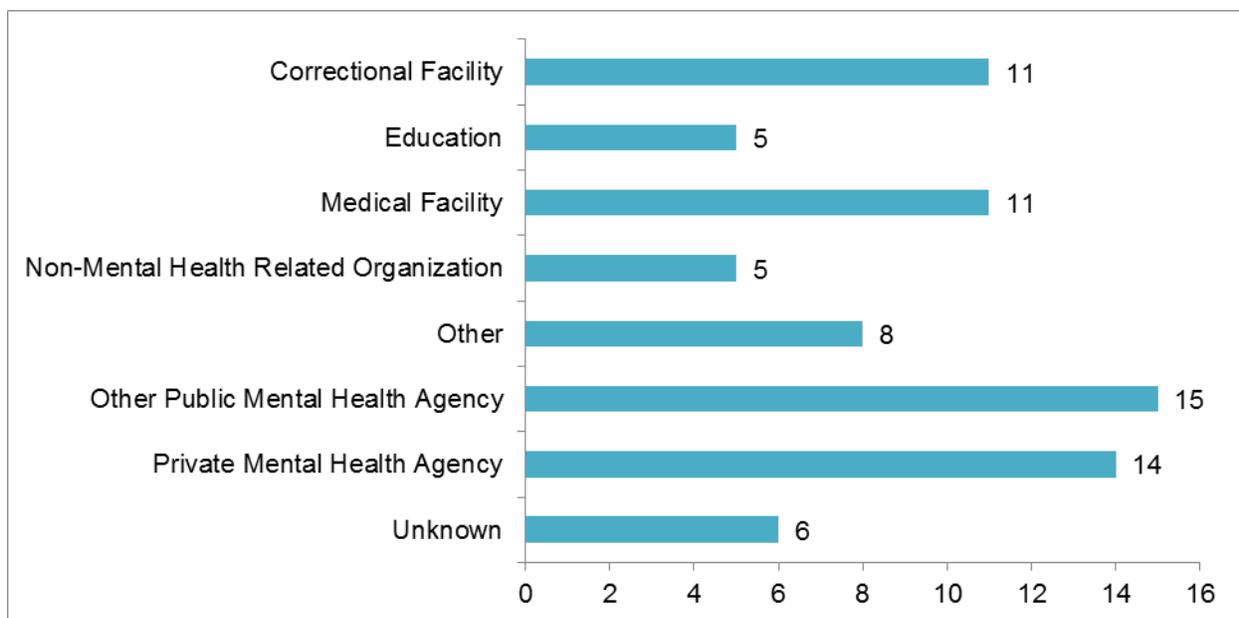
Departure Agencies

This section further explores hard-to-fill or hard-to-retain positions by examining the other agencies that staff in hard-to-fill or hard-to-retain positions went to when they vacated their previous agency.

Statewide Trends

Figure 81 displays the statewide departure agency trends. The top agencies hard-to-fill or hard-to-retain position workers across California left for were other public mental health agencies (n=15), private mental health agencies (n=14), and correctional and medical facilities (ns=11).

Figure 81: Departure Agencies across California, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

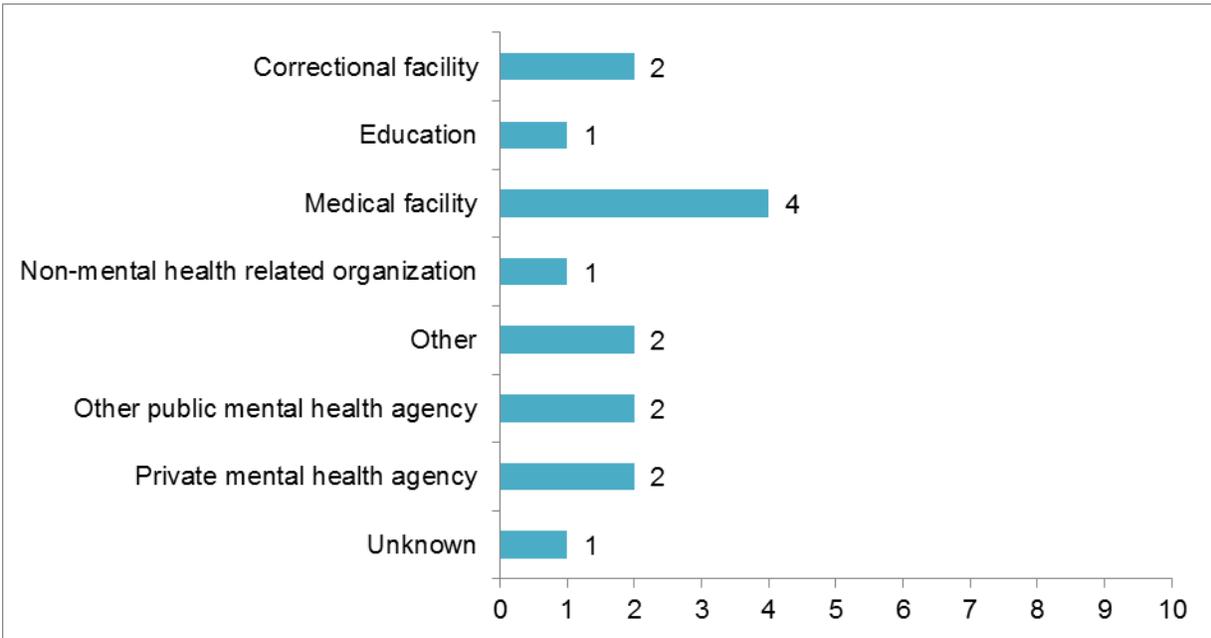
Trends by MHSA Region

For each MHSA region, the following section describes trends in the types of agencies that staff in hard-to-fill or hard-to-retain positions went to when they vacated their previous agency.

Bay Area Region

Figure 82 presents the Bay Area regional departure agency trends. Medical facilities were the most common agencies Bay Area region staff in hard-to-fill or hard-to-retain positions went to after vacating the agency (n=4). Similar to statewide trends, educational agencies and non-mental health related organizations were less common departure agencies.

Figure 82: Bay Area Region Departure Agencies, by Count (n=4)

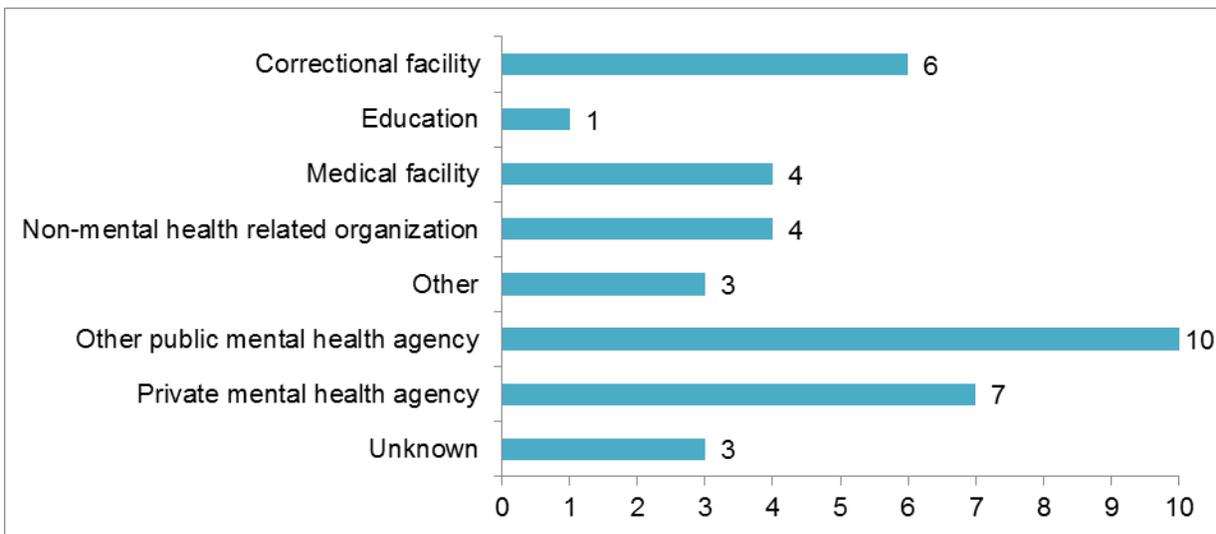


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Central Region

Figure 83 captures the Central region's departure agency trends. The Central region lost staff to the same top three departure agencies as the state (and in the same order): other public mental health agencies (n=10), private mental health agencies (n=7), and correctional facilities (n=6). As with the Bay Area region, educational agency departures were uncommon.

Figure 83: Central Region Departure Agencies, by Count (n=12)

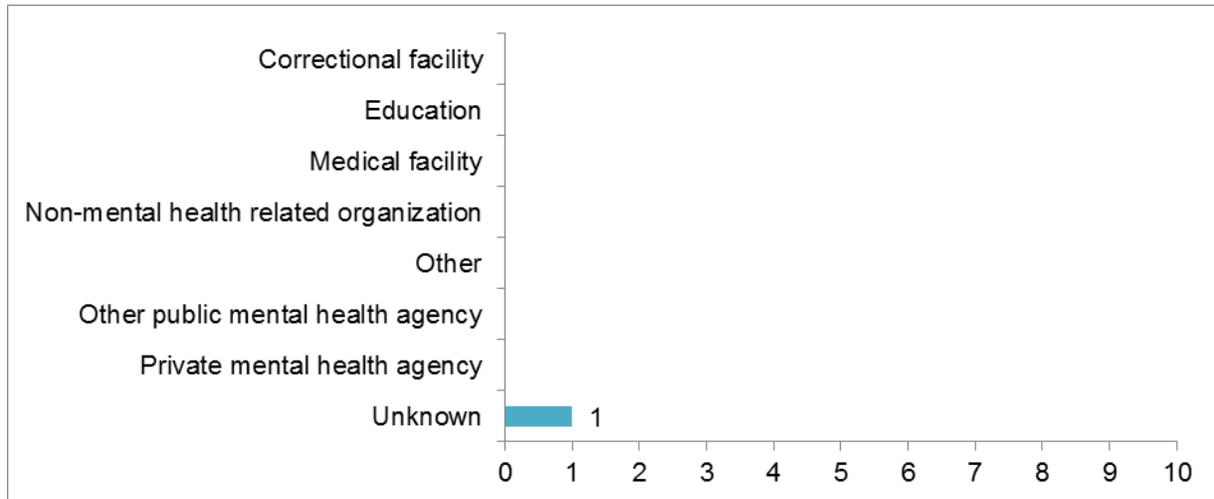


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Los Angeles Region

Figure 84 displays the Los Angeles region departure agency. The Los Angeles region departure agency was unknown (n=1). No comments were provided for explanation.

Figure 84: Los Angeles Region Departure Agency, by Count (n=1)

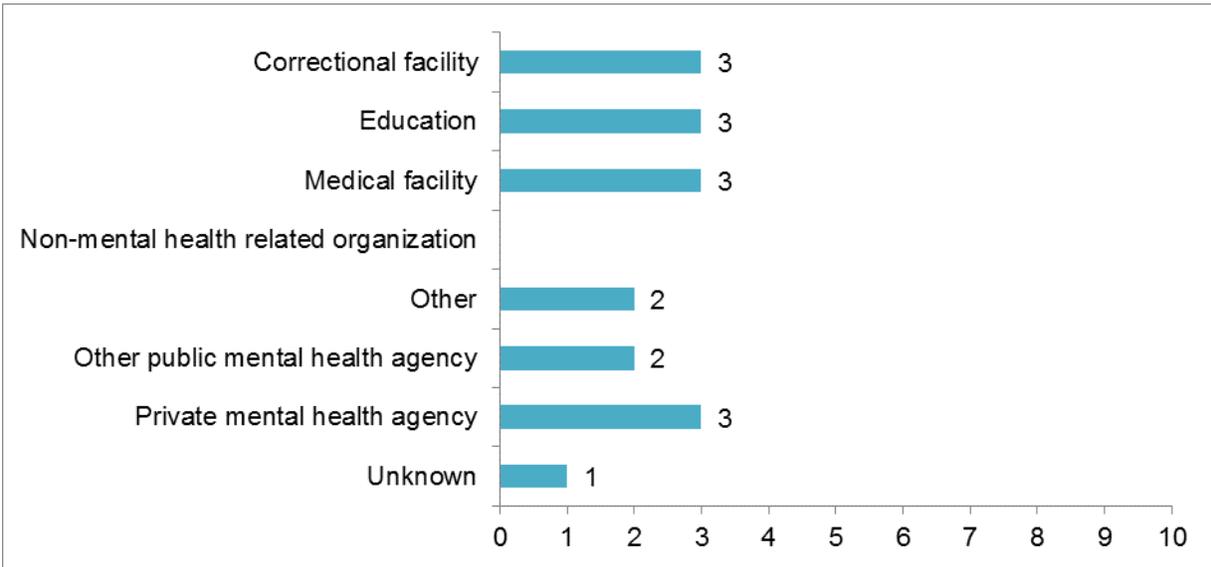


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Southern Region

The Southern region's departure agencies are shown in Figure 85. The Southern region named correctional facilities, educational agencies, medical facilities, and private mental health agencies as the most common departure agencies (n=3). Of those top Southern region departure agencies, all but educational agencies are captured in the state's top four departure agency rankings.

Figure 85: Southern Region Departure Agencies, by Count (n=5)

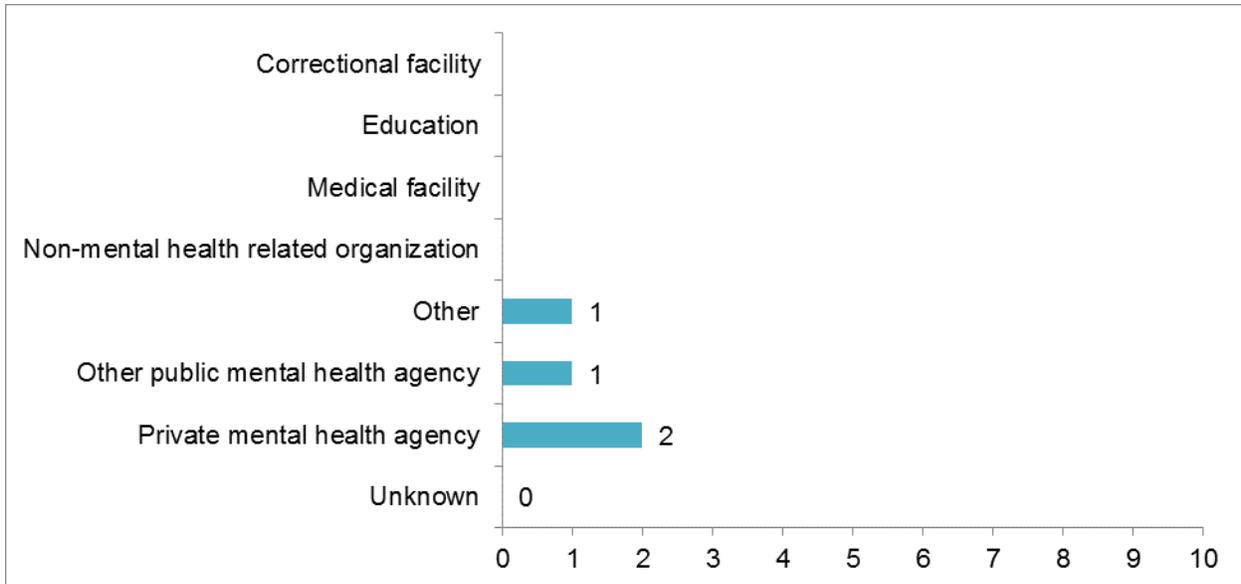


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Superior Region

Figure 86 presents the Superior region's departure agencies. Hard-to-fill or hard-to-retain staff in the Superior region left for private mental health agencies (n=2). Private mental health agencies were frequently cited in statewide trends (ranked second), and in the Central (ranked second) and Southern (tied for first) regions.

Figure 86: Superior Region Departure Agencies, by Count (n=2)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

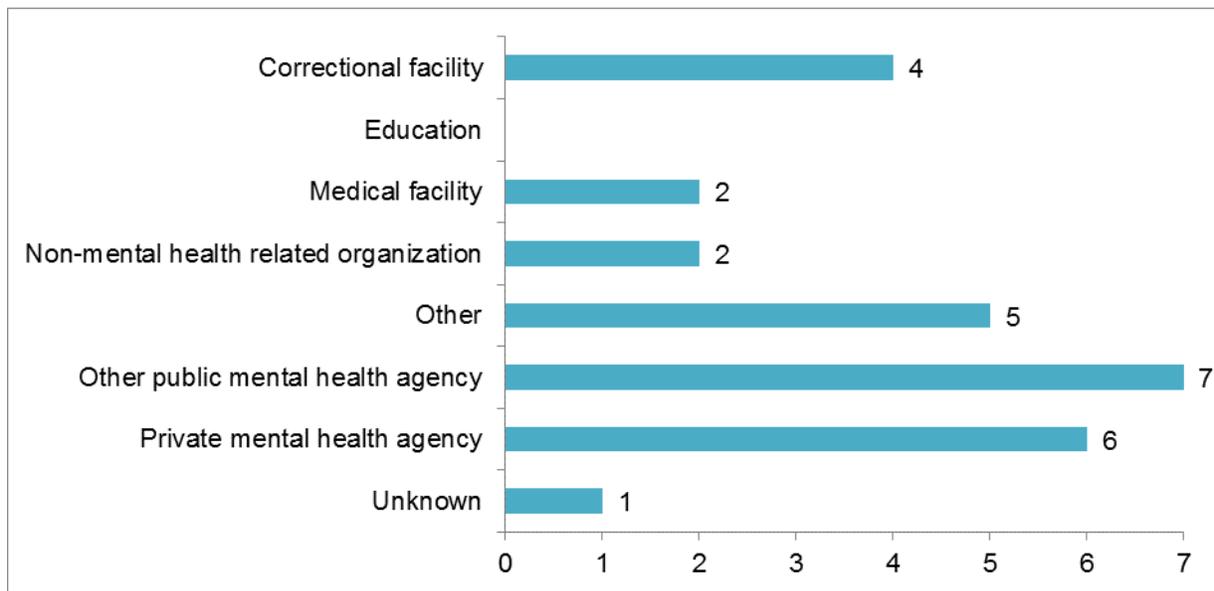
Trends by County Size

The following section describes trends in the agencies that staff in hard-to-fill or hard-to-retain positions went to when they vacated their previous agency, by county size.

Small Counties

Figure 87 shows small county size departure agencies. Similar to the state and Central region, small counties lost the most staff to other public mental health agencies (n=7).

Figure 87: Small County Size Departure Agencies, by Count (n=9)

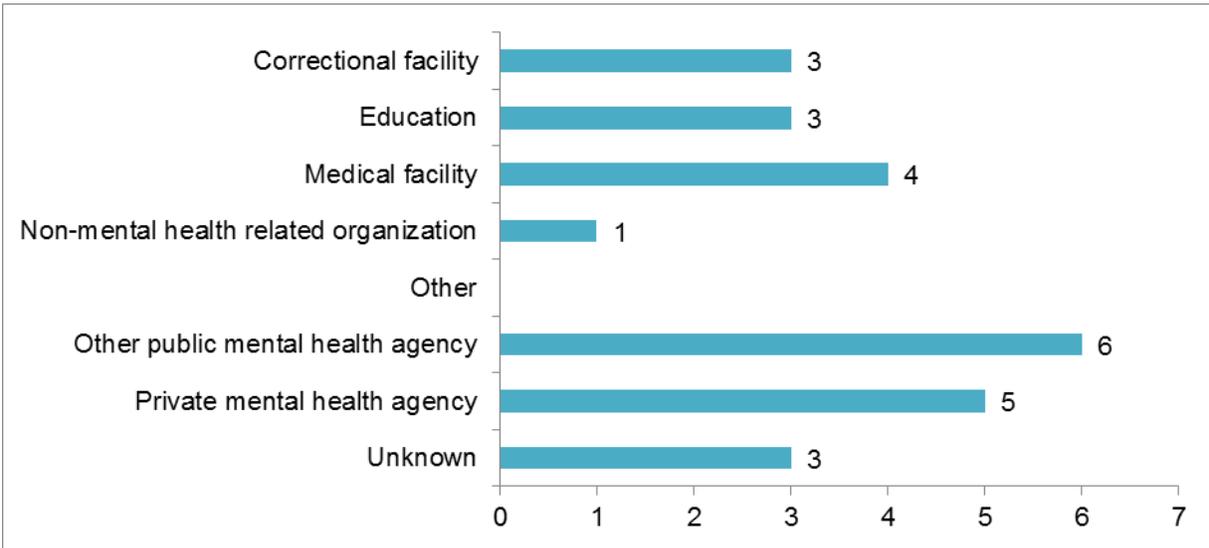


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Medium Counties

Departure agencies for medium-size counties are displayed in Figure 88. Medium counties recorded the most departures to other public mental health agencies (n=6) and private mental health agencies (n=5), congruent with the patterns of the state, Central region, and small counties.

Figure 88: Medium County Size Departure Agencies, by Count (n=7)

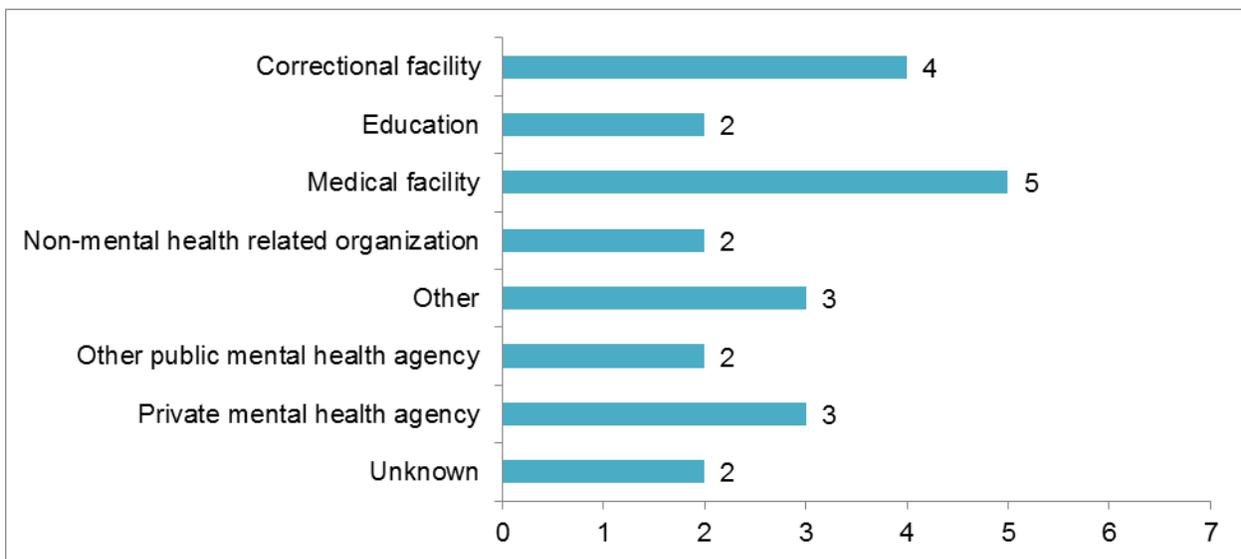


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Large Counties

Figure 89 describes large county size departure agencies. For large counties, medical facilities (n=5) and correctional facilities (n=4) were the most common agencies staff in hard-to-fill or hard-to-retain positions relocated to when they left their agencies. Medical and correctional facilities were not found to be popular departure agencies for small and medium counties, however, they were ranked as first most common departure agencies in Southern trends and third in statewide trends.

Figure 89: Large County Size Departure Agencies, by Count (n=8)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

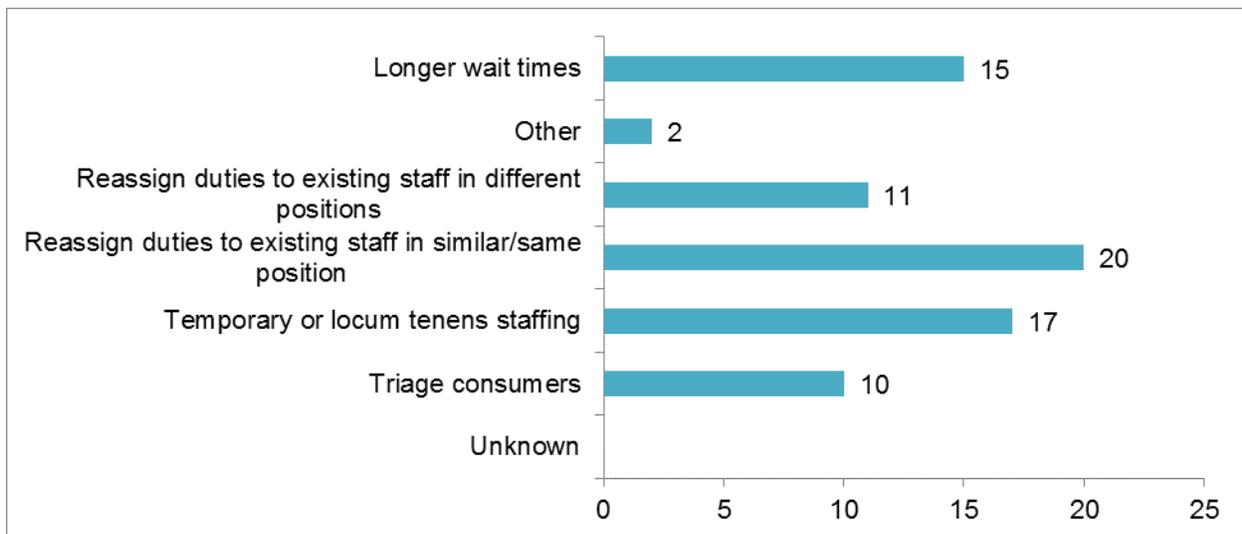
Vacancy Management

The survey asked counties how they have managed staff vacancies for the top seven hard-to-fill or hard-to-retain positions reported previously in this document. This section presents the management strategies they employed.

Statewide Trends

Figure 90 depicts statewide trends of strategies used to manage staff vacancies for the top seven hard-to-fill or hard-to-retain positions. Overall, reassigning duties to existing staff in similar/same positions was the most used strategy (n=20). Temporary or *locum tenens* staffing (n=17) and longer wait times (n=15) were also highly implemented strategies to manage staff vacancies.⁹

Figure 90: Staff Vacancy Management across California, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Trends by Region

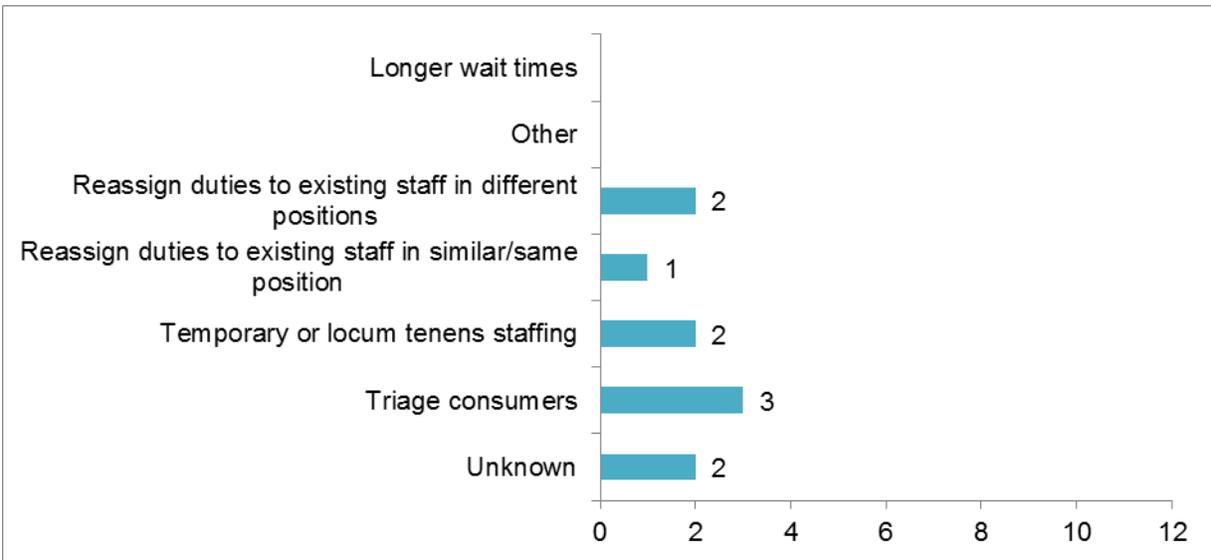
The following section describes how agencies managed staff vacancies for the top seven hard-to-fill or hard-to-retain positions by MHSA Region.

Bay Area Region

Figure 91 presents the Bay Area region's staff vacancy management strategies. The Bay Area region most frequently utilized triaging consumers (n=3), a strategy that appears in statewide trends with moderate frequency.

⁹ Locum tenens staffing refers to contracting a health professional to temporarily fill a position. The temporary health professional is considered an independent contractor and not an employee.

Figure 91: Bay Area Region Staff Vacancy Management, by Count (n=7)

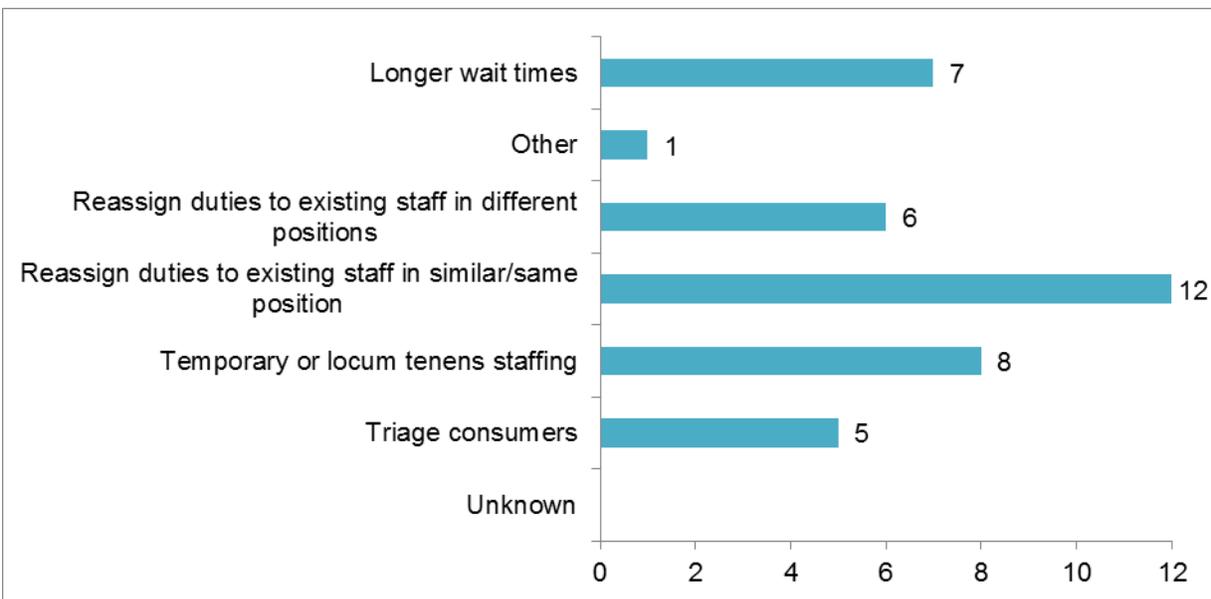


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Central Region

Figure 92 displays the Central region's staff vacancy management strategies. The most frequently cited strategy was reassigning duties to existing staff in similar/same positions (n=12). The Central region exhibited the same staff vacancy management strategy utilization order as seen in statewide trends.

Figure 92: Central Region Staff Vacancy Management, by Count (n=12)

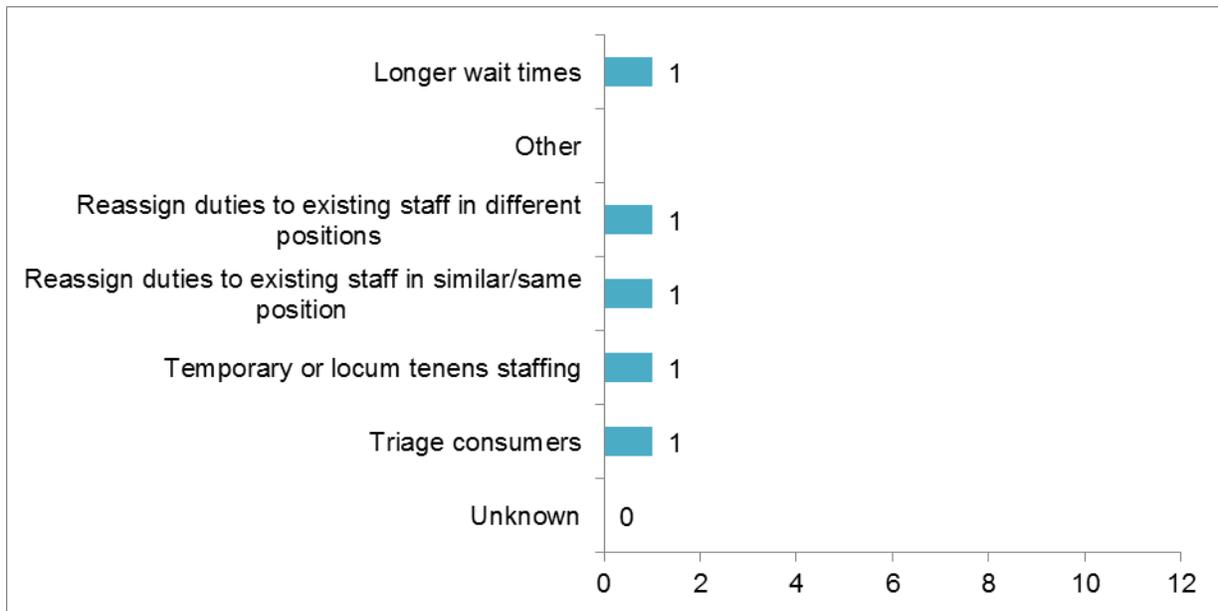


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Los Angeles Region

Figure 93 shows the Los Angeles region's staff vacancy management strategies. The Los Angeles region relied equally on five vacancy management strategies: longer wait times, reassigning duties to existing staff in different positions, reassigning duties to existing staff in similar/same positions, temporary or *locum tenens* staffing, and triaging consumers (ns=1).

Figure 93: Los Angeles Region Staff Vacancy Management, by Count (n=1)

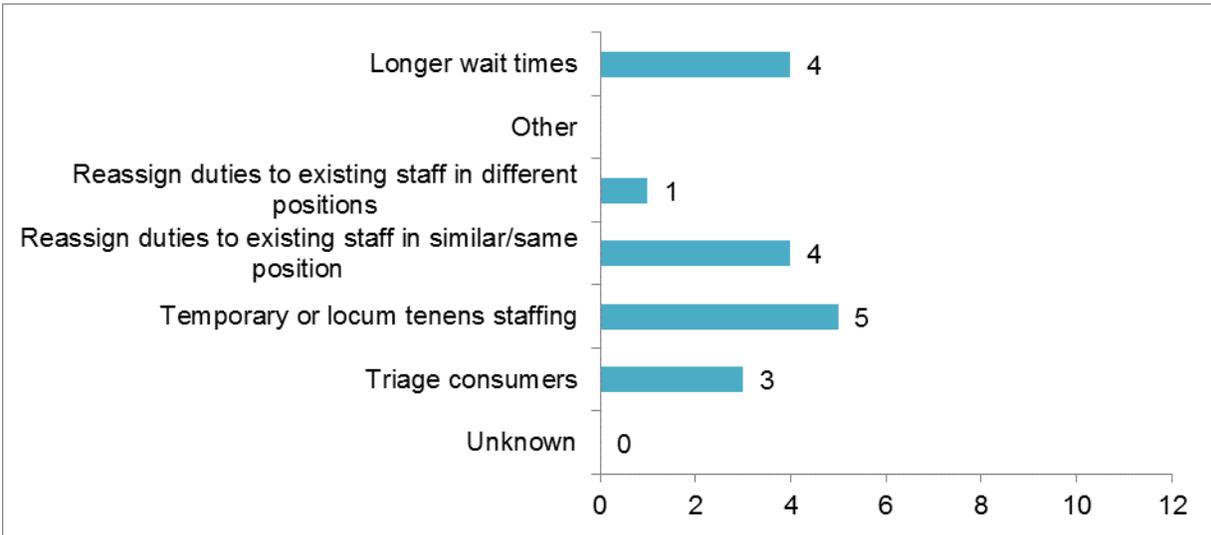


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Southern Region

The Southern region's staff vacancy management strategies are presented in Figure 94. Overall, the Southern region most employed temporary or *locum tenens* staffing to manage staff vacancies (n=5). Longer wait times (n=4), reassigning duties to existing staff in similar/same positions (n=4) and triaging consumers (n=4) were also commonly implemented. Temporary or *locum tenens* staffing was the second-most utilized strategy statewide, as well as in the Bay Area and Central regions, and tied for first-most utilized strategy in Los Angeles region.

Figure 94: Southern Region Staff Vacancy Management, by Count (n=5)

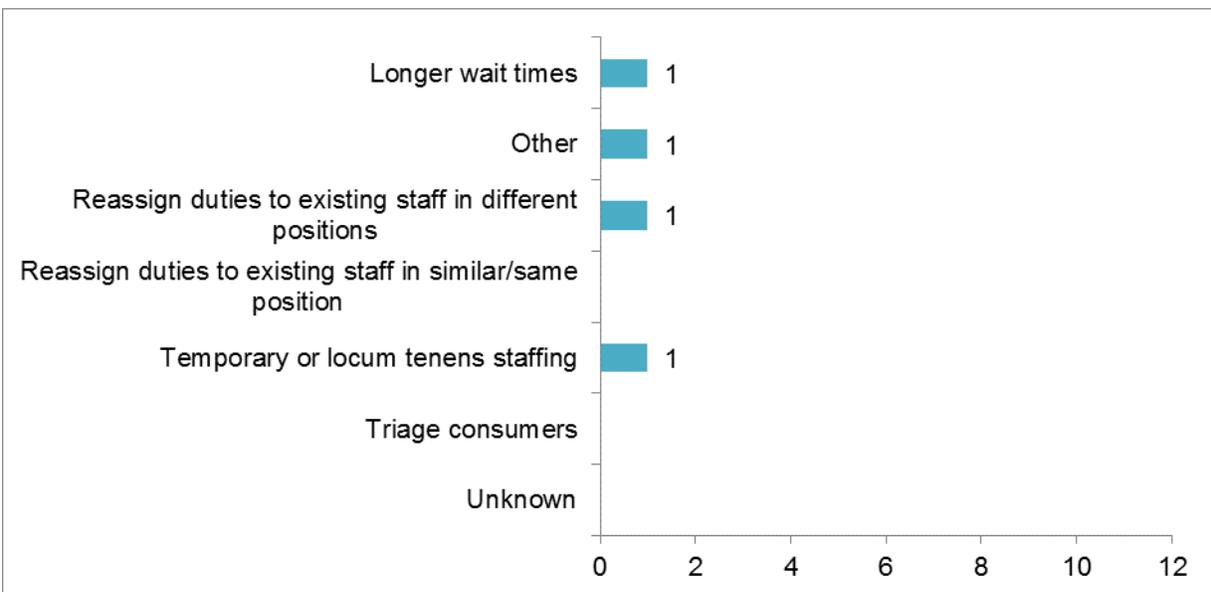


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Superior Region

Figure 95 displays the Superior region's staff vacancy management strategies. The Superior region depended equally on longer wait times, other strategies, reassigning duties to existing staff in different positions, and temporary or *locum tenens* staffing (ns=1). As with the Los Angeles region, no single strategy emerged as most utilized.

Figure 95: Superior Region Staff Vacancy Management, by Count (n=2)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

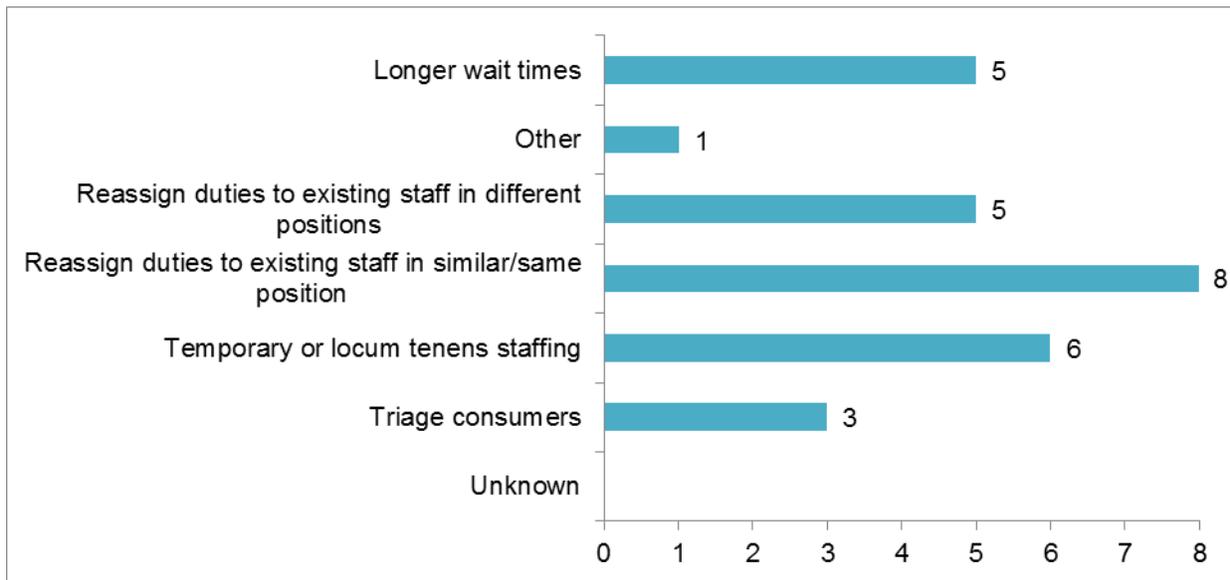
Trends by County Size

The following section describes how agencies managed staff vacancies for the top seven hard-to-fill or hard-to-retain positions, by county size.

Small Counties

Figure 96 shows small counties' staff vacancy management strategies. Consistent with statewide and Central regional trends, small counties manage staff vacancies for hard-to-fill or hard-to-retain positions by reassigning duties to existing staff in similar/same positions (n=8).

Figure 96: Small County Staff Vacancy Management, by Count (n=9)

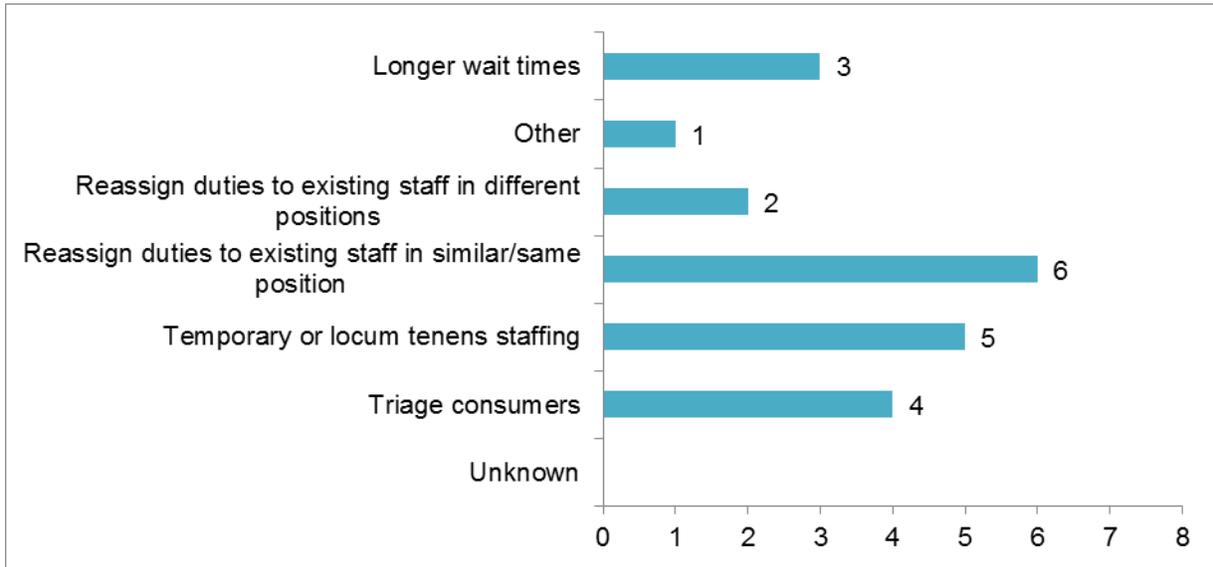


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Medium Counties

Medium county size staff vacancy management strategies are presented in Figure 97. As with statewide, Central region, and small county trends, medium counties most utilized the strategy of reassigning duties to existing staff in similar/same positions (n=6).

Figure 97: Medium County Size Staff Vacancy Management, by Count (n=7)

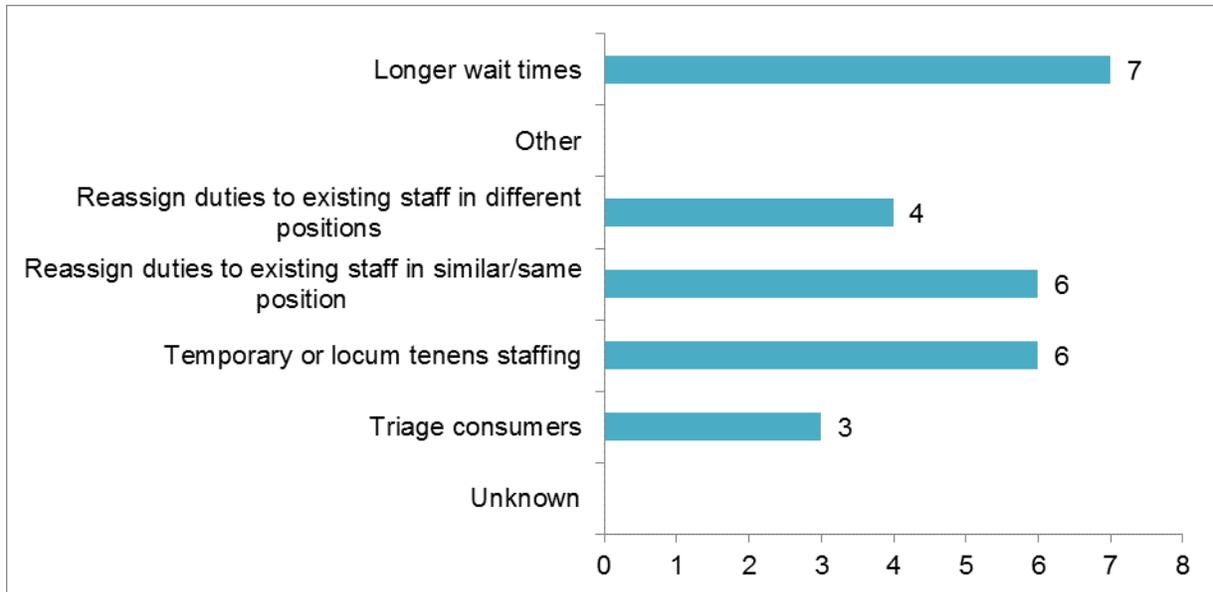


Source: OSHPD WET County Needs Assessment Follow-Up Survey

Large Counties

Figure 98 depicts large county size staff vacancy management strategies. Large counties relied heavily on longer wait times to cope with staff vacancies (n=7). They also frequently reassigned duties to existing staff in similar/same positions (n=6) and temporary or *locum tenens* staffing (n=6). These are the same top three strategies that emerged in statewide, Central and Southern region, and small county trends.

Figure 98: Large County Size Staff Vacancy Management, by Count (n=8)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Individual Hard-to-Fill or Hard-to-Retain Positions

This section presents individual analyses of the positions named as a number one, two or three hard-to-fill or hard-to-retain. The positions are listed in order of statewide hard-to-fill or hard-to-retain rankings (see Table 3), beginning with the hardest-to-fill/retain position. Positions not listed by any county as a top three hard-to-fill or hard-to-retain position were excluded from analyses: Licensed Psychiatric Technician, Occupational Therapist, and School Psychologist. Qualitative feedback is included for positions for which feedback was provided. The individual analysis for each hard-to-fill/hard-to-retain position includes county reported: number of current vacancies, reasons why positions are hard-to-fill/hard-to-retain, labor substitution and qualitative feedback by counties.

Counties were asked to estimate the number of current vacancies for each position ranked as number one, two or three hard-to-fill or hard-to-retain. Table 22 presents the total reported count of vacancies for each top three position. Reported vacancies ranged from 81 for Licensed Clinical Social Worker (the most) to one for Licensed Professional Clinical Counselor (the fewest). Current vacancies will be further described in each of the following position-specific sections.

Table 22: Vacancies by Position, by Count (n=24)

Position	Count of Reported Vacancies
Licensed Clinical Social Worker	81
Psychiatrist	67
Marriage and Family Therapist	46
Other (please specify in Comments box)	23
Child/Adolescent Psychiatrist	16
Consumer/Family Member/Peer Position	16
Psychiatric Mental Health Nurse Practitioner	13
Clinical Nurse Specialist	10
Geriatric Psychiatrist	6
Physician Assistant	3
Substance Abuse/Alcohol and Other Drug Counselor	3
Licensed Clinical Psychologist	2
Licensed Professional Clinical Counselor	1

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Child/Adolescent Psychiatrist

Number of Current Vacancies

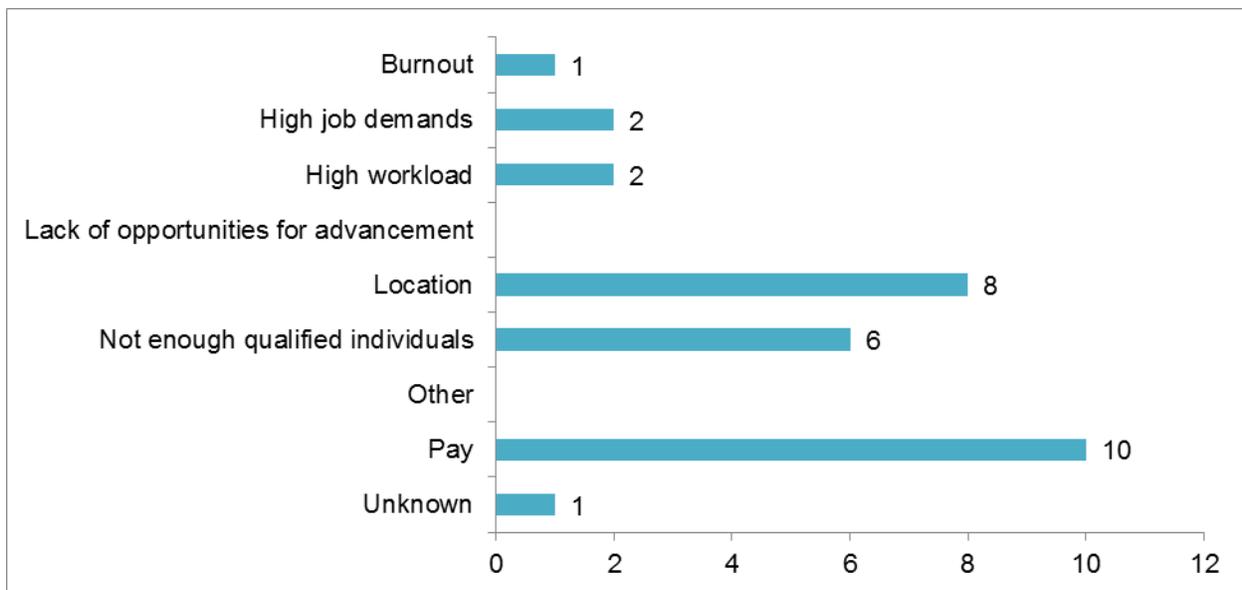
There were 16 estimated vacancies for the Child/Adolescent Psychiatrist position across 10 counties. Child/Adolescent Psychiatrist was identified as a number one hard-to-fill or hard-to-

retain position by five counties and as a number two hard-to-fill or hard-to-retain position by six counties.¹⁰

Reasons Hard-to-Fill or Hard-to-Retain

The reasons Child/Adolescent Psychiatrist positions were hard-to-fill or retain are presented in Figure 99. Pay (n=10), location (n=8), and not enough qualified individuals (n=6) were the main reasons the Child/Adolescent Psychiatrist position was hard-to-fill or hard-to-retain, reflecting the same top three reasons for the difficulty filling or retaining Psychiatrists, Licensed Clinical Social Workers, Marriage and Family Therapists, and Clinical Nurse Specialists.

Figure 99: Child/Adolescent Psychiatrist Hard-to Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 23 shows the positions employed to fill Child/Adolescent Psychiatrist vacancies. Counties primarily utilized Psychiatrists, the hardest-to-fill or retain position, to fill vacancies (n=7). Child/Adolescent Psychiatrist was listed as its own vacancy substitute (n=1).

¹⁰ One county ranked Child/Adolescent Psychiatrist as a number two hard-to-fill or hard-to-retain position but did not provide an estimate of current number of vacancies.

Table 23: Child/Adolescent Psychiatrist Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Psychiatrist	7	39%
Other	5	28%
Child/Adolescent Psychiatrist	1	6%
Clinical Nurse Specialist	1	6%
Geriatric Psychiatrist	1	6%
Nurse Practitioner	1	6%
Physician Assistant	1	6%
Psychiatric Mental Health Nurse Practitioner	1	6%
Total	18	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

Temporary, *locum tenens* staffing, and telepsychiatry services were used as Child/Adolescent Psychiatrist substitutions. However, the most frequent qualitative feedback referenced the lack of substitutions available for the Child/Adolescent Psychiatrist position due to the specialized skills inherent to that position. One county highlighted the need for local fellowship opportunities to help recruit and retain Child/Adolescent Psychiatrists.

Clinical Nurse Specialist

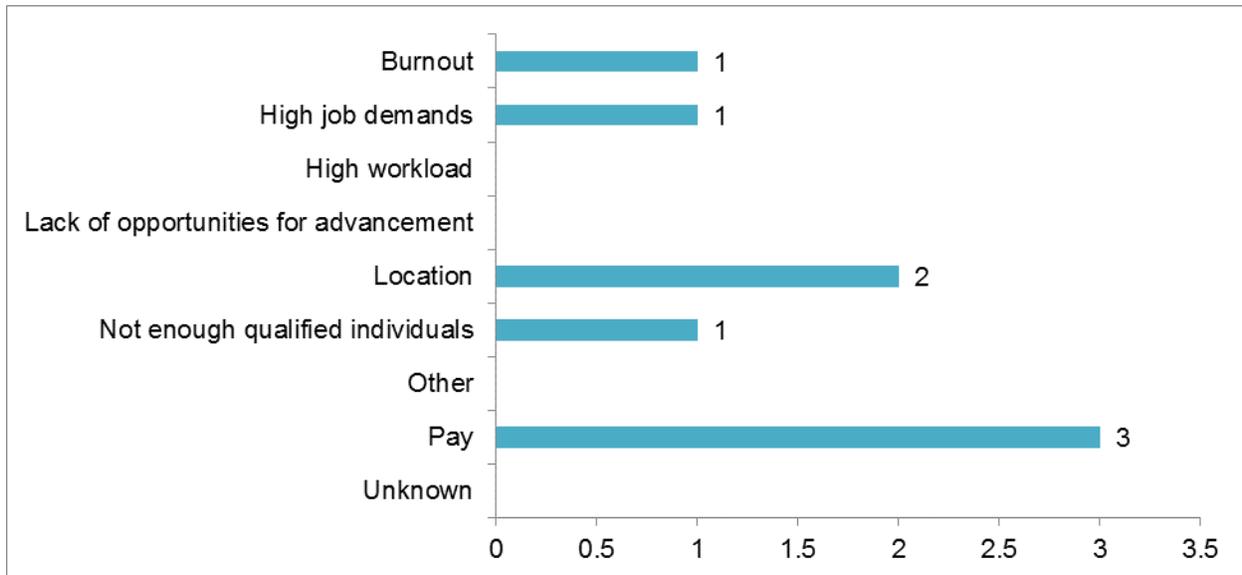
Number of Current Vacancies

There were 10 estimated vacancies for the Clinical Nurse Specialist position across three counties. Clinical Nurse Specialist was identified as a number two hard-to-fill or hard-to-retain position by two counties and as a number three hard-to-fill or hard-to-retain position by one county.

Reasons Hard-to-Fill or Hard-to-Retain

Figure 100 displays the reasons Clinical Nurse Specialist positions were hard-to-fill or hard-to-retain. The number one reason was due to pay (n=3). Pay is emerging as a primary reason for difficulty filling or retaining positions, as it has been cited as the number one reason for three of the top four (Psychiatrist, Licensed Clinical Social Worker, and Clinical Nurse Specialist; excluding Marriage and Family Therapist) hardest-to-fill or retain positions based on statewide trends.

Figure 100: Clinical Nurse Specialist Hard-to-Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 24 displays the positions employed to fill Clinical Nurse Specialist vacancies. Licensed Vocational Nurses most frequently filled Clinical Nurse Specialist vacancies (n=2), a position that had not yet emerged as a substitute for any of the three hardest-to-fill or hardest-to-retain positions analyzed above.

Table 24: Clinical Nurse Specialist Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Licensed Vocational Nurse	2	33%
Licensed Psychiatric Technician	1	17%
Nurse Practitioner	1	17%
Other	1	17%
Psychiatric Mental Health Nurse Practitioner	1	17%
Total	6	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

One county provided qualitative feedback indicating that they used temporary staffing or went without a Clinical Nurse Specialist when they experienced Clinical Nurse Specialist vacancies.

Consumer/Family Member/Peer Position

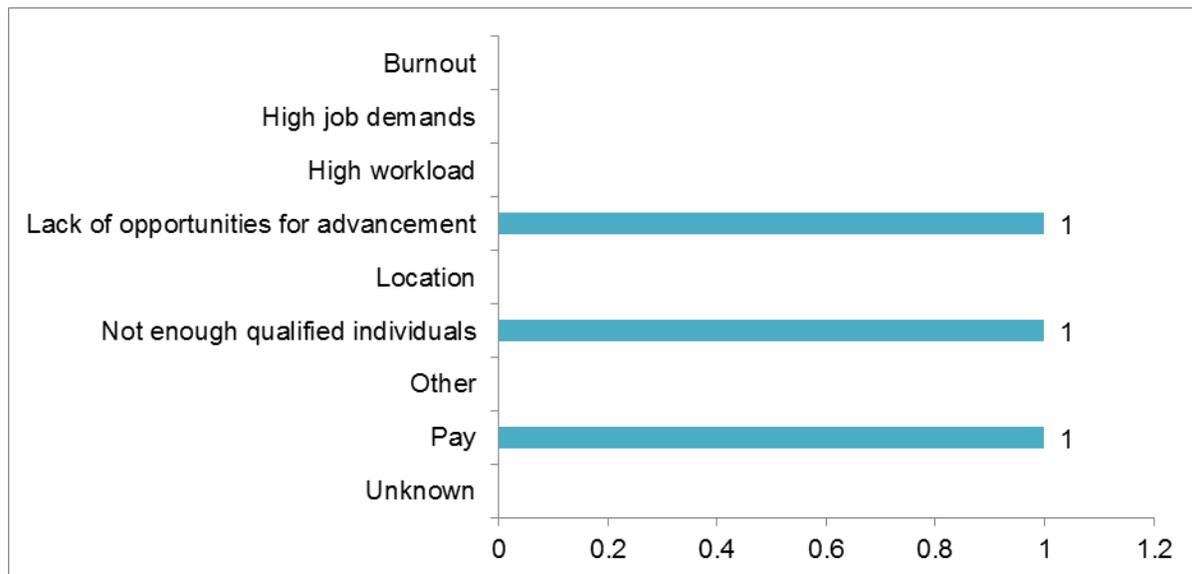
Number of Current Vacancies

There were 16 estimated vacancies for the Consumer/Family Member/Peer position across one county. This one county identified Consumer/Family Member/Peer position as a number two hard-to-fill or hard-to-retain position.

Reasons Hard-to-Fill or Hard-to-Retain

Reasons Consumer/Family Member/Peer positions were hard-to-fill or hard-to-retain are provided in Figure 101. The triad trend of lack of opportunities for advancement, not enough qualified individuals, and pay were the reasons the Consumer/Family Member/Peer position was hard-to-fill or hard-to-retain (ns=1).

Figure 101: Consumer/Family Member/Peer Position Hard-to-Fill/Hard-to-Retain Reasons by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 25 shows the single other position provided as a Consumer/Family Member/Peer position substitute. One county specified that the other positions previously used were Dependent Contractors and more recently, extra-help staff.

Table 25: Consumer/Family Member/Peer Position Substitute, by Count (n=24)

Position	Count of Responses	% of Total Responses
Other	1	100%
TOTAL	1	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

The one county that included Consumer/Family Member/Peer position as a top three hard-to-fill or hard-to-retain position commented that many applicants applying for position “don’t come from a peer perspective.”

Geriatric Psychiatrist

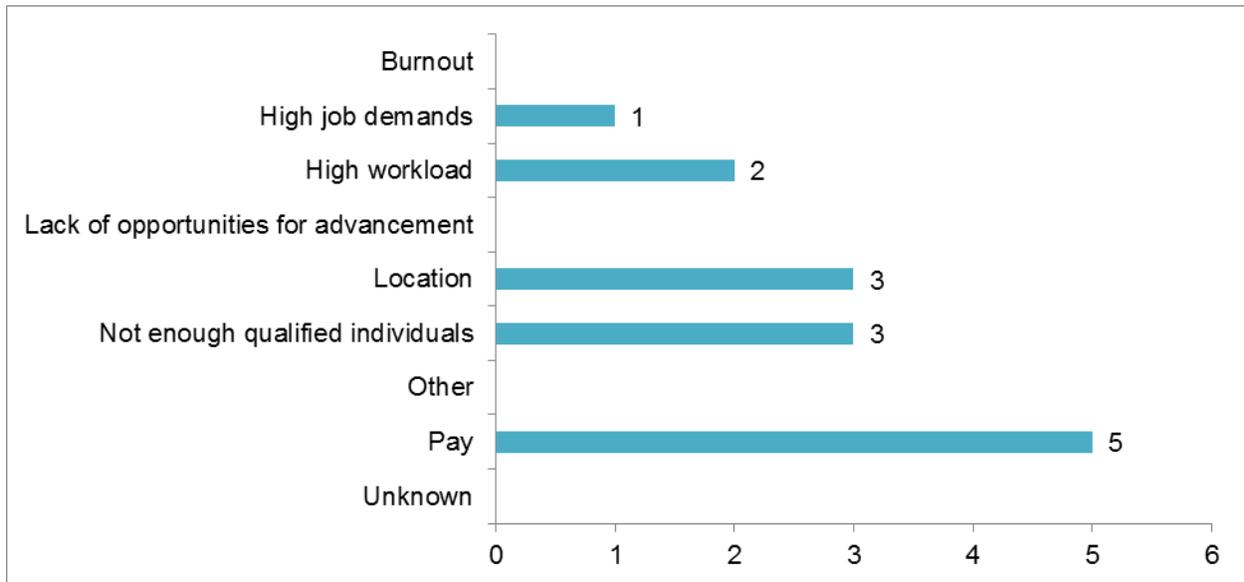
Number of Current Vacancies

There were six estimated vacancies for the Geriatric Psychiatrist position across four counties. Geriatric Psychiatrist was identified as a number two hard-to-fill or hard-to-retain position by two counties and as a number three hard-to-fill or hard-to-retain position by three counties.¹¹

Reasons Hard-to-Fill or Hard-to-Retain

Figure 102 displays the reasons the Geriatric Psychiatrist position was hard-to-fill or retain. Pay (n=5), location (n=3), and not enough qualified individuals (n=3) comprised the top three reasons, contributing to the persisting trend of pay, location, and not enough qualified individuals as the three primary reasons for difficulty filling or retaining positions.

Figure 102: Geriatric Psychiatrist Hard-to-Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 26 lists Geriatric Psychiatrist labor substitutes. Psychiatrist was employed most often to fill Geriatric Psychiatrist vacancies (n=3). There is demand for the Psychiatrist position as a labor

¹¹ One county ranked Geriatric Psychiatrist as a number three hard-to-fill or hard-to-retain position but did not provide an estimate of current number of vacancies.

substitute for all psychiatry-field positions: Child/Adolescent Psychiatrist, Psychiatrist Mental Health Nurse Practitioner, and Geriatric Psychiatrist.

Table 26: Geriatric Psychiatrist Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Psychiatrist	3	38%
Clinical Nurse Specialist	1	13%
Nurse Practitioner	1	13%
Psychiatric Mental Health Nurse Practitioner	1	13%
Registered Psychologist	1	13%
Registered Nurse	1	13%
Total	8	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

One county commented that they don't utilize any other position as a substitute due to Geriatric Psychiatrists' specialized skills. Another county observed that while they currently have no vacancies for the Geriatric Psychiatrist position, that they are expecting an increased need in 2014.

Licensed Clinical Psychologist

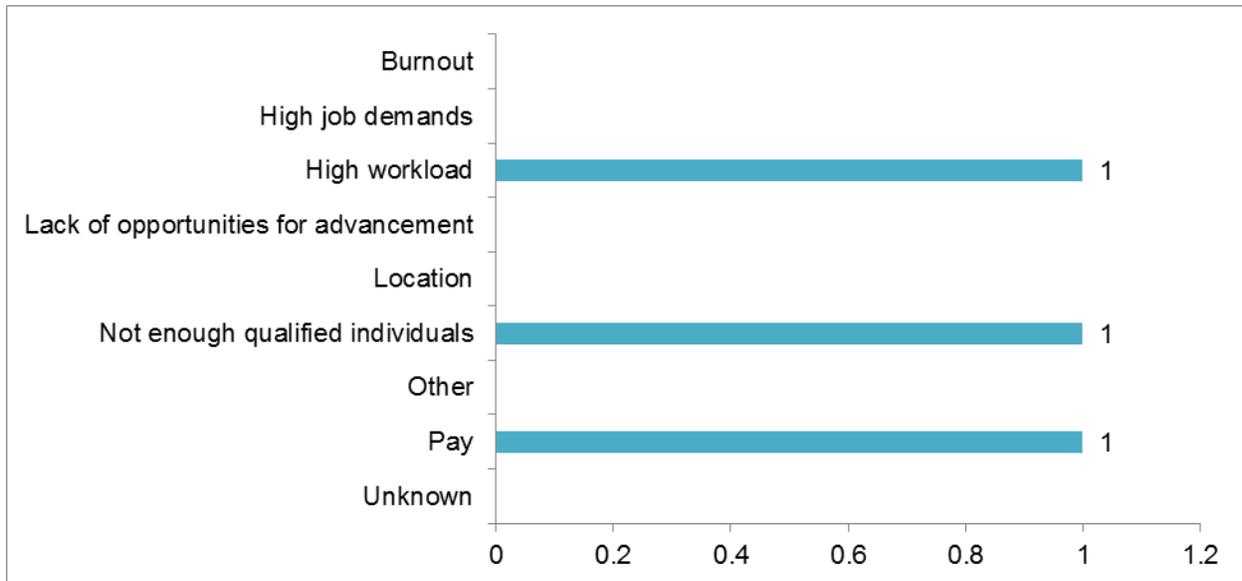
Number of Current Vacancies

There were two estimated vacancies for the Licensed Clinical Psychologist position across one county. This one county identified Licensed Clinical Psychologist position as a number one hard-to-fill or hard-to-retain position.

Reasons Hard-to-Fill or Hard-to-Retain

Figure 103 presents the reasons Licensed Clinical Psychologist positions were hard-to-fill or hard-to-retain. High workload, not enough qualified individuals, and pay (ns=1) are three of the top four reasons consistently provided for the previously mentioned mental health-related positions being hard-to-fill or hard-to-retain (location was the fourth oft-cited reason).

Figure 103: Licensed Clinical Psychologist Hard-to-Fill/Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 27 displays the positions used as Licensed Clinical Psychologist substitutes. Counties seek physician substitutes for this position, including Medical Doctors and Psychiatrists (ns=1).

Table 27: Licensed Clinical Psychologist Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Medical Doctor (not a Psychiatrist)	1	50%
Psychiatrist	1	50%
TOTAL	2	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Licensed Clinical Social Worker

Number of Current Vacancies

There were 62 estimated vacancies for the Licensed Clinical Social Worker position across 11 counties.¹² Licensed Clinical Social Worker was identified as a number one hard-to-fill or hard-

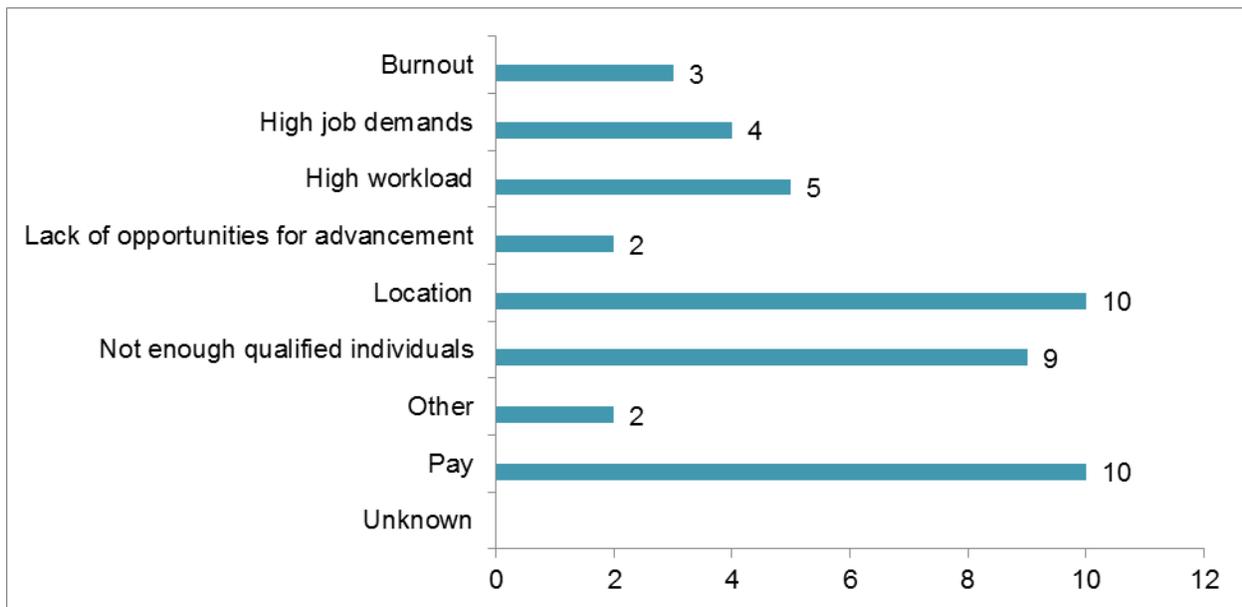
¹² One county provided a combined vacancy estimate of 38 for both Licensed Clinical Social Workers and Marriage and Family Therapists. For analysis, the combined estimated was divided in half to estimate 19 Licensed Clinical Social Workers and 19 Marriage and Family Therapists for that county.

to-retain position by three counties, as a number two hard-to-fill or hard-to-retain position by seven counties, and as a number three hard-to-fill or hard-to-retain position by two counties.¹³

Reasons Hard-to-Fill or Hard-to-Retain

Figure 104 displays the reasons Licensed Clinical Social Worker positions were hard-to-fill or hard-to-retain. Location (n=10), pay (n=10), and not enough qualified individuals (n=9) were the most common reasons; these are the same as the top three reasons Psychiatrist positions were hard-to-fill or hard-to-retain.

Figure 104: Licensed Clinical Social Worker Hard-to Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Figure 27 lists the positions used to fill Licensed Clinical Social Worker position vacancies. The top Licensed Clinical Social Worker substitutes were Associate Clinical Social Workers (n=9) and Marriage and Family Therapists (n=9), with Marriage and Family Therapist Interns following closely behind (n=7). Two comments indicated that the Licensed Clinical Social Worker position cannot be substituted by any position other than a Licensed Clinical Social Worker (n=2), however, compared to other hard-to-fill or hard-to-retain positions, Licensed Clinical Social Worker positions permit more substitute positions.

¹³ One county ranked Licensed Clinical Social Worker as a number one hard-to-fill or hard-to-retain position but did not provide an estimate of current number of vacancies.

Table 28: Licensed Clinical Social Worker Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Associate Clinical Social Worker (ASW)	9	30%
Marriage and Family Therapist	9	30%
Marriage and Family Therapist Intern (MFTi)	7	23%
Licensed Clinical Social Worker	2	7%
Licensed Clinical Psychologist	1	3%
Licensed Psychiatric Technician	1	3%
Other	1	3%
Total	30	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

Qualitative feedback noted competition with surrounding counties and urban areas as a point of difficulty staffing Licensed Clinical Social Workers. The competition is especially tough for Spanish-speaking providers. Also noted was the need for Licensed Clinical Social Workers for Medicare billing; no substitutes, other than licensed Psychologists, can bill for Medicare.

Licensed Professional Clinical Counselor

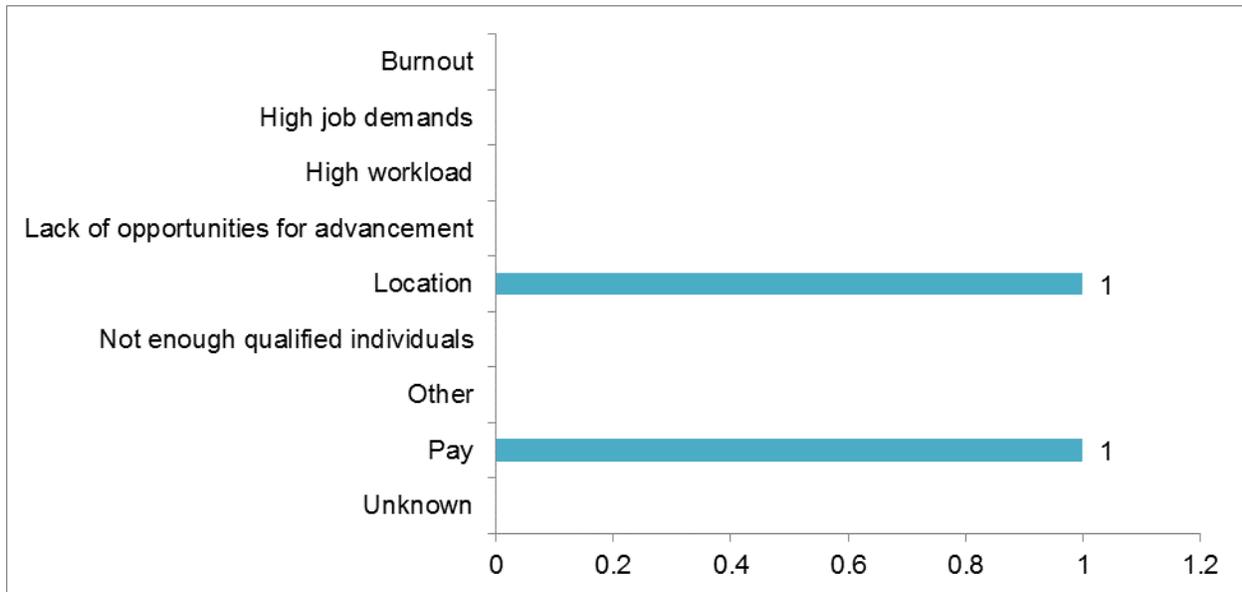
Number of Current Vacancies

There was one estimated vacancy for the Licensed Professional Clinical Counselor (LPCC) position across one county. The one county identified Licensed Professional Clinical Counselor as a number three hard-to-fill or hard-to-retain position. It should be noted that LPCC are a fairly new profession that many counties have not begun using at this point in time.

Reasons Hard-to-Fill or Hard-to-Retain

Reasons Licensed Professional Clinical Counselor positions were hard-to-fill or hard-to-retain are presented in Figure 105. Location and pay were the reported reasons (ns=1), in line with the trend of location and pay as top reasons for difficulty filling and retaining positions in general.

Figure 105: Licensed Professional Clinical Counselor Hard-to-Fill/Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Labor substitution for Licensed Professional Clinical Counselor positions is provided in Table 29. One county responded that a Licensed Professional Clinical Counselor was the only position used to substitute for a Licensed Professional Clinical Counselor vacancy (n=1).

Table 29: Licensed Professional Clinical Counselor Substitute, by Count (n=24)

Position	Count of Responses	% of Total Responses
Licensed Professional Clinical Counselor	1	100%
TOTAL	1	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Marriage and Family Therapist

Number of Current Vacancies

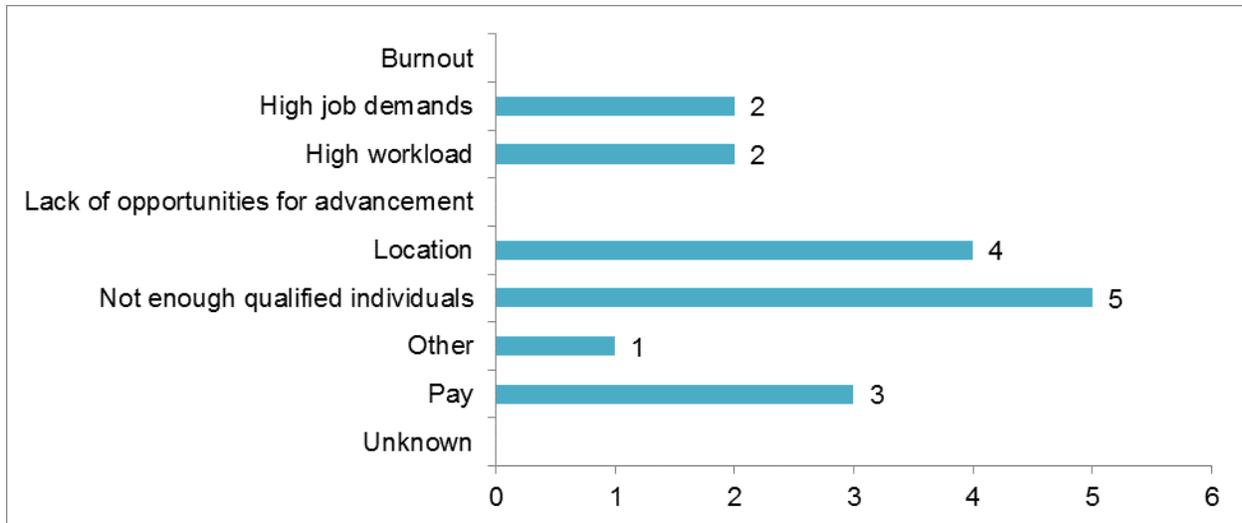
There were 27 estimated vacancies for the Marriage and Family Therapist position across six counties.¹⁴ Marriage and Family Therapist was identified as a number two hard-to-fill or hard-to-retain position by one county, and number three hard-to-fill or hard-to-retain position by five counties.

¹⁴ One county provided a combined vacancy estimate of 38 for both Licensed Clinical Social Workers and Marriage and Family Therapists. For analysis, the combined estimated was divided in half to estimate 19 Licensed Clinical Social Workers and 19 Marriage and Family Therapists for that county.

Reasons Hard-to-Fill or Hard-to-Retain

Figure 106 shows the reasons Marriage and Family Therapist positions are hard-to-fill or hard-to-retain. Congruent with Psychiatrist and Licensed Clinical Social Worker trends, lack of qualified individuals (n=5), location (n=4), and pay (n=3) were the primary reasons Marriage and Family Therapist vacancies were difficult to fill.

Figure 106: Marriage and Family Therapist Hard-to Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 30 shows the three positions used to fill Marriage and Family Therapist vacancies: Marriage and Family Therapist Interns (n=4), Associate Clinical Social Workers (n=3), and Licensed Clinical Social Workers (n=2). These positions mirror the top-three reported Licensed Clinical Social Worker labor substitutes.

Table 30: Marriage and Family Therapist Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Marriage and Family Therapist Intern (MFTi)	4	44%
Associate Clinical Social Worker (ASW)	3	33%
Licensed Clinical Social Worker	2	22%
Total	9	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

The one comment provided about the difficulty staffing Marriage and Family Therapists noted the need for bilingual Spanish-speaking Marriage and Family Therapists.

Physician Assistant

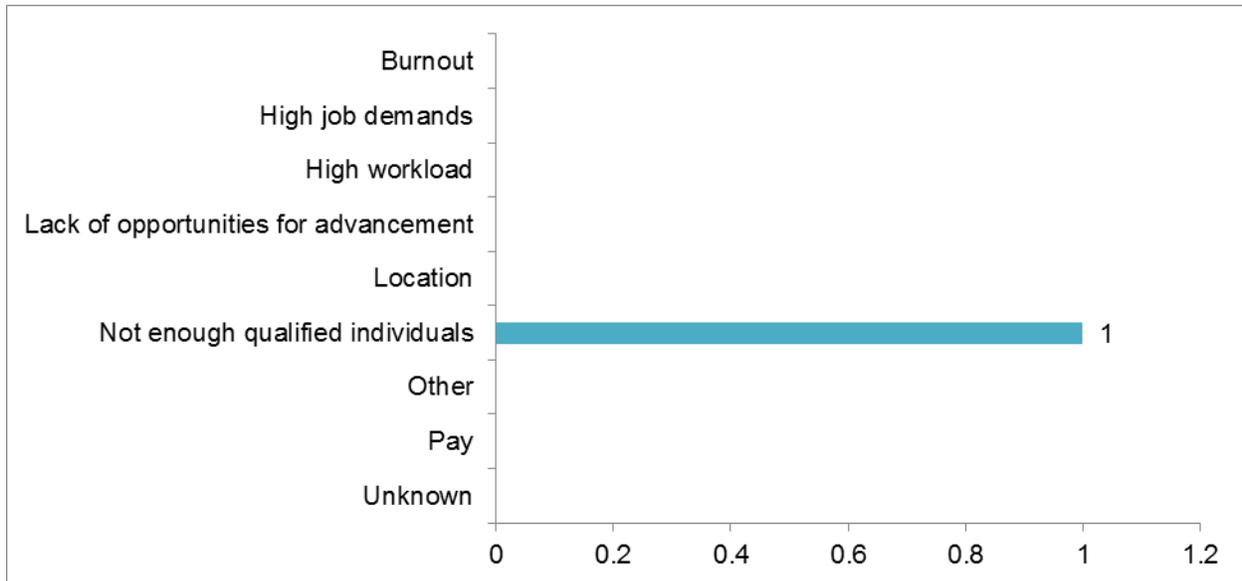
Number of Current Vacancies

There were three estimated vacancies for the Physician Assistant position across one county. The one county identified Physician Assistant as a number three hard-to-fill or hard-to-retain position.

Reasons Hard-to-Fill or Hard-to-Retain

As demonstrated in Figure 107, Physician Assistant positions were hard-to-fill or hard-to-retain due to the lack of qualified individuals (n=1), a top three reason found throughout analysis of all hard-to-fill or hard-to-retain positions.

Figure 107: Physician Assistant Hard-to-Fill/Hard-to-Retain Reason, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

None of the position answer choices provided in the survey were selected as substitutes for Physician Assistant vacancies. However, temporary or *locum tenens* staffing was noted in the comments section as utilized for Physician Assistant labor substitution.

Psychiatric Mental Health Nurse Practitioner

Number of Current Vacancies

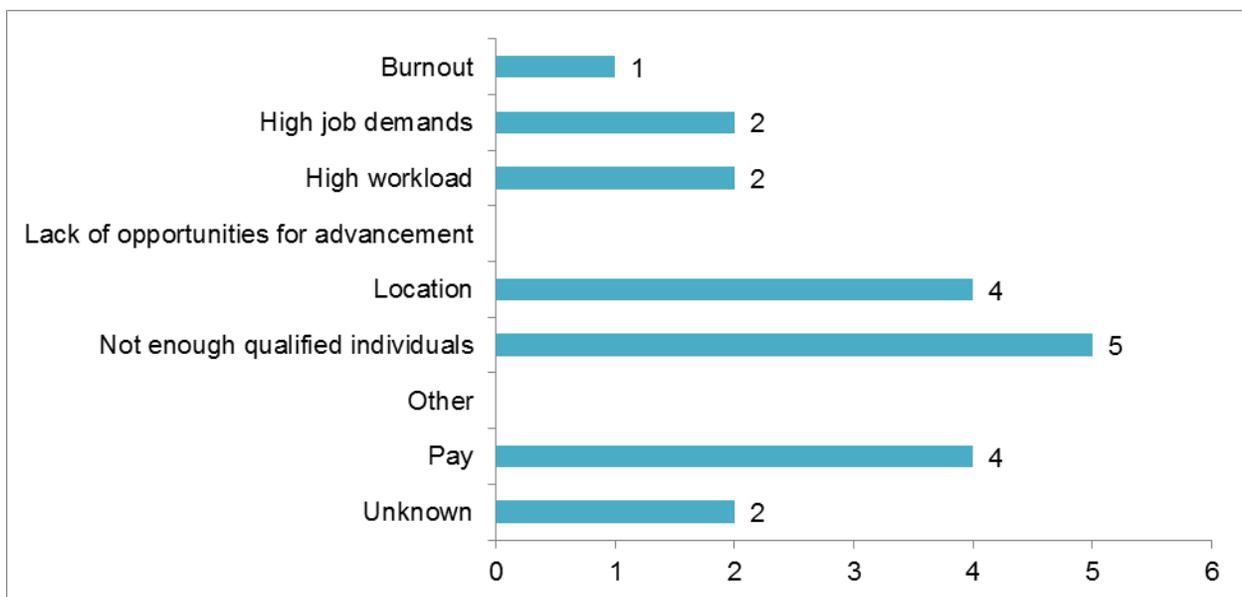
There were 13 estimated vacancies for the Psychiatric Mental Health Nurse Practitioner position across six counties. Psychiatric Mental Health Nurse Practitioner was identified as a number one hard-to-fill or hard-to-retain position by two counties, as a number two hard-to-fill or hard-to-

retain position by two counties, and as a number three hard-to-fill or hard-to-retain position by three counties.¹⁵

Reasons Hard-to-Fill or Hard-to-Retain

The reasons Psychiatric Mental Health Nurse Practitioner positions were hard-to-fill or retain are shown in Figure 108. Psychiatric Mental Health Nurse Practitioner positions were hard-to-fill or hard-to-retain primarily due to a lack of qualified individuals (n=5), location (n=4), and pay (n=4), the top three reasons consistently provided for all previously analyzed individual hard-to-fill or hard-to-retain positions.

Figure 108: Psychiatric Mental Health Nurse Practitioner Hard-to-Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 31 presents the positions used to fill Psychiatric Mental Health Nurse Practitioner vacancies. Counties used positions other than the ones noted below as Psychiatric Mental Health Nurse Practitioner substitutes the most often (n=2).

¹⁵ One county ranked Psychiatric Mental Health Nurse Practitioner as a number one hard-to-fill or hard-to-retain position but did not provide an estimate of current number of vacancies.

Table 31: Psychiatric Mental Health Nurse Practitioner Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Other	2	25%
Licensed Professional Clinical Counselor	1	13%
Licensed Vocational Nurse	1	13%
Psychiatric Mental Health Nurse Practitioner	1	13%
Psychiatrist	1	13%
Psychiatry Resident	1	13%
Registered Nurse	1	13%
Total	8	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

The difficulty staffing Psychiatric Mental Health Nurse Practitioner positions is that it is so specialized. *Locum tenens* staffing was used to staff these vacancies.

Psychiatrist

Number of Current Vacancies

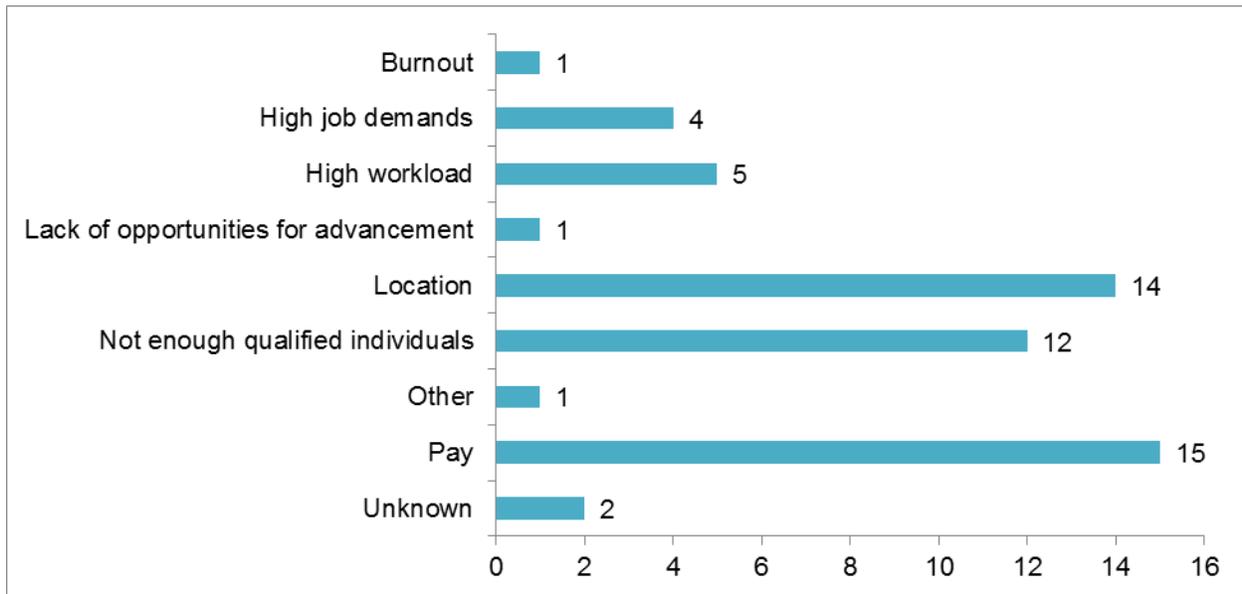
There were 67 estimated vacancies for the Psychiatrist position across 18 California counties. Psychiatrist was identified as a number one hard-to-fill or hard-to-retain position by 13 counties, as a number two hard-to-fill or hard-to-retain position by two counties, and as a number three hard-to-fill or hard-to-retain position by four counties.¹⁶

Reasons Hard-to-Fill or Hard-to-Retain

Figure 109 shows the reasons Psychiatrist positions were hard-to-fill or hard-to-retain. The top reasons that emerged were pay (n=15), location (n=14), and not enough qualified individuals (n=12).

¹⁶ One county ranked Psychiatrist as a number three hard-to-fill or hard-to-retain position but did not provide an estimate of current number of vacancies.

Figure 109: Psychiatrist Hard-to Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 32 presents the results of the survey question that asked what professionals counties use as substitutes to fill Psychiatrist positions when there have been vacancies. Responses indicated that counties mainly used Other (n=1) and Psychiatric Mental Health Nurse Practitioners (n=9) as substitutes.

NOTE: Here, and in the rest of the findings from this analysis, when counties noted “Other”, they did not follow-up that response with further clarification of what other types of positions they were referring to when marking “Other”.

Table 32: Psychiatrist Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Other	10	33%
Psychiatric Mental Health Nurse Practitioner	9	30%
Licensed Clinical Social Worker	2	7%
Nurse Practitioner	2	7%
Physician Assistant	2	7%
Child/Adolescent Psychiatrist	1	3%
Clinical Nurse Specialist	1	3%
Licensed Professional Clinical Counselor	1	3%
Marriage and Family Therapist	1	3%
Medical Doctor (not a Psychiatrist)	1	3%
Total	30	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

Qualitative feedback reflected the difficulty in filling the position with Psychiatrist alternatives; according to feedback, no other position can do the job. As a result, there is a suggested need for residency slots and assistance recruiting medical students into a career in psychiatry. Multiple counties noted the use of *locum tenens* to fill psychiatry positions. Family Nurse Practitioner and a Contract Psychiatrist were named once each as additional labor substitutes.

Substance Abuse/Alcohol and Other Drug Counselor

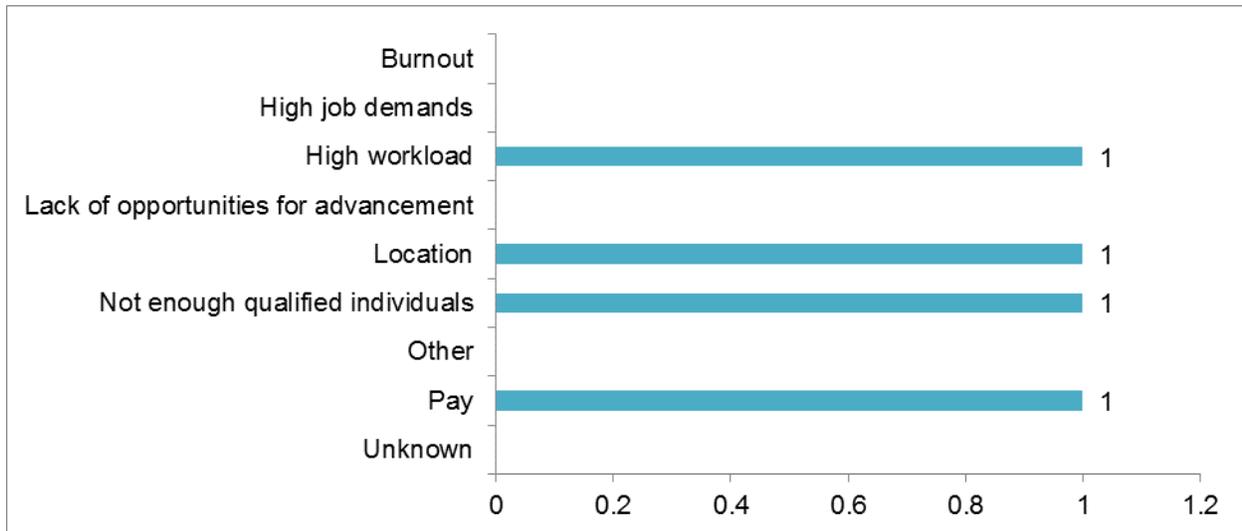
Number of Current Vacancies

There were three estimated vacancies for the Substance Abuse/Alcohol and Other Drug Counselor position across one county. The one county identified Substance Abuse/Alcohol and Other Drug Counselor as a number three hard-to-fill or hard-to-retain position.

Reasons Hard-to-Fill or Hard-to-Retain

Figure 110 shows the reasons Substance Abuse/Alcohol and Other Drug Counselor positions were hard-to-fill or retain. Four reasons were reported for difficulty filling or retaining Substance Abuse/Alcohol and Other Drug Counselor positions with equal frequency: high workload, location, not enough qualified individuals, and pay (ns=1). The placement of these four positions is consistent with the top four reasons for all previously-analyzed positions.

Figure 110: Substance Abuse/Alcohol and Other Drug Counselor Hard-to-Fill or Hard-to-Retain Reasons, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Labor Substitution

Table 32 displays the Substance Abuse/Alcohol and Other Drug Counselor substitute. A Marriage and Family Therapist and a Marriage and Family Therapist Intern were most typically used to fill Substance Abuse/Alcohol and Other Drug Counselor vacancies (ns=1).

Table 33: Substance Abuse/Alcohol and Other Drug Counselor Substitutes, by Count (n=24)

Position	Count of Responses	% of Total Responses
Marriage and Family Therapist	1	50%
Marriage and Family Therapist Intern (MFTi)	1	50%
TOTAL	2	100%

Source: OSHPD WET County Needs Assessment Follow-Up Survey

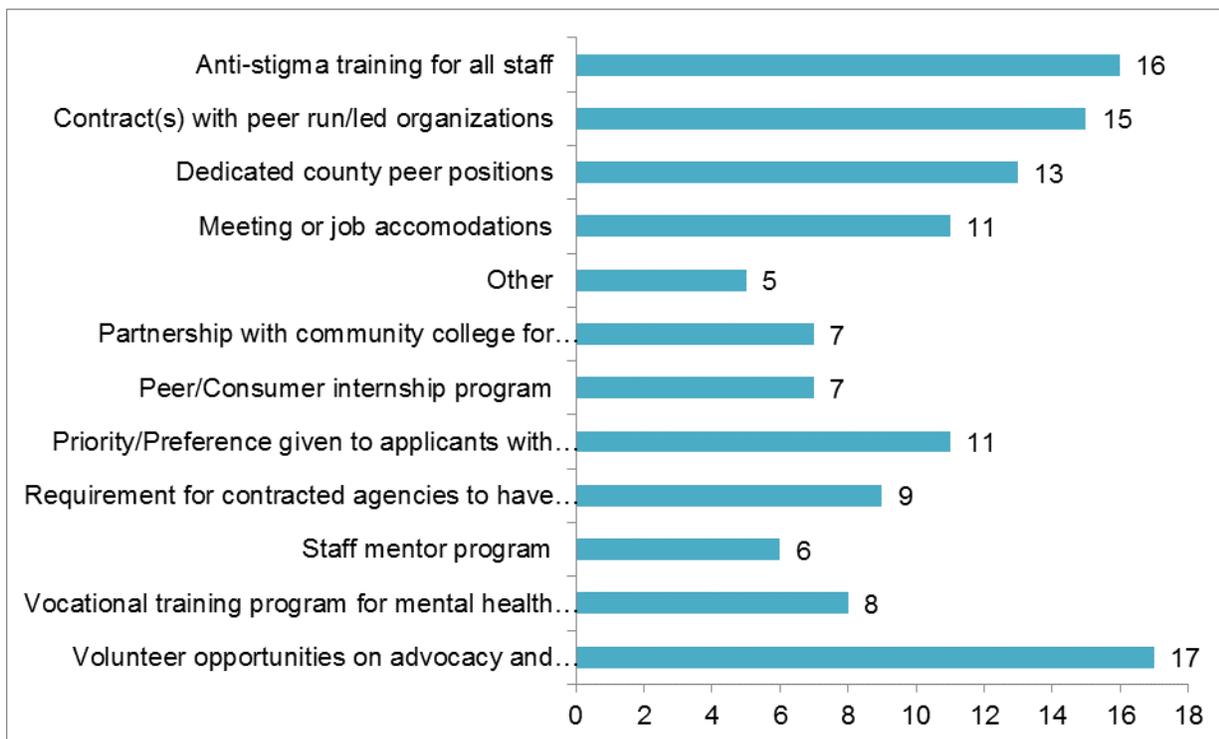
Recruitment, Orientation, and Training Strategies for Consumer and Family Members and Paraprofessionals

The OSHPD WET County Needs Follow-Up Survey asked counties to further describe the strategies they have used to recruit, orient, and train consumers and family members for county positions. The statewide trend of such strategies is presented in Figure 111.

Statewide Trends

Figure 111 demonstrates the statewide strategies identified to recruit, orient, and train consumers and family members for county positions. The most commonly-employed strategies were: volunteer opportunities on advocacy and other boards (n=17), anti-stigma training for all staff (n=16), and contract(s) with peer run/led organizations (n=15). The other reported strategies involved client leadership training, public speaking training for peers and family members, and consumer training programs.

Figure 111: Recruitment, Orientation, and Training Strategies across California, by Count (n=24)



Source: OSHPD WET County Needs Assessment Follow-Up Survey

Qualitative Feedback

Qualitative feedback emphasized the importance of finding ways to provide stipend for consumers and family members as well as finding ways to integrate consumers into working roles that are beyond entry-level counseling positions to create confidence and motivation to increase skills.

Synthesis of Findings

The distribution of California's hard-to-fill or hard-to-retain positions and the factors that influence and relate to such positions generate many interesting findings. Examination of the data by state level, MHSA Region, and county size provides cross-sections of the data that can

be compared throughout the topic areas. Cross-cutting findings contribute to increased understanding of California's public mental health workforce needs. Several key findings emerged from this county needs follow-up survey across three categories: (1) hardest-to-fill or hardest-to-retain positions; (2) county needs for hard-to-fill or hard-to-retain positions; and (3) consumer and family member positions.

Hardest-to-Fill or Hardest-to-Retain Positions

- **Statewide, Psychiatrist was noted as the hardest-to-fill or hardest-to-retain position.** Psychiatrist was cited most often by counties as a hard-to-fill or hard-to-retain position, followed by Licensed Clinical Social Worker and Marriage and Family Therapist. Clinical Nurse Specialist, Child/Adolescent Psychiatrist, and Psychiatric Mental Health Nurse Practitioner, the fourth, fifth, and sixth-ranked hard-to-fill or hard-to-retain positions, respectively, received nearly even response counts. Geriatric Psychiatrist, receiving significantly fewer responses, completed the top seven hard-to-fill or hard-to-retain position list.
- **The Central region's identification of top seven hard-to-fill or hard-to-retain positions was consistent with the statewide trends.** Despite different rank orders, the Central region cited the same seven positions the state identified as hard-to-fill or hard-to-retain. The Los Angeles region and medium and large counties each matched six of the state's top seven hard-to-fill or hard-to-retain positions and the Bay Area, Southern, and Superior regions and small counties each matched five positions. Four positions accounted for all eleven discrepancies between the region and county size top seven lists and that of the state: Consumer/Family Member/Peer Position (n=3), Licensed Clinical Psychologist (n=3), Licensed Psychiatric Technician (n=3), and Substance Abuse/Alcohol and Other Drug Counselor (n=2).
- **Psychiatrist, Licensed Clinical Social Worker, and Marriage and Family Therapist were the state's number one, two, and three hardest-to-fill or hardest-to-retain positions, respectively.** Individual analysis of the number one, two, and three hard-to-fill or hard-to-retain positions corroborated the earlier finding that Psychiatrist, Licensed Clinical Social Worker, and Marriage and Family Therapist were the state's three hardest-to-fill or hardest-to-retain positions.
- **Pay was the primary reason staff vacated hard-to-fill or hard-to-retain positions.** Throughout the state, all regions except for the Los Angeles region, and all county sizes, pay was the number one – or tied for number one – given reason for leaving a hard-to-fill or hard-to-retain position.
- **Staff most frequently left for private mental health agencies.** Excluding the "other" category, private mental health agencies were the most named departure agency. This trend emerged at the state level, across two of the five MHSA regions (Central and Superior), and across two of the three county sizes (small and medium). In the Southern region, private mental health agencies tied with three other agencies as the most common departure agency.
- **Reassigning duties to existing staff in similar/same positions was the number one strategy employed to manage staff vacancies across the state.** Other strategies, in

descending order of statewide utilization, were: temporary or *locum tenens* staffing, longer wait times, reassigning duties to existing staff in different positions, triaging consumers, and other strategies. Two MHSA regions (Central and Los Angeles) and two county sizes (small and medium) also named reassigning duties to existing staff in similar/same positions as their number one strategy. The Southern region and large counties included reassigning duties to existing staff in similar/same positions as a top three strategy.

County Needs for Hard-to-Fill or Hard-to-Retain Positions

- **When examined in aggregate, twelve positions made up the number one, two or three hard-to-fill or hard-to-retain positions.** The 12 positions, listed in order of statewide hard-to-fill or hard-to-retain rankings, beginning with the hardest-to-fill/retain were: Psychiatrist, Licensed Clinical Social Worker, Marriage and Family Therapist, Clinical Nurse Specialist, Child/Adolescent Psychiatrist, Psychiatric Mental Health Nurse Practitioner, Geriatric Psychiatrist, Substance Abuse/Alcohol and Other Drug Counselor, Consumer/Family Member/Peer Position, Licensed Clinical Psychologist, Licensed Professional Clinical Counselor, and Physician Assistant.
- **The most estimated statewide vacancies were associated with the Psychiatrist position.** Estimated vacancies ranged from 67 for Psychiatrists to one for Licensed Professional Clinical Counselor.
- **Labor substitution for hard-to-fill or hard-to-retain positions was especially difficult due to the specialized nature of many of the positions.** The overwhelming comment regarding substituting positions for hard-to-fill or hard-to-retain position vacancies was the inability to substitute as a result of the specialized skillset required with exceptions.

Consumer and Family Member Positions

- **A diverse range of strategies was utilized statewide to recruit, orient, and train consumers and family members for county positions.** The three most employed strategies, in descending order of use, were volunteer opportunities on advocacy and other boards, anti-stigma training for all staff, and contract(s) with peer run/led organizations. Qualitative feedback highlighted the need to pay consumers and family members for their work and guide them into intermediate counseling positions.

Conclusions

This section provided an analysis of the hard-to-fill or hard-to-retain positions in California's public mental health workforce. Key findings that emerged include: (1) Psychiatrist was the most difficult position to fill or retain and had the highest number of statewide estimated vacancies; (2) staff in hard-to-fill or hard-to-retain positions most frequently left for private mental health agencies and reported pay as their primary reason for vacating such positions; (3) to cope with these vacancies, county mental health departments most relied upon reassigning duties to



existing staff in similar/same positions; and (4) vacancy management places a tremendous burden on county mental health departments. Future policy efforts should address these trends in order to enable counties to more easily hire and retain staff in positions that are crucial to the public mental health system.

Section 3: Analysis of MHSA County Annual Updates WET Sections

Introduction

This document contains a review of the Workforce Education and Training (WET) sections of the 2012-2013 MHSA County Annual Updates. The Annual Updates, developed and published online by individual counties, provide details regarding counties' plans for the use of MHSA funds and information regarding those activities that they have already implemented. Within each County's Annual Update report is a section documenting their WET-related activities and forthcoming plans – these WET-specific sections are the subject of analysis for this report. A total of 44 counties made their 2012-2013 Annual Update publically available.

The purpose of this document is to describe trends in the formats and contents of the 2012-2013 MHSA County Annual Updates. While the reports were previously standardized in formatting and content, legislative change in 2011 allowed counties to individualize their approaches to these reports to be most functional to their own county needs. The result is a very broad range of detail, formatting, and content among the Annual Updates, and consequently limitations to using the Annual Updates as standardized sources of all MHSA activities across the state.

WET Program Reporting Trends

Of the 44 counties that made their 2012-2013 Annual Update publically available, 41 counties included specific sections in their MHSA Annual Update on WET programs. All 41 counties with WET sections planned or implemented WET programs as of their 2012-2013 MHSA Annual Update submission. One additional county implemented WET programs, but did not include a WET section in their Annual Update. WET implementation was determined based on whether the county's budget summary indicated WET expenditures, whether the WET section of the Annual Update described past or current WET programs, or whether the county had completed an RFP process to decide which WET programs would receive funding.

Counties utilized various approaches to their WET sections, which were reflected in the content and its presentation. Some of the major variances include:

- WET sections varied in length from less than one page to 39 pages.¹⁷ The average length of a WET section was 4.3 pages.

¹⁷ Napa County released a 39-page addendum to their Annual Update that included a detailed account of their Workforce Needs Assessment, a summary of the potential strategies for addressing their WET needs with feedback from important stakeholders, and their three-year WET plan, which contained program descriptions, objectives, and budget justifications for each action.

- Twenty-six counties narrated WET initiatives in paragraph form, while four counties simply provided bullets, and 11 fell somewhere in between. Additionally, nine counties included tables and two counties used diagrams to highlight specific data.
- Most counties included descriptions of their WET programs, a brief summary of WET or their objectives for WET programs, and a summary of the county's WET budget.
- Counties often included the WET budget information at the end of their MHSA Annual Update along with other MHSA budget summaries while some counties included information concerning their WET budget within their WET section.

Limitation in Analysis of WET Program Reporting Trends: Due to the sheer diversity of length, detail, and style of program reporting, there is reason to believe that not all counties chose to use their Annual Update to comprehensively report on their WET programs and activities. This is the major limitation in interpreting the number or types of programs administered across the state, and should be a consideration when interpreting the next section, "Types of WET Programs Implemented."

Table 34 notes all of the specific components that were included in each county's 2012-2013 MHSA Annual Update report. The elements that were found to be included in each county's report are noted with the "X" symbol.



Table 34: 2012-2013 County MHA Annual Updates: WET Section Availability, Format, and Content

County	Annual Update Available	WET Section	Any WET Programs Planned or Implemented	Number of Pages of WET Section	Format: Paragraphs	Format: Bullets	Format: Tables	Format: Diagram	Brief Summary of WET	Outline of Goals/ Objectives	List of Programs	Program Descriptions	Proposed Changes to Implemented Programs	Description of Challenges	Budget or Funding Summary	Evaluation/Outcomes
Alameda	No															
Alpine	Yes	No	No													
Amador	No															
Berkeley City	Yes	Yes	Yes	4.5	X		X			X		X	X		X	
Butte	Yes	Yes	Yes	1		X			X	X	X					
Calaveras	Yes	Yes	Yes	1	X				X			X		X		
Colusa	No															
Contra Costa	No															
Del Norte	Yes	No	No													
El Dorado	No															
Fresno	Yes	Yes	Yes	12		X						X			X	X
Glenn	Yes	Yes	Yes	1	X							X		X	X	
Humboldt	Yes	Yes	Yes	3	X							X				
Imperial	Yes	Yes	Yes	4.5	X				X			X	X		X	
Inyo	No															
Kern	Yes	Yes	Yes	3	X				X			X				
Kings	Yes	Yes	Yes	3	X		X		X			X			X	
Lake	Yes	Yes	Yes	1	X							X				
Lassen	No															
Los Angeles	Yes	Yes	Yes	6	X		X				X	X			X	X
Madera	No															

County	Annual Update Available	WET Section	Any WET Programs Planned or Implemented	Number of Pages of WET Section	Format: Paragraphs	Format: Bullets	Format: Tables	Format: Diagram	Brief Summary of WET	Outline of Goals/Objectives	List of Programs	Program Descriptions	Proposed Changes to Implemented Programs	Description of Challenges	Budget or Funding Summary	Evaluation/Outcomes
Marin	Yes	Yes	Yes	5	X	X	X		X			X			X	
Mariposa	Yes	No	Yes													
Mendocino	Yes	Yes	Yes	< 1		X			X			X				
Merced	Yes	Yes	Yes	3	X	X		X				X				
Modoc	No															
Mono	No															
Monterey	Yes	Yes	Yes	8.5	X	X				X		X			X	
Napa	Yes	Yes	Yes	39	X	X	X		X	X		X			X	
Nevada	Yes	Yes	Yes	7.5	X	X			X	X		X			X	
Orange	No															
Placer	Yes	Yes	Yes	2.5	X				X			X				
Plumas	Yes	Yes	Yes	< 1	X				X						X	
Riverside	Yes	Yes	Yes	7.5	X				X			X			X	
Sacramento	Yes	Yes	Yes	2.5	X							X			X	
San Benito	Yes	Yes	Yes	< 1	X							X	X	X	X	
San Bernardino	Yes	Yes	Yes	4	X	X			X	X				X	X	X
San Diego	Yes	Yes	Yes	1	X	X			X			X			X	
San Francisco	Yes	Yes	Yes	5	X	X	X		X			X				
San Joaquin	Yes	Yes	Yes	1.5	X				X	X		X				
San Luis Obispo	Yes	Yes	Yes	2	X							X			X	
San Mateo	No															
Santa Barbara	Yes	Yes	Yes	< 1	X							X			X	



Office of Statewide Health Planning & Development

MHSA WET Five-Year Plan Assessment: Analysis of County-Reported Public Mental Health Workforce Needs

County	Annual Update Available	WET Section	Any WET Programs Planned or Implemented	Number of Pages of WET Section	Format: Paragraphs	Format: Bullets	Format: Tables	Format: Diagram	Brief Summary of WET	Outline of Goals/Objectives	List of Programs	Program Descriptions	Proposed Changes to Implemented Programs	Description of Challenges	Budget or Funding Summary	Evaluation/Outcomes
Santa Clara	No															
Santa Cruz	Yes	Yes	Yes	6.5	X					X		X			X	X
Shasta	Yes	Yes	Yes	3.5	X	X	X		X	X		X	X		X	
Sierra	No															
Siskiyou	Yes	Yes	Yes	1	X							X	X	X	X	
Solano	Yes	Yes	Yes	9	X	X	X					X		X	X	X
Sonoma	Yes	Yes	Yes	< 1		X					X				X	
Stanislaus	Yes	Yes	Yes	10.5	X	X	X	X		X		X			X	X
Sutter-Yuba	Yes	Yes	Yes	< 1	X							X	X	X		
Tehama	Yes	Yes	Yes	< 1	X				X							
Tri City	Yes	No	No													
Trinity	Yes	Yes	Yes	1	X							X				
Tulare	Yes	Yes	Yes	6	X					X		X	X		X	
Tuolumne	Yes	Yes	Yes	1.5	X							X			X	
Ventura	Yes	Yes	Yes	3.5	X							X	X	X	X	
Yolo	Yes	Yes	Yes	< 1	X				X			X	X		X	

Types of WET Programs Implemented

Within the WET category of funding, counties implemented five types of programs:

- 1) Career Pathway Programs;
- 2) Financial Incentive Programs;
- 3) Residency and Internship Programs;
- 4) Training and Technical Assistance; and
- 5) Workforce Staffing and Support.

Counties typically included initiatives in each of the program types. As depicted in Table 35 a plurality of counties (n=13) implemented initiatives in all five program types, while only six counties implemented initiatives in just one program type.

Table 35: Number of Types of Programs Implemented by Counties

Number of Types of WET Programs Implemented	Number of Counties
5	13
4	6
3	8
2	8
1	6

The following section summarizes the initiatives listed in each category of program based on the counties' Annual Updates.¹⁸

Workforce Staffing and Support

Workforce staffing and support involved hiring staff members or consultants to assist with planning and implementing WET programs.

- Out of 41 counties that submitted 2012-2013 Annual Updates, 24 counties planned to or spent funds on workforce staffing and support.
- Hiring a WET coordinator was the most typical initiative under workforce staffing and support.

Training and Technical Assistance Programs

Training and technical assistance programs included any training events (either one-time or ongoing) related to professional development and technical support for persons providing or receiving mental health services. The primary recipients of training and technical assistance programs included county mental health department staff, law enforcement, family members, and consumers.

¹⁸ Analysis included programs that had been implemented and later cut.

- Out of 41 counties that submitted 2012-2013 Annual Updates, 40 counties planned or implemented training and technical assistance programs.
- Trainings covered a wide variety of MHSA-related topics, such as cultural and linguistic competency and evidence-based practices.
- In-person trainings and electronic learning management systems, such as Essential Learning, were examples of the types of trainings offered.

Career Pathway Programs

Career pathway programs aimed to foster awareness of mental health careers, provide support to students who have received some training in mental health fields, and recruit young students and other potential contributors to the public mental health workforce. Many counties implementing career pathway programs also explicitly discussed goals to promote greater diversity within the public mental health system.

- Out of 41 counties that submitted 2012-2013 Annual Updates, 24 counties planned or implemented career pathway programs.
- Career pathway programs included outreach and support services for high school and undergraduate students and job training and certification programs for consumers and family members interested in mental health careers.

Residency and Internship Programs

Residency and Internship programs included any residency, fellowship, or internship programs that counties created or expanded.

- Out of 41 counties that submitted 2012-2013 Annual Updates, 22 counties planned or developed existing residency or internship programs.
- One example of a typical residency and internship program was hiring a clinical supervisor to support and oversee interns.

Financial Incentive Programs

This category included any programs where counties provided financial incentives to encourage individuals to pursue careers in the public mental health system.

- Out of 41 counties that submitted 2012-2013 Annual Updates, 25 counties planned or implemented financial incentive programs.
- Financial incentive programs typically took the form of either stipends for hard-to-fill internship positions, educational scholarships, or loan repayment programs. The Mental Health Loan Assumption Program (MHLAP) was a popular loan repayment program.

Limitation in Analysis of Types of WET Programs Implemented: This analysis of the types of WET programs implemented at the county level is limited to the information provided in the Annual Updates. While some counties provided detailed descriptions of their WET programs, it is possible that counties only reported on a sample of their administered WET programs; this limitation is also noted in the previous section, “WET Program Reporting Trends.”

Table 36: 2012-2013 County MHSA Annual Updates: WET Section Availability and Program Type

County	Annual Update Available	WET Section	Any WET Programs Planned or Implemented	Workforce Staffing Support	Training and Technical Assistance	Career Pathways Programs	Residency /Internships	Financial Incentive Programs
Alameda	No							
Alpine	Yes	No	No					
Amador	No							
Berkeley City	Yes	Yes	Yes	X	X	X		X
Butte	Yes	Yes	Yes		X	X		X
Calaveras	Yes	Yes	Yes		X			
Colusa	No							
Contra Costa	No							
Del Norte	Yes	No	No					
El Dorado	No							
Fresno	Yes	Yes	Yes	X	X	X	X	X
Glenn	Yes	Yes	Yes		X		X	
Humboldt	Yes	Yes	Yes		X			
Imperial	Yes	Yes	Yes		X			
Inyo	No							
Kern	Yes	Yes	Yes		X		X	
Kings	Yes	Yes	Yes	X	X		X	
Lake	Yes	Yes	Yes	X	X	X		X
Lassen	No							
Los Angeles	Yes	Yes	Yes	X	X	X	X	X
Madera	No							
Marin	Yes	Yes	Yes	X	X			X
Mariposa	Yes	No	Yes					X
Mendocino	Yes	Yes	Yes					
Merced	Yes	Yes	Yes		X		X	X
Modoc	No							
Mono	No							
Monterey	Yes	Yes	Yes	X	X	X		X
Napa	Yes	Yes	Yes	X	X	X	X	X
Nevada	Yes	Yes	Yes	X	X	X	X	X
Orange	No							
Placer	Yes	Yes	Yes	X	X	X	X	X
Plumas	Yes	Yes	Yes		X			X

County	Annual Update Available	WET Section	Any WET Programs Planned or Implemented	Workforce Staffing Support	Training and Technical Assistance	Career Pathways Programs	Residency /Internships	Financial Incentive Programs
Riverside	Yes	Yes	Yes	X	X	X	X	X
Sacramento	Yes	Yes	Yes	X	X	X	X	X
San Benito	Yes	Yes	Yes		X	X	X	
San Bernardino	Yes	Yes	Yes		X	X	X	X
San Diego	Yes	Yes	Yes		X	X		
San Francisco	Yes	Yes	Yes	X	X	X	X	X
San Joaquin	Yes	Yes	Yes	X	X	X		X
San Luis Obispo	Yes	Yes	Yes	X	X	X	X	X
San Mateo	No							
Santa Barbara	Yes	Yes	Yes		X		X	
Santa Clara	No							
Santa Cruz	Yes	Yes	Yes	X	X	X	X	X
Shasta	Yes	Yes	Yes		X	X	X	
Sierra	No							
Siskiyou	Yes	Yes	Yes	X	X	X		X
Solano	Yes	Yes	Yes	X	X			X
Sonoma	Yes	Yes	Yes		X		X	
Stanislaus	Yes	Yes	Yes	X	X	X	X	X
Sutter-Yuba	Yes	Yes	Yes	X	X	X	X	X
Tehama	Yes	Yes	Yes		X			
Tri City	Yes	No	No					
Trinity	Yes	Yes	Yes	X	X			
Tulare	Yes	Yes	Yes	X	X	X		
Tuolumne	Yes	Yes	Yes		X			
Ventura	Yes	Yes	Yes	X	X	X	X	X
Yolo	Yes	Yes	Yes	X	X			

Conclusion

The Workforce Education and Training (WET) sections of counties' 2012-2013 MHSA Annual Update reports contain an assortment of information. A wide breadth of elements is included in these reports, with the many counties often providing varying levels of information. Table 34 describes trends in the formats and contents of the 2012-2013 MHSA County Annual Update

reports. Additionally, the WET portions of counties' 2012-2013 MHSA Annual Update reports also provide information regarding the specific types of WET programs that counties across California are administering and/or participating in. Table 36 describes the WET programs that were present within each California county in 2012-2013.

Appendices

Appendix 1: OSHPD's 2013 County-Reported Workforce Needs Assessment Form

California's Public Mental/Behavioral Health Workforce Needs Assessment

Due July 28, 2013

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

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

Contact Information (email and phone number): _____

County: _____

GENERAL

Existing and Future Mental/Behavioral Health Workforce Shortages (Provide the top 7 mental/behavioral health workforce shortages in your county in order starting with highest need by using sample occupational categories outlined in Appendix 1):

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

6.

7.

Mental/Behavioral Health Workforce Demands Met (Does your county have occupational categories that are declining in need and/or demand? Provide the top 5 mental/behavioral health workforce occupational categories in your county that are declining in needs starting with the least need by using sample occupational categories outlined in Appendix 1):

1.

2.

3.

4.

5.

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

1.

2.

3.

4.

5.

6.

7.

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

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

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

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

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

STATEWIDE WET PROGRAMS

Stipends (Provide the top 5 mental/behavioral health workforce occupational categories that should have a statewide WET stipend program in order starting with highest need by using sample occupational categories outlined in Appendix 1):

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

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

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

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

5.

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

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

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

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

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

Statewide WET Programs (What other mental health workforce development programs should be included in the statewide WET Program?)

Statewide WET Programs (Other comments not referenced above)

OTHER

Other miscellaneous: (Provide a description of any other critical mental/behavioral health workforce needs not identified in the sections above including but not limited to supervisor needs, succession planning needs, needs for individuals with lived experience):

Appendix 1- Definitions

Mental/Behavioral Health Workforce Occupational Categories: *Unlicensed Mental Health Professional:* Benefits/Eligibility Specialist; Case Manager/Service Coordinator; Designated Consumer and/or Family Member Position, Direct Service Provider (e.g. peer specialist, peer navigators, community support workers; Designated Consumer and/or Family Member Position, Training and Education (e.g. speakers bureaus, recovery educators, peer provider training staff); Designated Consumer and/or Family Member Position, Administrative/ Policy and Planning (e.g. consumer relations managers, clerical, IT support); Designated Consumer and/or Family Member Position, Advocacy (e.g. peer advocates, patient rights advocates, community organizers,); Employment Service Staff (e.g., vocational rehabilitation specialist); Housing Support Services Staff; Mental Health Rehabilitation Specialist; Promotora; Substance Abuse Counselor (Alcohol and Other Drug Abuse Counselor); Other Non-Licensed Mental Health Staff Not listed above; *Licensed Mental Health Professional:* Clinical Nurse Specialist; Clinical Psychologist; Licensed Clinical Psychologist; Licensed Clinical Social Worker; Licensed Professional Clinical Counselors; Licensed Psychiatric Technician; Marriage and Family Therapist; Occupational Therapist; Physician Assistant; Psychologist; Psychiatrist; Psychiatrist, Child/Adolescent; Psychiatrist, Geriatric; Psychiatric Mental Health Nurse Practitioner; School Psychologist.

Diversity: Includes dimensions of race/ethnicity, gender, sexual orientation, socio-economic status, age, physical and/or mental abilities, and/or other pertinent characteristics.

Language: English; Spanish; Vietnamese; Chinese; Cantonese; Mandarin; Tagalog; Korean; Cambodian; Russian; Armenian; Khmer; Farsi; Arabic; Hmong; and Sign Language.

Appendix 2: Counties, Regions, Sizes, and Available Data

Table 37: Counties, Regions, Sizes, and Available Data

County	Region	County Size	Needs Assessment	Annual Update
Alameda	Bay Area	Large	Needs Assessment	
Alpine	Central	Small		Annual Update
Amador	Central	Small	Needs Assessment	
Berkeley City¹⁹	Bay Area	Small		Annual Update
Butte	Superior	Medium	Needs Assessment	Annual Update
Calaveras	Central	Small	Needs Assessment	Annual Update
Colusa	Superior	Small		
Contra Costa	Bay Area	Large	Needs Assessment	
Del Norte	Superior	Small		Annual Update
El Dorado	Central	Small	Needs Assessment	
Fresno	Central	Large	Needs Assessment	Annual Update
Glenn	Superior	Small		Annual Update
Humboldt	Superior	Small		Annual Update
Imperial	Southern	Small	Needs Assessment	Annual Update
Inyo	Central	Small	Needs Assessment	
Kern	Southern	Large	Needs Assessment	Annual Update
Kings	Central	Small	Needs Assessment	Annual Update
Lake	Superior	Small	Needs Assessment	Annual Update
Lassen	Superior	Small	Needs Assessment	
Los Angeles	Los Angeles	Large	Needs Assessment	Annual Update
Madera	Central	Small	Needs Assessment	
Marin	Bay Area	Medium	Needs Assessment	Annual Update
Mariposa	Central	Small	Needs Assessment	Annual Update
Mendocino	Superior	Small	Needs Assessment	
Merced	Central	Medium		Annual Update
Modoc	Superior	Small		
Mono	Central	Small		
Monterey	Bay Area	Medium		Annual Update
Napa	Bay Area	Small	Needs Assessment	Annual Update
Nevada	Superior	Small		Annual Update
Orange	Southern	Large	Needs Assessment	
Placer	Central	Medium	Needs Assessment	Annual Update
Plumas	Superior	Small		Annual Update

¹⁹ The City of Berkeley and the Tri-City Region are MHA municipalities, not counties.

County	Region	County Size	Needs Assessment	Annual Update
Riverside	Southern	Large	Needs Assessment	Annual Update
Sacramento	Central	Large	Needs Assessment	Annual Update
San Benito	Bay Area	Small	Needs Assessment	Annual Update
San Bernardino	Southern	Large	Needs Assessment	Annual Update
San Diego	Southern	Large	Needs Assessment	Annual Update
San Francisco	Bay Area	Large	Needs Assessment	
San Joaquin	Central	Medium	Needs Assessment	Annual Update
San Luis Obispo	Southern	Medium		Annual Update
San Mateo	Bay Area	Medium	Needs Assessment	
Santa Barbara	Southern	Medium		Annual Update
Santa Clara	Bay Area	Large		
Santa Cruz	Bay Area	Medium	Needs Assessment	Annual Update
Shasta	Superior	Small	Needs Assessment	Annual Update
Sierra	Superior	Small		
Siskiyou	Superior	Small	Needs Assessment	
Solano	Bay Area	Medium	Needs Assessment	
Sonoma	Bay Area	Medium		
Stanislaus	Central	Medium	Needs Assessment	Annual Update
Sutter-Yuba	Central	Small	Needs Assessment	
Tehama	Superior	Small		Annual Update
Tri City²⁰	Southern	Medium	Needs Assessment	Annual Update
Trinity	Superior	Small	Needs Assessment	Annual Update
Tulare	Central	Medium	Needs Assessment	Annual Update
Tuolumne	Central	Small	Needs Assessment	
Ventura	Southern	Large	Needs Assessment	Annual Update
Yolo	Central	Medium	Needs Assessment	

²⁰ The City of Berkeley and the Tri-City Region are MHSA municipalities, not counties.

Appendix 3: Occupational Categorizations

Table 38: Professions Categorizations

OSHDP Occupational Categories
Benefits/Eligibility Specialist
Bilingual
Case Manager/Service Coordinator
Clinical Nurse Specialist
Clinical Psychologist
Designated Consumer/Family Member, Admin/Policy
Designated Consumer/Family Member, Direct Service
Designated Consumer/Family Member, General
Designated Consumer/Family Member, Training/Education
Employment Service Staff
Housing Support Services Staff
Licensed Clinical Psychologist
Licensed Clinical Social Worker
Licensed Professional Clinical Counselors
Licensed Psychiatric Technician
Marriage and Family Therapist
Mental Health Rehabilitation Specialist
Nurse, Other
Occupational Therapist
Other Non-Licensed Mental Health Staff Not listed above
Physician Assistant
Promotora
Psychiatric Mental Health Nurse Practitioner
Psychiatrist
Psychiatrist, Child/Adolescent
Psychiatrist, Geriatric
Psychologist
School Psychologist
Spanish
Substance Abuse Counselor

Table 39: OSHPD-Designated Languages

OSHPD Designated Languages
Arabic
Armenian
ASL
Cambodian
Cantonese
Chinese
English
Farsi
Hmong
Khmer
Korean
Mandarin
Other
Spanish
Tagalog
Vietnamese

Table 40: OSHPD-Designated Diversity Categories

Any Element of:
Race/Ethnicity
Age
Gender
Language
Physical/Mental Abilities
Sexual Orientation

Appendix 4: OSHPD WET County Needs Follow-Up Survey 2013

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

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

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

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

Comments:

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

- Career change
- Involuntary termination
- Retired
- Went back to school
- Location
- Pay
- Workload
- Lack of opportunity for advancement
- Burnout
- Poor organizational fit
- Personal
- Unknown
- Other: _____

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

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

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

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

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

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

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

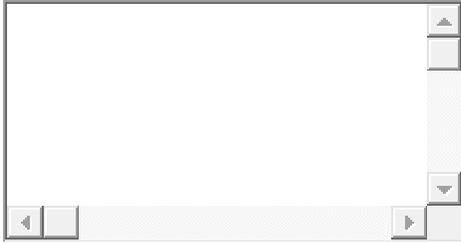
- | | |
|--|---|
| <input type="checkbox"/> Not enough qualified individuals | <input type="checkbox"/> High job demands |
| <input type="checkbox"/> Location | <input type="checkbox"/> High workload |
| <input type="checkbox"/> Pay | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Burnout | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lack of opportunities for advancement | |

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

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

Comments:

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



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

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

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

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

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

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

Comments:

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

▲
▼

◀
▶

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

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

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

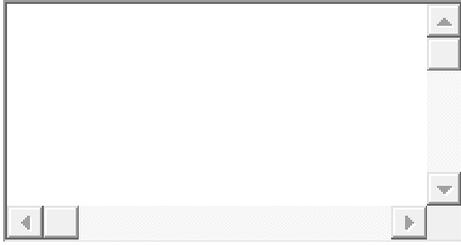
- | | |
|--|---|
| <input type="checkbox"/> Not enough qualified individuals | <input type="checkbox"/> High job demands |
| <input type="checkbox"/> Location | <input type="checkbox"/> High workload |
| <input type="checkbox"/> Pay | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Burnout | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lack of opportunities for advancement | |

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

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

Comments:

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



Consumer and Family Members as Paraprofessionals

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

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

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

Statewide WET Programs

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

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

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

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

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

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

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

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



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

Thank You!

Appendix 5: OSHPD WET Needs County Follow-Up Survey: Participating Counties and their Region and Size

Table 41: OSHPD WET Needs County Follow-Up Survey: Counties, Regions, and Sizes

County	Region	County Size
Amador	Central	Small
Butte	Superior	Medium
Calaveras	Central	Small
Contra Costa	Bay Area	Large
El Dorado	Central	Small
Inyo	Central	Small
Kern	Southern	Large
Kings	Central	Small
Los Angeles	Los Angeles	Large
Mariposa	Central	Small
Mendocino	Superior	Small
Placer	Central	Medium
Riverside	Southern	Large
Sacramento	Central	Large
San Benito	Bay Area	Small
San Bernardino	Southern	Large
San Joaquin	Central	Medium
San Mateo	Bay Area	Medium
Santa Barbara	Southern	Medium
Santa Clara	Bay Area	Large
Stanislaus	Central	Medium
Sutter-Yuba	Central	Small
Tulare	Central	Medium
Ventura	Southern	Large